



International  
Services  
Network

International Services Network  
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 Sydney NSW 2000 - AUSTRALIA  
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 www.isn.au.com  
 e-mail: [claims@isn.au.com](mailto:claims@isn.au.com)

## Downer EDI Limited

### Personal Accident & Illness Claim Form

Name and contact details of your business unit:							
Start date of employment with Downer:							
Policy Number:				Expiry Date		31 October 2008	
Insured Employer (i.e., Downer Engineering, Downer Mining):							
Claimant's Name							
Address							
Usual occupation:				Date of Birth			
Height				Weight			
Telephone (private)				Telephone (work)			
Telephone (mobile)				<b>Email (important)</b>			
What Are your Gross Weekly Earnings?				\$			
For whom are you claiming?		<input type="checkbox"/> Self <input type="checkbox"/> Spouse / Partner <input type="checkbox"/> Child		Give Name			
For what are you claiming?		<input type="checkbox"/> Total Permanent Disablement <input type="checkbox"/> Temporary Partial Disablement <input type="checkbox"/> Death					
GST Tax Status:		Registered <input type="checkbox"/> Yes <input type="checkbox"/> No		ABN No:		Taxable %	
<b>SUMMARY OF CLAIM:</b> I am claiming the following benefits under this Insurance:							
Capital Benefits		_____		Amount		\$ _____	
Weekly Benefits		Period / / to / / .		Amount		\$ _____	
Other (Please specify)		_____		Amount		\$ _____	
				<b>TOTAL</b>		\$ _____	
<b>CLAIMS FOR INJURY / ILLNESS / DEATH:</b>							
What is the injury or illness?							
If injury, how exactly did it occur?				i.e. playing sport, etc.			
When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed?						/ /	
Did the injury or illness cause you to stop work?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes state when		/ /	
Have you returned to work full-time?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes state when		/ /	
Have you returned to work part-time?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes state when		/ /	
– if Yes, what hours and duties are you working?		___ Days ___ Hours		If Yes state when		/ /	
Is this condition due to injury or sickness arising out of your employment?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
- If yes give details							

<b>Who is your usual family doctor?</b>				
Name		Telephone Number		
Address				
<b>When did you first get treatment from a medical practitioner for this condition?</b>				
Name		Telephone Number		
Address				
When did you first see the medical practitioner?			/	/
<b>Have you consulted any other medical practitioner for this condition?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name		Telephone Number		
Address				
When did you first see the medical practitioner?			/	/
<b>Did you go to hospital?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Name		Telephone Number		
Address				
Admission Date	/	/	Discharge Date	/
				No of Days _____.
<b>During the 24 hours before the injury, did you drink any alcohol or take any drugs?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
State types & quantities				
<b>Have you ever had this or a similar condition in the past?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Received				
Treatment Start	/	/	Treatment Completed	/
				No of Days _____.
Doctor's Name		Telephone Number		
Address				
<b>What other significant medical or surgical treatment have you had in the past 5 years?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Received				
Treatment Start	/	/	Treatment Completed	/
				No of Days _____.
Doctor's Name		Telephone Number		
Address				
<b>Are you affected by any other long term or chronic disability</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details				
<b>CLAIMS FOR ADDITIONAL BENEFITS FOR INJURY OR ILLNESS</b>				
NOT ALL POLICIES PROVIDE THESE BENEFITS. PLEASE ONLY COMPLETE IF APPLICABLE.				
Are you claiming for:-				
<ul style="list-style-type: none"> <li>• homecare or income replacement after major surgery for cancer</li> <li>• childminding or income replacement after a child's accident</li> <li>• home tuition fees after a child's accident</li> <li>• medical expenses not covered by Medicare</li> <li>• damage to personal property</li> </ul>				
Give details, specifying each item				
ITEM				AMOUNT
				\$
				\$
				\$
				\$
PLEASE ATTACH INVOICES OR OTHER EVIDENCE OF THE EXPENSES YOU HAVE INCURRED OR RECEIPTS FOR DAMAGED PROPERTY.				

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**OTHER INSURANCE / BENEFITS**

Are you claiming insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, sports body or any income replacement.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Provide Details	
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Name of insured organisation/employer & telephone number	
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Name of Insurer & Telephone number	
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Type of cover	
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Amount claimed per week	\$	Per week
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Do you have private health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Provide Details	
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Do you have ambulance cover?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Provide Details	
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**TO BE COMPLETED BY YOUR EMPLOYER**

If self-employed, please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earnings.

Employer's Name	
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This is to Certify that	Of
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has been unable to attend his/her occupation as a result of Injury or Sickness from	/ /
---	-----

until	/ /
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His/Her average Gross Weekly Salary at the time of this accident/sickness was	AUD \$
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He/She has been employed since	/ /
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His/Her Sick Leave Entitlement at the time of this accident/sickness was	days
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Has a claim for Worker's Compensation been lodged	<input type="checkbox"/> Yes <input type="checkbox"/> No
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In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>SIGNATURE OF EMPLOYER OR SUPERVISOR:</b>	
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<b>NAME OF EMPLOYER OR SUPERVISOR (PLEASE PRINT)</b>	
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<b>TELEPHONE NUMBER</b>	
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<b>DATED</b>	
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## PRIVACY CONSENT - CLAIM ASSESSMENT

### Protection of My Privacy Acknowledgement and Consents

By signing this form I agree that International Services Network (including the Insurers they represent and claims management services) 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 ISN, 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 ISN 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 ISN to investigate the claim;
- The Health Record Holders;
- The Health Insurance Commission;
- Other insurers;
- Re-insurers;
- 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;
- ISN holds a record of their personal information for this purpose; and
- He/she may contact ISN or request access to his/her information, by calling +61 2 8256 1791.

If ISN 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 ISN 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 ISN 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, ISN may be unable to assess the claim.

\*\* To find out what sort of personal information ISN have about you, or to make a request for access, telephone +61 2 8256 1791.

## MEDICAL AUTHORITY, DECLARATION AND POWER OF ATTORNEY

I DECLARE THAT,

- I will use my best endeavors and render all reasonable assistance and co-operation to International Services Network in the assessment of my claim;
- the information supplied by me is true and correct and that I have not withheld any information likely to affect the acceptance of the claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proofs of my claim, ISN has made no acceptance of liability, nor waived any of its rights in defense of any claim arising under the policy.

I hereby appoint ISN to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I hereby authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as ISN in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);
- my Health Insurance claims history, including Medicare;
- any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

<b>SIGNATURE OF CLAIMANT:</b>		<b>DATED</b>	
<b>SIGNATURE OF WITNESS:</b>		<b>DATED</b>	

## MEDICAL PRACTITIONER'S STATEMENT TO COMPANY

The policyholder is responsible for any fee for this statement  
This form should be completed and returned promptly

Patients Name			
Usual occupation:		Date of Birth	
Height		Weight	
<b>Diagnosis</b> (if fracture or dislocation, describe nature and location i.e.: Simple, Compound)			
Cause:-			
If available please provide a copy of X-ray report		Is this condition <input type="checkbox"/> an injury or <input type="checkbox"/> an illness	
Does the patient have any other injury or illness that is contributing to the condition? e.g. Osteoporosis			<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details			
Is condition due to injury or sickness arising out of the patient's employment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details			
Was the disability sports related?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details			
Date of onset/first symptoms?			/ /
When did the patient first consult you for this condition?			/ /
Has the patient ever had the same or similar condition?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details			
Name of patient's usual doctor/medical practice			
How long have you been the patient's usual doctor/medical practice?			
Has the patient been hospitalized	Date of Admission	/ /	Date of Discharge
Name of Hospital			
Has the patient had surgery or is it anticipated?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details			
Date performed or anticipated	/ /	Give name of hospital?	
Did you provide other medical services (including pathology) to the patient?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details	/ /		
	/ /		
Was the patient referred by you or to you?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Details		/ /	Doctors details
Is the patient still disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes	Totally disabled (unable to perform any part of their occupation)	/ /	to
	Partially disabled (able to perform part of their occupation)	/ /	to
If partially disabled, what duties could the patient perform and for how many hours a week?			Hours
Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers' Compensation insurer, Social Security, sports body or any other insurance body?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Company & Claim number			
Contact Name & Telephone number			
<b>SIGNATURE OF MEDICAL PRATICITIONER:</b>		<b>DATED</b>	
<b>NAME (PRINT):</b>			
<b>ADDRESS</b>			
<b>TELEPHONE NUMBER:</b>			

## WHAT TO DO

- 1 Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employers and Medical Practitioner have signed this form.
- 2 Send this form to International Services Network
  - Level 2, 280 George Street, Sydney NSW 2000, or
  - Fax +61 2 8256 1775 or
  - [claims@isn.au.com](mailto:claims@isn.au.com)

## DISPUTES

ISN has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.

Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.

If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access to the Lloyd's General Representative in Australia who can review Your complaint.

If You or an Insured Person are still dissatisfied, the complaint may be referred, at no cost to you, to the Insurance Ombudsman Service operated by Insurance Ombudsman Service Limited under the terms of the General Insurance Code of Practice.

## PRIVACY

International Services Network has always protected the privacy of personal information of our valued clients. The standards by which we handle this personal information have now been set by the Privacy Act and the National Privacy Principles (NPP), which came into effect on 21st December 2001.

All Staff, Broker Representatives, Agents and Contractors have agreed to hold all information in confidence and not use it for any purpose except to carry out the service they are providing. We do not sell or share names, addresses or any other information with third parties, except to the extent necessary to complete our obligations as an Underwriting Agency or as stated in this document.

### How & why do we require your Personal Information

We collect information either directly from the relevant individuals or in some cases, from third parties. They may provide information for someone else requiring the benefit of the services that we offer, such as a nominated driver, director or officer or other staff member.

The information is collected to allow us to provide our insurance services including to arrange and place insurance cover, assess and underwrite risks, and to properly administer your claims.

### What we expect of you

When you provide us with information about other individuals, we rely on you to have made, or make them, aware that you will or may provide their information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties will use it for and how they can access it. If it is sensitive information, we rely on you to have obtained consent to the above. If you have not done these things, we expect you to tell us before you provide the relevant information. If you collect, use, disclose, or handle personal information on our behalf, or receive it from us, you & your representatives must meet the relevant requirements of the NPP set out in the Privacy Act 1988 and only use and disclose it for the purposes we agree to.

### Transfer of information overseas

We may transfer your personal information overseas where it is necessary to provide our service. Some insurers or reinsurers are based overseas and we need to provide your personal information to them to arrange your cover.

### Opting out

We regularly distribute to our clients information about our products & services, such as newsletters, which we believe may be of interest to you. If you do not wish to receive this additional information, please contact our office.