Bill Reimbursement Insurance
-Claim Form-

You must answer **ALL** questions. Where indicated please tick box ✓ as applicable.

Policy No. Period of Insurance: From / / to / /

SECTION 1:MANDATORY INFORMATION

Full Name of Insured: Surname:________________ Given Names:________________

Date of Birth: ______/______/______

Private Address:________________

Postal Address:________________

Name of Employer:________________

Occupation:________________

Telephone: Private:________________ Business:________________ Email:________________

Vehicle Details (make and model):________________ Registration No:________________

Finance Company:________________ Finance Contract No.________________

Amount of Monthly Payment:________________ Outstanding Balance:________________ Date Payment Due:________________

Reason for Claim: PLEASE TICK ONE

☐ Involuntary Unemployment — Complete Sections 2, 4 & 5

☐ Trauma & Disability — Complete Sections 3, 4 & 5

SECTION 2: INVOLUNTARY UNEMPLOYMENT CLAIM

Name of last employer: ________________

Address of last employer:________________ P/Code:________________

Was this employment Permanent, Seasonal, Casual, Contract of Service or of a specific period?________________

Date employment Commenced:______/______/______

Date employment Ceased:______/______/______

Period employed:________________

Hours worked per week:________________

Reason for termination:________________

Did you voluntarily resign? ☐ YES ☐ NO

Date you registered with Centrelink as Unemployed: ______/______/______

Date re-employment commenced: ______/______/______

Office of Commonwealth Employment Service where you registered as Unemployed:________________

Period for which you are claiming: From:______/______/______ To:______/______/______

SECTION 3: TRAUMA & DISABILITY (TO BE COMPLETED BY TREATING DOCTOR)

1.Name of Claimant:_______________

2.Occupation:_______________

3.Are you the Claimant's usual medical attendant?_______________

4.State the exact nature and extent of injuries sustained and/or illness/disabilities suffered by the Claimant (Detail organs affected etc): _______________

____

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____

5.On what date did you first attend the Claimant in connection with his/her present disablement?_______/_______/_______

6.Was there any external and visible sign of injury? ☐ YES ☐ NO

If YES, give details:_______________

7.In your opinion would the symptoms have been evident to the Claimant for any length of time?_______________

____

8.State period that the claimant:

a) will be totally unable to attend his/her usual occupation or business: From:_____/_____/_____To:_____/_____/_____

b) has been totally unable to attend his/her usual occupation or business: From:_____/_____/_____ To:_____/_____/_____

9.When did he/she or at what date do you expect that the Claimant will be able to resume:

a) some part of his/her work? From:_____/_____/_____ To:_____/_____/_____

b) the whole part? From:_____/_____/_____To:_____/_____/_____

10.Has the treatment or medicine prescribed by you been adhered to by the Claimant: ☐ YES ☐ NO

11.Are you aware of the claimant previously suffering from this condition: ☐ YES ☐ NO

If YES please provide FULL details: _______________

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12.Has the Claimant previously suffered from any illness which would have contributed to or would have accelerated the occurrence of the Claimaint's current medical condition: ☐ YES ☐ NO

If YES please provide FULL details: _______________

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GENERAL REMARKS

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Name:_______________Qualifications:_______________

Address:_______________P/Code:_______________

Signature:_______________**Date:**_____/_____/_____

SECTION 4: REQUIRED DOCUMENTATION

You must provide copies of account/invoice and evidence of payment:

- Accommodation/Rental Fees
- Body Corporate Fees, Council Rates (primary residence only)
- Cable or Satellite TV Bill
- Electricity Bill
- Gas Bill
- Health Insurance Bill
- Home & Contents Insurance Bill
- Home Mortgage (primary residence only)
- Home Phone Bill (landline)
- Internet usage Bill (excluding any connection fees)
- Mobile Phone Bill (after the deduction of any "plan" credits)
- Subscriptions to established clubs
- Union Dues or Fees
- Vehicle Insurance
- Vehicle Loan Repayment
- Vehicle Registration/CTP

Unemployment

- A copy of your separation certificate

SECTION 5: DECLARATION AND SIGNATURE OF INSURED

- I hereby declare that the information I have submitted in relation to this claim is true and correct in every particular;
- In the event that this claim references any Accident, Injury or Illness, I authorise all Medical Professionals to supply Avea Insurance with my complete medical history including fully detailed medical reports, clinical notes, examination findings, and full details of any period of incapacity that may have arisen from the condition for which treatment was sought;
- I agree to provide any information that is requested by Avea that it deems is relevant to assessing this claim; and
- I acknowledge that Avea Insurance may provide, and obtain from, other insurers and/or the Insurance Reference Bureaux personal information relating to this claim as well as claims I have previously lodged, in accordance with Avea's Privacy policy. I understand that I may request a copy of Avea's Privacy policy at any time or obtain it from Avea's website.

Signature of Insured:____ Date:______/_____/_____

Print Name: ____

(A photocopy of this authority has the same effect as the original)

RETURNING INSTRUCTIONS:

Please complete and return this form to the Postal Address below, together with all documentation requested to:

Avea Insurance Limited

PO Box 116 BERWICK VIC 3806

claims@avea.com.au

CLAIM ENQUIRIES:

Avea Insurance Limited claims officers are available to assist you with any queries relating to your claim. Please contact our Australia wide phone service on Free Call 1800 99 99 77 for assistance. If you have an unresolved complaint or dispute, you should first speak with our Operations Manager.

If you are not able to resolve your concerns with the Operations Manager, you should ask that your query be referred to Avea's Internal Disputes Department.

Avea Insurance Limited
Customer Service 1800 999 977
Email: claims@avea.com.au