Protecting and supporting your community

Personal Accident/Illness
Claim Form

Claim Form or Notification of a circumstance that could give rise to a claim.

IMPORTANT NOTICE TO POLICY HOLDER.
It is essential that this form be returned directly to Ansvar Insurance, with all questions answered, at the earliest opportunity. Please print your answers and ☑ where appropriate.

Please provide copies of all out of pocket expenses incurred directly from the incident. All claims must be supported by the medical evidence obtained at the Claimant's expense.

Please note that the Health Insurance Act 1973 does not permit Ansvar Insurance Limited to contribute to any charges covered by Medicare. (This includes a Medicare gap payment).

Policyholder details

Name of Policy Holder:

Policy Number:

Registered Business Name:

Tick this box if your registered business name is the same as the policy holder's name: ☐

Australian Business Number (ABN) if applicable:

Are you registered for GST? Yes ☐ No ☐

Is the amount claimed less than 100% of the GST applicable to the premium? Yes ☐ No ☐ Specify the percentage amount claimed? ☐ %

Your Registered Address:

State:

Post Code:

Contact details of persons notifying us of this claim:

Contact Name:

Title/ Occupation:

Telephone (Direct Line):

Telephone (Mobile):

Email:

Your Broker's Contact details:

Name of Broker:

Contact Person:

Brokers reference:

Telephone Number:

Email Address:

Incident Details

Date of Incident ☐ / ☐ / ☐

Time (specify am/pm)

Location of Incident

Date reported to you ☐ / ☐ / ☐

Describe exactly how the accident occurred:

If insufficient room, use space on back of form or attach separate sheet.

Nature and extent of the injury:

Personal Details

Claims must be supported by the medical evidence obtained at your expense. Kindly note that the Health Insurance Act 1973 does not permit Ansvar Insurance Limited to contribute to any charges covered by Medicare. (This includes the Medicare gap payment).

Full name of the claimant:

Title/ Occupation:

Address:

State:

Postcode:

Telephone (Direct Line):

Telephone (Mobile):

Email:

Date of Birth:

Non Medicare Medical Expenses

Non Medicare Medical Expenses (Only complete this section if claiming for these expenses). Original accounts and receipts must be submitted together with details of recoveries from any Private Health Insurance.

Name of provider	Nature of service e.g Physiotherapy or dental etc.	Date of Service	Total Bill	Benefit Paid by Private Health Fund	Gap (Private Health Fund not Medicare)
				Total	$

Loss of Income (Only complete section if claiming Loss of Income)

Claims must be supported by a medical certificate from your doctor. Ansvar Insurance Limited is able to accept a backdated medical certificate where we have been provided with an explanation from the medical practitioner as to the reasons why the certificate has been backdated.

Will the Claimant be prevented from attending work: Yes ☐ No ☐ If YES, details please:

Dates of total disablement From: To:

Dates of partial disablement From: To:

Can compensation or benefits be claimed under Worker's Compensation or any other insurance? Yes ☐ No ☐ If YES, details please:

To the Claimant's knowledge have they sustained an injury of this type in the past? Yes ☐ No ☐ If YES, details please:

Electronic Funds Transfer

Settlement of your claim may involve a cash settlement. Please complete the following if you are interested in an EFT Payment.

Account name

Bank

BSB number

Account number

Declaration

I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information. I have read and understood the Privacy Notice below and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons covered by this claim form. Where personal information has been provided on someone else's behalf, that person has consented to the provision of this information.

Signature of insured or person with authority to sign for or on behalf of the insured:

Signature

Date / /

Name

Contact Us

Liability Claims Team:
Ansvar Insurance Limited
Level 5, 1 Southbank Boulevard
Southbank Vic 3006
Ph: 1300 650 540

All correspondence:
GPO Box 1655
MELBOURNE VIC 3001
Email: liabilityclaims@ansvar.com.au

Privacy Act

Ansvar places the highest priority on providing prompt, efficient and friendly service including the protection of your privacy.

We collect your personal information (including sensitive information) for the purposes set out in our Privacy Policy including assessing and processing claims. We generally collect personal information (including sensitive information) directly from you. In some cases, we may collect personal information from third parties e.g. medical practitioners and other health professionals.

At times we may provide your personal information to third party suppliers (agents, lawyers, other insurance companies, assessors, investigators, loss adjusters, market research and mailing houses) to perform specialised activities for us. Where the information is sensitive information (e.g. health information), we may provide this information to medical practitioners, other health professionals, other insurers and reinsurers and lawyers. We are unlikely to provide your personal information to overseas recipients.

If you do not provide the requested information, the assessment of your claim may be delayed or we may not accept the claim.

Our Privacy Policy includes further information about how we handle your personal information including how you can access and correct your information or make a privacy related complaint. For more information please visit our website: www.ansvar.com.au/privacy/ or you can contact one of our offices.