Personal Accident and/or Illness for Pastors
Claim Form

This form should be completed and returned to us via email (claims@acsfinancial.com.au) , facsimile (1300 881 552) or post.

Section A. Policy Information

Policy Number: Expiry Date: DD / MM / YYYY

Church Name:

Church Postal Address: Suburb: State: Postcode

Church Contact Name: Email:

Phone (BH): ( ) Mobile: Fax: ( )

Section B. Claimant Details

Full Name: Date of Birth: DD / MM / YYYY Male Female

Parent/Legal Guardian Name (if claimant under 18 years of age):

Residential Address Suburb: State: Postcode

Email: Phone:

Complete bank details for payments

Bank: Branch:

BSB Account No.: Account Name:

Section C. ACCIDENT - Complete only if as a result of an accident

1. Injury date and nature

Date of injury: DD / MM / YYYY Time am pm

Address where injury occured: Suburb: State: Postcode

Nature of injury:

Section C. ACCIDENT (Continued)

2. Cause and location of injury

Cause of injury:

Was this an authorised voluntary activity? Yes No

3. Witness Details

Were there any witnesses to the accident? Yes No Witness Name:

Witness Email: Witness Phone:

4. Previous Claims

Give details of any previous claim made for any previous injury against any insurance company:
(please use separate sheet if insufficient space)

Section D. ILLNESS/SICKNESS - Complete only if disability is as a result of an illness/sickness

When did the illness begin? Date: DD / MM / YYYY

Section E. Medical History

1. Have you ever had this or a similar condition in the past? Yes No If no, please proceed to Section F

If yes, how long were you disabled? Day/s Month/s Year/s

If yes, please advise us of the nature of the condition, date(s) of the treatment, name(s) and address(es) of treating doctor(s), hospital(s) and clinic(s). Use separate page if required.

Condition(s): Date: DD / MM / YYYY

Treated by: Name of Hospital/Clinic:

Section F. Treatment

1. Was hospital treatment required? ◯ Yes ◯ No

If yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From: DD / MM / YYYY **To:** DD / MM / YYYY **Hospital Name:**

Hospital Address: **Suburb:** **State:** **Postcode**

2. When did you stop work? Date: DD / MM / YYYY Time: ◯ am ◯ pm

3. When did you first obtain treatment from a doctor? Date: DD / MM / YYYY Time: ◯ am ◯ pm

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctor's Name: **Address:** **Telephone Number:**

Is this doctor still treating you for the injury/illness? ◯ Yes ◯ No

Is this doctor your regular doctor? (If no, please give details below) ◯ Yes ◯ No

Doctor's Name: **Address:** **Telephone Number:**

4. Is there any condition (past or present) affecting your current disability? (If yes, please give details below) ◯ No ◯ Yes

5. Are you now:

Fully Recovered ◯ Yes ◯ No When did you return to school or work? DD / MM / YYYY

Partially Recovered ◯ Yes ◯ No When did you return to school or work undertaking partial duties? DD / MM / YYYY

Totally Disabled ◯ Yes ◯ No When do you expect to return to school or work? DD / MM / YYYY

7. Have you made, or will you make, a claim for benefits under any Workers Compensation Act or Transportation Act because of the injury? (If yes, please give details below) ◯ No ◯ Yes

Employer: **Claim Number (if known):** **Name:**

Address: **Suburb:** **State:** **Postcode:**

Workers Comp/ Transport Insurer: **Claim Number (if known):** **Name:**

Address: **Suburb:** **State:** **Postcode:**

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Section F. Treatment (Continued)

Are you entitled to claim benefits for this injury/illness from other Insurers, Persons, Companies, Health Fund, Friendly Society or Government? (If yes, please give details below) ◯ No ◯ Yes

Name:

Address: **Suburb:** **State:** **Postcode:**

Name:

Address: **Suburb:** **State:** **Postcode:**

Please note that if you have private health insurance you must first make a claim on them.

Section G. Claimed Expenses

We are unable to process benefit payments without a confirmation of income.

1. Are you claiming medical expenses? ◯ Yes ◯ No If yes, please complete **Medical Expenses Form**

2. Are you claiming for loss of income? ◯ Yes ◯ No If yes, please complete 3 and 4 below:

THE BELOW IS TO BE COMPLETED BY AN AUTHORISED REPRESENTATIVE FROM YOUR CHURCH

I hereby certify that

has been unable to attend his/her usual occupation with the church as a result of an injury/illness as outlined in Section C or D of this form.

His/her gross salary, exclusive of bonuses, commissions, allowances, etc., at the date of injury was $ per week.

During the period of incapacity, he/she received $ from: DD / MM / YYYY to: DD / MM / YYYY

Please specify type of pay

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

Name of Company: Has been employed since: DD / MM / YYYY

Address: Suburb: State: Postcode:

Email Address:

Name of Supervisor or Paymaster: Telephone Number: ( )

Signature of Supervisor or Paymaster **Date** DD / MM / YYYY

3. Other. Please specify:

Section H. Complaints Process

ACS Financial is a broker for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute, and after talking to ACS Financial staff you are still dissatisfied and you wish to take the matter further , we have a Complaints Process which you will find at www.acsfinancial.com.au/customer-support - important information.

If you are dissatisfied with our decision or the way we handled your complaint, you may be able to refer your complaint to the Australian Financial Complaints Authority (AFCA).

Access to the Complaints Process is free of charge to you.

Section I. Privacy Statement

ACS Financial Pty Ltd (ACN 062 448 122) (AFSL 247388) (ABN 91 460 778 961) ("ACS Financial") ("we"/"us") is committed to ensuring the confidentiality and security of your personal information.

We are bound by the Australian Privacy Principles ("APPs") under the Privacy Act 1988 (Cth) regarding the way we handle your personal information.

We have implemented a Privacy Policy, under the APPs, which explains how we collect, hold, use and disclose your personal information, and how you can access and/or correct that information. Nothing in this policy limits any of our obligations at law.

You can obtain a copy of the 'ACS Group Privacy Policy' by calling 1800 646 777 or by downloading a copy at www.acsfinancial.com.au/ Customer-Support - Privacy Policy.

Your personal information is collected for the purposes set out in the ACS Group Privacy Policy and is relevant to any recommendation that you acquire or offer to arrange for the issue of an insurance policy or a mutual protection to you as well as the amount of your premiums or contributions or the assessment of any claims made by you or your personal representative. If you do not provide the full information that we request and disclose every matter that you know or could reasonably be expected to know, we may be unable to assist you with your application or if you accept insurance cover and/or mutual protections you may be in breach of your Duty of Disclosure.

Ensure that you seek permission from individuals before you provide us with their personal information, and let them know about this Privacy Statement and how they can contact us if they want to access or correct information we hold about them.

We do not trade, rent or sell your personal information. We may use your personal information to provide you with information about other products, services and special offers. If you do not want your personal information used in this way, please write or email ACS Insurance Services at insuranceservices@acsfinancial.com.au with your opt-out request and we will arrange accordingly.

Section J. Declaration

Declaration

I/We declare that:

- the information I/we have provided is true, complete and correct to the best of my/our knowledge, and I/we will inform ACS Financial should any of this information change in the future;
- the information I/we have provided includes every matter known to me/us that is relevant to the claim;
- I/We are duly authorised to act for and on behalf of the above-named organisation and have completed this form on behalf of it and all those who may be entitled to indemnity/Protection, after due enquiry of all directors or office bearers and senior staff;
- I/We authorise ACS Financial to obtain from or give to any insurer or ACS Mutual Limited (ACN 162 909 346) or insurance reference bureau or credit reporting agency any personal information relating to this or other insurance cover/Protection relating to me or the above-named organisation including claims or credit history; and
- I/We understand that I/we can obtain the ACS Group Privacy Policy, access personal information held about me/us, or raise privacy concerns by calling the ACS Group Privacy Officer on 1800 646 777, and consent to ACS Financial and its service providers using and disclosing my/our information in the way described in the Privacy Statement. Where information about a third party individual is supplied, I/we declare that the person has been made aware of that fact and of the Privacy Policy.

Section K. Authority

I hereby authorise any hospital, physician or other person who has attended to me to furnish ACS Financial or its representatives, any and all information with respect to any injury, medical history, consultation, prescriptions, or treatment, copies of all hospital and medical records as requested.

Signature _____ **Date** DD / MM / YYYY

Full Name: _____ Position Held: _____

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Medical Certificate

THE CLAIMANT MUST OBTAIN AT THEIR OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES
IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRIES

Section L.

1. Patient Details

Full Name:

Date of Birth: DD / MM / YYYY

Please give complete diagnosis of this condition:

2. History

When did the patient first receive medical treatment? DD / MM / YYYY

Is there a previous history of this or a similar condition? Yes No If yes, please provide detials:

How long have you known the patient? Day/s Month/s Year/s

Are you the regular general practitioner? Yes No If no, please advise who is:

Regular Doctor's Name: **Address:** **Telephone Number:**

3. Illness

When was the illness first contracted? DD / MM / YYYY

When did the symptoms become evident? DD / MM / YYYY

OR

4. Injury

When did the patient first suffer the injury? DD / MM / YYYY

What was the cause of the injury?

5. Degree of Disability

When was the patient obliged to cease school or work? DD / MM / YYYY

When was/will the patient be able to return to school or work?

Some duties? DD / MM / YYYY Full dutues? DD / MM / YYYY

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6. Treatment of Present Condition

When were you consulted? Initially DD / MM / YYYY Most recently DD / MM / YYYY

Was the patient confined to hospital?

No Yes From: DD / MM / YYYY To: DD / MM / YYYY If 'yes', please advise:

Name and Address of Hospital:

What other surgical or medical procedures are possibly contemplated?

Are there any underlying conditions affecting recovery from the current conditions? ◯ Yes ◯ No

If 'yes' please advise the nature of underlying conditions and how they affect disability and recovery

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Print Full Name of Medical Practitioner:

Qualifications:

Postal Address:

Suburb:

State:

Postcode

Phone (BH): ( )

Fax: ( )

Signature of Medical Practitioner

Date DD / MM / YYYY

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