Medical Practitioner's Statement to Company

The claimant is responsible for any fee for this statement. This form along with an accident claim form should be completed and returned to ACE Insurance Limited promptly.

Patient's details

Patient's full name _____

_____

Date of birth _____ / _____ / _____

Diagnosis

(If fracture or disclocation, describe nature and location ie: simple, compound)

_____

_____

_____

Does the patient have any other injury that is contributing to the condition?

☐ No ☐ Yes, give details _____

_____

_____

Was the disability accident related?

☐ No, give details ☐ Yes _____

_____

_____

Date of accident/first symptoms

_____ / _____ / _____

When did the patient first consult you for this condition?

_____ / _____ / _____

How long have you been the patient's usual doctor/medical practice?

_____ years

Name of patient's usual doctor/medical practice

_____

_____

Has the patient had surgery or is it anticipated?

☐ No ☐ Yes, give details _____

_____

Date performed or anticipated _____ / _____ / _____

Give name of hospital _____

_____

Did you provide other medical services (including pathology) to the patient?

☐ No ☐ Yes, give details

Date _____ / _____ / _____ _____

_____

Date _____ / _____ / _____ _____

_____

RISK446 1105

Was the patient referred by you or to you?

☐ No ☐ Yes, give details

Please provide name and address of referring doctor

Name: _____

Street address _____

_____ City _____ State _____ Postcode_____

Date of referral _____ / _____ / _____

Is the patient still disabled?

☐ No ☐ Yes, if yes, how long will the patient be:

- totally disabled (unable to return to their pre-injury education)

  from _____ / _____ / _____ to _____ / _____ / _____

- partially disabled (unable to return to a substantial part of their pre-injury education)

  from _____ / _____ / _____ to _____ / _____ / _____

If partially disabled, what educational activities could the patient perform and how many hours a week?

_____

_____

_____ hours per week _____

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, sports body or any other insurance body?

☐ No ☐ Yes, give details _____

_____

Name of company and claim number _____

_____

Contact name and telephone number _____

_____

Remarks

_____

_____

_____

Signature

Signature of medical practitioner _____

Name *(in print)* _____

_____ Date _____ / _____ / _____

Qualifications _____

Street address _____

_____

City _____ State _____ Postcode _____

Telephone (___) _____

Privacy Consent – Claim Assessment

Protection of My Privacy

Acknowledgement and Consents

By signing this form I agree that ACE Insurance Limited ABN 23 001 642 020, AFS Licence No. 239687 ('ACE') and third parties such as my insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by ACE, my employers (past and present), my accountant, any business which provides information about the commercial activities of persons and if I am or have been bankrupt, the trustee of my estate ('the Parties') may exchange with each other any information about me, excluding health or other sensitive information, including:

- Any information provided by me in relation to my claim;
- Any other personal information I provide to any of them or which they otherwise lawfully obtain about me;
- Any information relating to this insurance or any other insurance held by me or on my life, including terms and conditions and claims history;
- Details of my employment, including position, period of employment, remuneration, hours worked and duties performed; and
- Any information relating to my income and solvency.

I agree that any information referred to above can be used by the Parties and any Service Provider (as identified below) for assessing the claim or my entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

I agree that ACE may exchange my personal and/or sensitive information, for the purposes of assessing the claim or my entitlement to benefits with:

- Any investigator appointed by ACE to investigate the claim;
- The Health Record Holders;
- The Health Insurance Commission;
- Other insurers;
- Reinsurers;
- Any private or government organisation which investigates fraud including the police; and
- Any witness identified by me.

If I have identified any person as a witness, I agree to ensure that each person is made aware that:

- I have identified him/her as a witness in relation to the claim;
- ACE holds a record of their personal information for this purpose; and
- He/she may contact ACE or request access to his/her information, by calling 1800 815 675.

If ACE engage anyone (a 'Service Provider') to do something on its behalf (for example technology providers) then I agree to them exchanging any information referred to above, with each other.

I understand ACE might give any information referred to above to entities other than the Parties, the Service Providers, the Health Record Holders and the other persons/organisations referred to above where it is required or allowed by law or where I have otherwise consented.

I understand that I can access** most personal information that members of ACE Insurance Limited hold about me (sometimes there will be a reason why that is not possible, in which case I will be told why).

I understand that if I fail to provide any information requested in this form, or do not agree to any of the possible exchanges or uses detailed above, ACE may be unable to assess the claim.

** To find out what sort of personal information ACE have about you, or to make a request for access, please telephone 1800 815 675.

Dated _____ / _____ / _____

Signed _____

Please complete claim form and return to:

ACE Insurance Limited
GPO Box 4907 Sydney 2001
Phone (02) 9335 3355
Fax (02) 9231 3697