Community
Underwriting

Community Underwriting Personal Accident Claim Form

About the Insurer

Calliden Insurance Limited (us/we/our) (Calliden) (ABN 47 004 125 268, AFSL 234438) is the insurer and issuer of this Policy and this PDS.

Calliden specialises in manufacturing general insurance products for individuals, the SME sector and groups across metro and regional Australia. To find out more about the us, visit www.calliden.com.au.

About the Agent

Community Underwriting Agency Pty Ltd (Community Underwriting) (ABN 60 166 234 715, AFSL 448274) was set up by NSW Meals on Wheels Association Inc (ABN 87 418 074 604) to specifically cater for insurance to the not for profit community sector in Australia.

This product is underwritten by Calliden Insurance Limited (Calliden) (ABN 47 004 125 268, AFSL 234438), the insurer. Community Underwriting acts under a binding authority as agent for the insurer to issue, vary and cancel policies on Calliden's behalf. In all aspects of this Policy, Community Underwriting acts as an agent for the insurer and not for you.

General Insurance Code of Practice

Calliden is a signatory to the General Insurance Code of Practice (the Code). The Code aims to raise standards of service between insurers and their customers. Calliden's service standards are in accordance with the Code.

For any information about the Code, including a copy of the Code, contact us or the Financial Ombudsman Service on 1300 78 08 08 or visit www.codeofpractice.com.au

Privacy Statement

Both Calliden (the insurer) and Community Underwriting (the agent) respect your privacy. Any personal information provided by you will be treated in accordance with the *Privacy Act 1988* (Cth). This privacy notification provides a summary of how Calliden and Community Underwriting treat your personal information.

Calliden and Community Underwriting collect your personal information to assess your request for insurance, to administer your Policy, to settle an insurance claim, provide other insurance services as requested by you, and also to notify you about other services or promotions from time to time.

If you do not provide the information requested you may breach your duty of disclosure, your claim may not be capable of being accepted, your Policy may not be able to be administered or it may be difficult to assess your claim.

In order to provide its insurance services Calliden and Community Underwriting may need to disclose your personal information to third parties including, but not limited to: agents, underwriters, advisors and brokers, claims management and other service providers, claims adjusters, loss assessors and other claims investigators, lawyers, reinsurers and reinsurance brokers, and the Financial Ombudsman Service, or as required by law (for a full list see Calliden's and Community Underwriting's Privacy Policy). Calliden and Community Underwriting may also disclose your personal information overseas. Calliden and Community Underwriting will only share this information where Calliden and Community Underwriting reasonably believe it is necessary in assessing your insurance claim and in providing the products and services requested.

Calliden's and Community Underwriting's Privacy Policies contain information about how to access and correct the personal information about you and also how to complain about a breach of privacy. If you would like additional information about privacy or would like to obtain a copy of the Privacy Policies, please contact Community Underwriting's Privacy Officer by:

Phone: +61 2 8045 2580;

Fax: +61 2 9555 1886;

Email: enquiries@communityunderwriting.com.au;

Mail: to Privacy Officer
Unit 24 Waterview Wharf, 37 Nicholson Street,
Balmain East, NSW 2041.

You can download a copy of Calliden's Privacy Policy by visiting: www.calliden.com.au/docs/PrivacyPolicy.pdf

You can also download a copy of Community Underwriting's Privacy Policy by visiting: www.communityunderwriting.com.au

GST and Insurance Requirements

If you are registered for GST purposes and have an entitlement to claim an Input Tax Credit (ITC) for GST paid on your insurance, you are required to inform your insurer, at or before the time of any subsequent claim, of the extent to which you are eligible to claim an ITC.

The amount that we are liable to pay under this policy will be reduced by the amount of any ITC that you are or may be entitled to claim for the supply of goods or services covered by that payment.

If you are liable to pay an excess under this policy, the amount payable will be calculated after deduction of any ITC that you are or may be entitled to claim on payment of the excess.

Dispute Resolution

If you think we have let you down in any way, or our service is not what you expect (even if through one of our representatives), please tell us so we can help. We are committed to resolving your complaint fairly.

We will address all complaints, except where specific circumstances apply, in accordance with Calliden's Complaints Handling Process. This process is compliant with the Insurance Council of Australia's Code of Practice. Both the Code of Practice and our Complaints Brochure, which contains a guide to our process, are available upon request.

If you have a complaint:

Step 1: On the spot, if we can!

You can contact us by:

Phone: +61 2 9551 1111;

Fax: +61 2 9551 1155;

Email: servicefeedback@calliden.com.au;

Mail: PO Box 348, Milsons Point, NSW 1565.

- If we can't resolve your complaint immediately, we will commit to responding to your complaint within 15 business days of first being notified of the complaint.
- If we need more information or more time to respond properly to your complaint we will contact you to agree an appropriate timeframe to respond.

Step 2: Internal Dispute Resolution

- If you are not happy with our response, please tell us in writing. You may escalate it as a dispute and our Internal Dispute Resolution panel (the panel) will review the matter. The panel will be independent of the person who initially considered your complaint.
- The Disputes Resolution Officer will acknowledge your dispute in writing within 2 business days of receipt and will investigate all details of your dispute and will provide you with a written response of the outcome within 15 business days of first being notified of your dispute.
- In some cases we may be unable to reach a conclusion within this timeframe, and may request a later response date. If this occurs, we will keep you informed of progress of the dispute no less than once every 10 days.

Step 3: External Dispute Resolution scheme

Should we be unable to resolve your complaint (including the IDR process referred to above) within 45 days or you are not happy with our response/handling of your complaint at any given time, you can seek an external review via our external dispute resolution scheme, administered by the Financial Ombudsman Service Limited (FOS).

This is an independent national body and its services are free to you. As a member we agree to accept the FOS' decision.

You can contact the FOS by:

Mail: Financial Ombudsman Service Ltd,
GPO Box 3, Melbourne, Victoria 3001;

Phone: 1300 78 08 08;

Fax: +61 3 9613 6399;

Website: www.fos.org.au

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Section 1 Volunteers Information

Name: ____________________

Address: ____________________ Postcode: __________

Telephone: (Work): ____________________ (Home): ____________________

Mobile: ____________________

Date of Birth: ___/___/___ Height: __________ Weight: __________ Sex: M ☐ F ☐

Normal occupation prior to disablement: ____________________

Association or Organisation you volunteer for: ____________________

Details of injury

A . Give full description of injury from which you are suffering. State when, where and how it happened. (attach extra page if required).

Type of injury:

____

____

____

____

How did injury occur?

____

____

____

____

Place where you were injured: ____________________

Date of injury: ___/___/___ Time: __________ am/pm Training: Yes ☐ No ☐ Playing: Yes ☐ No ☐

B. 1) Have you ever had this, or a similar condition in the past? Yes ☐ No ☐

2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if insufficient space).

Condition(s):

____

____

____

____

Date: ___/___/___ Treated by: ____________________

To be completed by the Association/ Organisation. Please ensure that all questions have been fully answered.

Name of Volunteer: ____________________ was injured as stated.

Name of Association/ Organisation: ____________________

Name of person completing this form: ____________________ Telephone: __________

Position of person completing this form: ____________________

Address of Association: ____________________

____________________ Postcode: __________

I HEREBY CERTIFY THAT the particulars shown on this form are, to the best of my knowledge, true and correct.

Signature: ____________________ Date: ___/___/___

Witness: ____________________ Date: ___/___/___

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Section 2 — Details of Non Medicare Expenses Claimed

NB. Only forward accounts for services which are not subject to a Medicare rebate ie. Physiotherapy, Chiropractic, Ambulance Private Hospitals, Dental etc.

Are you a member of a private health fund? Yes ☐ No ☐

If yes, which one? ______

Hospital cover: Yes ☐ No ☐ Extras covering dental, physiotherapy, etc. Yes ☐ No ☐

Date of treatment	Name of provider	Type of service	Amount	Health fund rebate	Amount claimed
a) / /					$
b) / /					$
c) / /					$
d) / /					$

When did you first consult a physician for this condition? / /

When did you become totally disabled (unable to work)? / /

When were you able to again perform part of your occupational duties? / /

If still totally disabled, when do you expect your disability to terminate? / /

When will you resume training? / /

Hospital: ______ From: / / To: / /

Address: ______

a) Give names, address and telephone numbers of all attending physicians. (Attach extra page if insufficient space)

Name	Address	Telephone

b) Give names, address and telephone numbers of usual family physicians. (Attach extra page if insufficient space)

Name	Address	Telephone

Section 3 — Loss of Income Claims

1. If self employed (please attach proof of earnings over past 12 months eg. Tax Return)

Who is your accountant? ______

Address: ______

Telephone: ______

2. If employed as a wage earner (to be completed by your employer)

I HEREBY CERTIFY THAT: ______

has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on / /

He/she has been incapacitated since / / and is expected to/did resume duties on / /

His/her gross basic salary (excluding bonuses, commission and overtime) at the date of the injury was $______ per week.

During this period of incapacity he/she received:

a) Normal pay: $ ______ From: / / To: / /

b) Sick pay: $ ______ From: / / To: / /

c) Workers compensation: $ ______ From: / / To: / /

d) Other (please specify): $ ______ From: / / To: / /

He/she has been employed since: ______

His/her sick leave entitlements at date of injury is ______ days.

Name of company: ______ Company stamp:

Address: ______

Name of Manager or Paymaster (please print): ______

Signature of Manager or Paymaster: ______

Telephone: ______ Date: / /

Section 3 | Loss of Income Claims continued

Are you claiming or entitled to claim any other form of income (eg. Department of Social Services, loss of income protection insurance, etc.)? If so, please provide details:

Declaration and Authorisation

I hereby authorise any hospital, physician or any other person who has attended me, or any employer, to furnish Calliden or its agents with any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all medical records and copies of all records of employers including verification of earnings.

I declare that I have read and understood the Privacy information and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons covered by this Form. Where personal information has been provided on someone else's behalf, that person has consented to this provision.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail.

Signature of Volunteer: ______________________ **Date:** ____ / ____ / ______
(or parent /guardian if under 18 years of age)

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Section 4 — Attending Physicians Statement

(The insured is responsible for completion of this form without expense to the Company)

Patients name: ______________________ Sex: M ☐ F ☐

Address: ______________________

What is disabling patient? (please give a complete diagnosis of this condition)

____

____

____

History

1. When did patient first receive medical treatment? ___/___/___
2. Was there a previous history of this or a similar condition? Yes ☐ No ☐

If yes, please state condition and advise when previous treatment given.

____

____

____

____

____

3. a) How long have you known the patient? ______________________

   b) Are you the regular general practitioner? Yes ☐ No ☐

   If no, please advise who is: ______________________

If Injury

1. When did patient suffer the injury? ___/___/___
2. What were the circumstances surrounding the injury?

____

____

____

____

____

If Disability

1. Patients occupation? ______________________
2. When was patient obliged to cease work? ___/___/___
3. Is patient still disabled, when will the patient be able to commence any type of employment?

   a) Some duties: ______________________ b) Full duties: ______________________

4. If patient has recovered, when was patient able to resume?

   a) Some duties: ______________________ b) Full duties: ______________________

Treatment of present condition

1. When were you initially consulted?

   a) Initially? ___/___/___ b) Most recently? ___/___/___

2. How often has the patient consulted you? ______________________
3. Was the patient confined to hospital? Yes ☐ No ☐

   If yes, please advise. Hospital name: ______________________

   Address: ______________________

   Period of confinement: From ___/___/___ To ___/___/___

4. Was confinement in a convalescent home necessary after hospitalisation? Yes ☐ No ☐

   If yes, please give details:

____

____

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Treatment of present condition (cont'd)

5. What are the current subjective symptoms?

6. Please give results of any objective finding:
   a) X-rays

   b) Other test - Please advise test done and findings:

7. What surgical procedures have been performed?

8. What surgical procedures have been contemplated?

9. What other treatment has the patient undergone?

10. What other treatment is required?

11. Are there any underlying conditions affecting recovery from the current condition? Yes ☐ No ☐
    If yes, please advise nature of underlying conditions and how they affect disability and recovery?

12. Has the patient any other physical or mental impairment? Yes ☐ No ☐
    If yes, please describe:

13. Please advise names and addresses of other treating physicians.

Name	Address	Telephone

14. If you have terminated treatment please advise date: ____/____/____
15. What is your current prognosis?

16. Is there any further remarks which may assist in assessing this condition?

17. Is there any permanent disability present? Yes ☐ No ☐
    If yes, please explain giving estimated percentage of loss function.

Name: ______________________ Telephone ______________

Address: ______________________ Postcode ______________

Signature: ______________________ Date: ____/____/____

Degree: ______________________

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