

First Notice of Claim for Illness or Injury

GE Money
GPO Box 1571
Sydney NSW 1025
Phone: 1800 800 230
Fax: (02) 8249 3885
www.gemoney.com.au/insurance

How to help us process your claim

Checklist

Before submitting your claim form, make sure you can tick **all** the boxes below:

Illness or Injury claims - documents required



Section A: Statement of claimant (you) – all questions answered.

Section B: Statement of employer – completed and signed by your employer.

Section C: Medical certificate - completed, signed, dated and stamped by your usual treating doctor OR a copy of a hospital Discharge Certificate is supplied (for accidents only) OR your initial Workers Compensation Medical Certificate is supplied.

Privacy consent and declaration - read, signed and dated by you. This is on the last page of this claim form. It's important that we have your signature here so we can start processing your claim straight away.

Authorised Third Party - Complete relevant section on page 6 if you wish to give authority to **another person** to obtain updates on your claim.

**Without the above information we will be unable to process your claim.
This could delay any payment to your account that you may be entitled to.**

If you are having any difficulties completing this claim form, please contact our Customer Service Centre on **1800 800 230**.

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What needs to be filled out?

Section A – to be completed by claimant (you)

Section B – to be completed and signed by your employer

Section C – to be completed by your usual treating doctor

Privacy consent and declaration - to be read, signed and dated by you



Who needs to fill this out?

All questions need to be answered by you

Section A: Statement of claimant (you)

Loan/card account or Insurance policy number: _____

First name: _____ Surname: _____

Date of birth: __ / __ / ____ Phone: (H) _____ (M) _____

Address:

Unit/house number: _____ Street name: _____

Suburb: _____ State: _____ Postcode: _____

Medical condition that has stopped you from working? _____

Have you suffered from this condition previously? Yes No If Yes, provide details: _____

Date of injury/illness: __ / __ / ____ Last day worked: __ / __ / ____

Full details of ALL doctors you have consulted over the past five years:

Year	Doctor's name	Address	Reason
e.g. 2000 - 2002	e.g. Doctor Smith	e.g. 1-2 Smith Street Sydney	e.g. Knee Injury

Please attach details of additional doctors if applicable.

Are you receiving, or do you expect to receive any income/benefits from Workers Compensation? Yes No

If yes, please provide details:

Name of insurance company: _____ Claim number: _____

Insurance company address: _____

Phone: _____ Fax: _____

Important notice:

This needs to be completed in full by you. If you require any assistance in completing this claim form please contact us toll free on **1800 800 230**.

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Section B: Employer certificate



Who needs to fill this out?

To be completed by your employer. If you are self-employed, you can fill this out yourself

Employee name: _____

Name of company: _____

Address: _____

Telephone number: _____

Employment Status

Full time Casual Seasonal Part time Self-employed

Occupation at time of injury or illness: _____

Average number of hours worked per week: _____ Date of hire: __ / __ / ____ Last day worked: __ / __ / ____

Provide full details of the employee's usual duties: _____

Reason for stopping work? _____

Has the employee returned to work? Yes No *If yes, please give date:* __ / __ / ____

Has the employee been terminated? Yes No *If yes, please give date:* __ / __ / ____

If the employee has not returned to work, when do you expect him/her to return to:

a) partial duties: __ / __ / ____

b) full duties: __ / __ / ____

Is the employee's disablement as a result of an injury? Yes No

Did the injury occur on the business premises, or during work hours? Yes No

Is the employee in receipt of, or entitled to, Workers Compensation benefits? Yes No

If yes, please provide details:

Name of insurance company: _____ Claim number: _____

Employer's signature:

Signed: _____ Date: __ / __ / ____

Title: _____ ABN number: _____

Important notice:

This needs to be completed in full by your **employer**. If you require any assistance in completing this claim form please contact us toll free on **1800 800 230**.

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Section C: Medical certificate



Who needs to fill this out?

To be completed, signed, dated and stamped by your usual treating doctor

Accident Only: We will also accept a copy of your hospital Discharge Certificate OR your initial Workers Compensation Medical Certificate.

Patient's name: _____ Date of birth: __ / __ / ____

Are you the patient's usual medical practitioner? Yes No

The date the patient first consulted your Practice for **any** condition: _____ Date: __ / __ / ____

What is the primary condition restricting the patient returning to work? _____

When did the patient first consult you for this condition? _____ Date: __ / __ / ____

Is this diagnosis defined as any of the following?

Heart attack Major organ transplant Cancer

Kidney failure Coronary artery disease requiring surgery Stroke

Date the patient was first noted to suffer symptoms of, or receive treatment for, the condition: _____ Date: __ / __ / ____

Has the patient suffered from the same or similar condition or conditions previously? Yes No

If yes, please provide initial consultation date: __ / __ / ____ If yes, what treatment was received? _____

Describe below any other conditions that are preventing the customer from working

Condition: _____ Date diagnosed: __ / __ / ____

Treatment received: _____

Is the patient's diagnosis the direct result of an accident? Yes No

If yes, please provide details of the accident: _____

If hospitalised, please advise the following:

Hospital: _____

From: __ / __ / ____ To: __ / __ / ____

Have you referred the patient to a specialist? Yes No

If yes, please provide details: _____

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Who needs to fill this out?

To be completed, signed, dated and stamped by your usual treating doctor

Doctor's Statement

To the best of my knowledge, the patient has been entirely prevented from engaging in all the duties of an occupation for which he/she is reasonably suited by education, training or experience.

From: __ / __ / ____ To: __ / __ / ____

Average number of hours worked per week: _____ Last day worked: __ / __ / ____

In my opinion the claimant's prognosis is: _____

I anticipate that he/she will return to work: _____

Please provide further details if necessary: _____

Name: _____ Provider number: _____

Address: _____ Postcode: _____

Phone: _____ Fax: _____

Signature of medical practitioner: _____ Date: __ / __ / ____

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Privacy notice and consent

We collect personal information about you so that we can process your claim. Without this information we may not be able to process your claim.

We may disclose personal information to third parties to assist us (and where applicable them) in processing our customers claims. Those third parties may include medical practitioners, hospitals, other health service providers, present and past employers, other insurance companies holding information relevant to our customers claims, other General Electric companies (both in Australia and overseas), and claims handlers. We limit the use and disclosure of any personal information we give those parties to the specific purpose for which we give it.

By completing this claim form you consent to us collecting and disclosing personal information about you in the ways set out above.

You can have access to the personal information we hold about you (subject to the Privacy Act 1988) by telephoning 1800 800 230 or writing to GE Money at GPO Box 1571, Sydney NSW 1025.

Declaration (to be signed and dated by you)

I declare that the information supplied by me on this form is in every respect true and correct and that I have not withheld any information likely to affect the acceptance of the claim. I also agree to the collection and disclosure of the information described under the heading "Privacy notice and consent". I understand that the claim may be denied if the information supplied is untrue or I have not revealed all relevant facts.

I hereby authorise my employer, their Workers Compensation insurer, my insurers or any hospital or medical practitioners who have treated me to provide GE Money with any information it may request regarding any illness, injury, medical history, treatment or copies of medical, hospital or employment records relating to this claim. A photocopy of this authorisation shall be considered as effective and valid as the original.

I authorise my employer and/or their Workers Compensation insurer to provide GE Money with information relating to my employment including but not limited to my employment history, payroll information, employment records and termination.

Name: _____

Current address: _____

Home phone number: _____

Signed: _____ Date: __ / __ / ____

Authorised Third Party (ATP)

By completing this section, you authorise GE Money to disclose and discuss information relating to claims on your policy to the person nominated below. We will only provide information to the ATP on: claim approval, claim decline decision (not reasoning behind decision), claim wait periods, any further claim information requested and/or payment amounts and schedule of payments.

My personal details.

Name: _____

Signed by: _____ Date: __ / __ / ____

My authorised person's details.

Name: _____

Address: _____

Date of birth: _____ Relationship with person named above: _____