Consumer Credit Insurance
-Claim Form-

INSTRUCTIONS ON HOW TO COMPLETE YOUR CONSUMER CREDIT INSURANCE CLAIM FORM

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

If you have had an ILLNESS complete Sections 1, 2, 3, 5 & 7

If you have had an ACCIDENT complete Sections 1, 2, 4, 5 & 7

If you have been UNEMPLOYED complete Sections 1, 6 & 7

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

SECTION 1: GENERAL INFORMATION

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

Date of Birth: ______/______/________

Private Address:________________

Postal Address:________________

Name of Employer:________________

Occupation:________________

Telephone: Private:________________ Business:________________ Email:________________

Finance Company:________________ Finance Contract No.________________

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

SECTION 2: GENERAL MEDICAL INFORMATION

Date of first examination or treatment by medical attendant for this occurrence:______/______/________

Name and Address of doctor who first attended you:________________

____

Name and Address of usual medical attendant:________________

____

Name and Address of the medical attendant now treating you:________________

____

Name and Address of other medical attendants for any accident or illness in the last 5 years:________________

____

Have you engaged in or attended to your usual profession, business or occupation since the date of accident or the date upon which the illness became evident (even if only in a reduced capacity)? ☐ YES ☐ NO

State dates between which you were confined:

To Bed: From:______/______/______ To:______/______/______

To House: From:______/______/______ To:______/______/______

SECTION 3: ILLNESS

What is the nature of the illness?________________

When did it first become evident?________________

Have you ever suffered from or sought treatment for the illness in respect of which you are now claiming? ☐ YES ☐ NO

If YES, give details including date you last sought treatment:________________

____

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

SECTION 4: ACCIDENT

When did the accident occur:______________________Date:________/_____/_________Time:________am/pm

State exactly how the accident occurred:____

Nature and extent of injuries: (if a limb or an eye, state whether left or right)______________________

Name and address of all witnesses of the accident

Witness #1 Name:______________________

Address:______________________

Witness #2 Name:______________________

Address:______________________

Witness #3 Name:______________________

Address:______________________

Witness #4 Name:______________________

Address:______________________

Have you suffered from or sought treatment previously for the disability in respect of which you are now claiming: ☐ YES ☐ NO

If YES, give details including date you last sought treatment:______________________

Period for which you are claiming: From:_______/_____/_____To:_____/_____/__________

PLEASE NOTE

1. If you are claiming for an accident or an illness, then Section 5 must be completed by your Medical Attendant. You are also reminded that any charge for completion of that Report must be borne by you as per the terms of your policy.
2. You signature is required in Section 7 of this form before lodgement.

SECTION 5: MEDICAL ATTENDANT'S REPORT (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 or all illness/disabilities suffered by the Claimant:____________________

____

5.What organs are affected (state whether mild or severe)?______________________________

____

6.On what date did you first attend the Claimant in connection with his/her present disablement?__________/____/______

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

If YES, give details:____

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

____

9.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:____/____/____

10.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:____/____/____

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

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

If YES please provide FULL details:__________________________________

____

13.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:__________________________________

____

GENERAL REMARKS

____

____

Name:__________________________Qualifications:__________________________

Address:____P/Code:__________

Signature:____________________________________Date:_____/____/____

SECTION 6: UNEMPLOYMENT

Name and Address of last employer: Name:____

Address:____________________________________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?____________________________________

Date you registered with Commonwealth Employment Service as Unemployed: _______/_______/__________

Date re-employment commenced: _______/_______/__________

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

Period for which you are claiming: From:________/_______/__________To:________/_______/_______

Attach a copy of separation certificate from your employer and certificates from the Commonwealth Employment

Service for the period that you were registered as Unemployed.

SECTION 7: 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:

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.