Golf – Personal Accident

Australian Golf Insurance

ZURICH

Claim form

The company does not admit liability by the issue of the form. It is issued to enable the insured to lodge a written statement of claim.

CASE/CLAIM NUMBER

General Insurance Code or Practice

Zurich Australian Insurance Ltd is a signatory to the General Insurance Code of Practice. For more information about the General Insurance Code of Practice please go to www.zurich.com.au and select About Zurich.

Brokers please note: You can monitor the progress of a claim via Zurich Claims Online 24 Hours a Day, 7 days a week.

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any Personal or Sensitive Information ('Information'), you should know that:

We collect, use, process and store Personal Information and, in some cases, Sensitive Information about you such as health information, in order to comply with our legal obligations, assess your application and, if your application is successful, to administer the products or services provided to you, to enhance customer service and product options and manage a claim ('purposes').

If you do not agree to provide us with the Information, we may not be able to process your application, administer your policy or assess your claims.

By providing us or your intermediary with your Information, you consent to our use of this Information and where relevant for the purposes, you consent to our disclosure of your Personal Information, including your Sensitive Information, to your intermediary, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our business partners, medical and health practitioners, your employer, policy owners, government offices and agencies, regulators, law enforcement bodies, and as required by law within Australia or overseas. These laws include the Anti-Money Laundering and Counter-Terrorism Financing Act 2006, Personal Property Securities Act 2009, Corporations Act 2001, Insurance Contracts Act 1984, Autonomous Sanctions Act 2011, Income Tax Assessment Act 1997, Income Tax Assessment Act 1936, Income Tax Regulations 1936, Tax Administration Act 1953, Tax Administration Regulations 1976, A new Tax System (Goods and Services Tax) Act 1999 and the Australian Securities and Investments Commission Act 2001 as those laws are amended, and includes any associated regulations. From time to time other acts may require, or authorise us to collect your personal information.

Zurich may obtain Information from government offices, the parties listed above and third parties to assess applications, administer policies and assess a claim in the event of loss or damage.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your Information to, a list of countries in which recipients of your Information are likely to be located, details of how you can access or correct the Information we hold about you or make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 132 687, by email at privacy.officer@zurich.com.au or by mail at 'The Privacy Officer', Zurich Financial Services Australia Limited, P. O. Box 677, North Sydney NSW 2059.

1 Claimant details

Surname | Given name(s) | Date of birth / /

Postal address | State | Postcode

Phone number – Private | Business

Mobile | Fax

Your height | Your weight

Please indicate (tick (✔) the box) which of the following best describes your present occupation.

(a) Clerical Work only ◯ (b) Performing Manual Work ◯ (c) Supervising Manual Work ◯ (d) Combination of (b) & (c) ◯

Are you self employed? Yes ◯ No ◯ If 'No', please provide the name & address of your employer

Name

Address | State | Postcode

If 'Yes', (i.e. you are self employed), please provide the details of your business

Name | ABN

Address | State | Postcode

ZU07496 - V3 03/19 - CWAN-006481-2012

2 Details of the policy

Name of your Golf club

ABN | Policy number | Date of birth / /

3 Details of the event

Date of accident / / | Time of incident | am ◯ pm ◯

Golf course (name and address) where accident happened

Name

Postal address | State | Postcode

Describe what happened in detail

Name of the person who caused the event (if relevant)

Address of person who caused the event | State | Postcode

Phone number of person who caused the event

Name of witness

Address of witness | State | Postcode

Phone number of witness

3 Details of the event (continued)

Please tell us what you are claiming for (see A to G) below.

Depending upon your injury, you will need to provide us with evidence of the injury as follows:

A. If you are claiming for dental benefits, you must provide us with a statement from a registered dentist on his/her letterhead confirming:
   - The type of treatment given
   - The number of teeth involved
   - The injury was as a result of the accident which occurred on the golf course

B. If you are claiming for broken or fractured bones or the amputation of an arm, foot, hand, leg, finger, toe or eye, you must provide us with a statement from a registered medical practitioner on his/her letterhead confirming:
   - The nature of the injury and treatment given
   - In the case of fractures, the statements needs to disclose if the fractures were compound (open) or simple (closed) fractures.
   - That the injury was as a result of the accident which occurred on the golf course

C. If you are claiming for emergency transport benefits, you will need to provide us with a statement from the party who provided the transport, outlining the following:
   - The service provided and the cost
   - That the transport was emergency in nature and provided immediately following the accident which occurred on the golf course

D. If you are claiming for internal injuries, you must provide us with a statement from a registered medical practitioner on his/her letterhead confirming:
   - The internal injuries suffered and treatment given
   - That the injury was as a result of the accident which occurred on the golf course

E. If you are claiming for the suture of a wound, you must provide us with a statement from a registered medical practitioner on his/her letterhead confirming:
   - Where the wound was and the number of sutures
   - That the wound was as a result of the accident which occurred on the golf course

F. If the claim is for accidental death, the legal representatives will need to:
   - Provide written evidence of their right to represent the deceased person
   - Provide a copy of the death certificate and evidence that the death occurred as a result of the accident which occurred on the golf course

G. If claiming for temporary total disability benefits, you will need to:
   - Provide evidence of earnings
     - If you are an employee this means your average pre-tax weekly rate of pay over the past 12 months (or over such period as you have been employed over the past 12 months), prior to your accident, excluding bonuses, commission overtime & any allowances
     - If you are self employed, this means your average pre-tax weekly income over the past 12 months prior to your accident (or over such period as you have been self employed in this business) derived from your personal exertion after deducting necessarily incurred in deriving that income
   - Have a registered medical practitioner complete the attached certificate

4 Medical statement – Temporary total disablement

To be furnished by the person claiming at his own expense

Name of Claimant (Patient)

Address State Postcode

Occupation

Date accident happened and where / /

How caused

On what date did you first attend the Claimant in consequence of present injury? / /

(If the injuries sustained to a hand or an arm, a foot or a leg, state whether it is the Right or Left).

Have you reason to suspect Claimant was not sober at the time of accident? Yes ◯ No ◯ If 'Yes', please give details

How long have you known the Insured?

Are you the Claimant's regular Medical Attendant? Yes ◯ No ◯ If 'No', who is the regular medical attendant?

To your knowledge, was the Insured at the time of the accident suffering from any disease or physical infirmity? Yes ◯ No ◯
If 'Yes', please provide details

Give date of last visit by the Claimant / /

Is the Claimant's incapacity due solely and directly to the accident stated, independently of any other cause? Yes ◯ No ◯
If 'Yes', please provide details

Note:
Temporary total disablement, for the purpose of this claim means that as a result of an accident one or more of the following conditions applies:

- the patient is for the time being wholly prevented from engaging (for reward or otherwise) in their own occupation or from attending school/college/university.
- the patient is for the time being unable to carry out all their domestic duties and have been required to employ domestic assistance to carry out these household duties.
- the patient is for the time being unable to perform at least two of the five following "Activities of Daily Living"
  - bathing and showering;
  - dressing and undressing;
  - eating and drinking;
  - using a toilet to maintain personal hygiene; and
  - moving from place to place by walking, either with or without the use of a walking aid.

I Estimate the Claimant will be **Temporally, Totally** disabled (as per the attached definitions) for:

weeks days

Commencing / /

I HEREBY CERTIFY that the foregoing statements are to the best of my knowledge, information and belief, true and complete, and that I am firmly of the opinion that the stated periods of the patient's Total and/or Partial Disablement are due solely and directly to the cause or causes I have stated.

Name (Please Print)

Address State Postcode

Qualification

Signed Date

✗ / /

5 Your declaration

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the Policy shall be void and all rights to recover thereunder in respect of past or future injuries shall be forfeited.

I further agree that any professional person, Medical Practitioner, Dentist or Hospital Authority who has been or may hereafter be consulted by me relative to the injury is hereby authorised and directed to divulge at any time to Zurich Australian Insurance Limited, their legal representatives or Loss Adjusters, any information or history they may acquire with regard to any injury.

Signed	Date
✗	/ /

6 Golf Club Membership Verification

(To be completed by Golf Club's Secretary/Manager, if this is a Club Policy

I am the Secretary/Manager of the club named in this claim and I verify that the above named person was a member of this club

Membership number at the time of event which lead to this claim. Furthermore I believe this to be a genuine claim.

Your name

Position

Signed	Date
✗	/ /

Please return this claim form to:

Zurich Australian Insurance Limited
PO Box 232E
Melbourne VIC 3001