

## Consumer Credit Insurance -Claim Form-

### INSTRUCTIONS ON HOW TO COMPLETE YOUR CONSUMER CREDIT INSURANCE CLAIM FORM

You must answer **ALL** questions. Where indicated please tick box  as applicable.

If you have had an **ILLNESS** complete **Sections 1, 2, 3, 5 & 7**

If you have had an **ACCIDENT** complete **Sections 1, 2, 4, 5 & 7**

If you have been **UNEMPLOYED** complete **Sections 1, 6 & 7**

**Policy No.** \_\_\_\_\_ **Period of Insurance: From** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **to** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### SECTION 1: GENERAL INFORMATION

Full Name of Insured: Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Private Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Telephone: Private: \_\_\_\_\_ Business: \_\_\_\_\_ Email: \_\_\_\_\_

Finance Company: \_\_\_\_\_ Finance Contract No. \_\_\_\_\_

Amount of Monthly Payment: \_\_\_\_\_ Outstanding Balance: \_\_\_\_\_ Date Payment Due: \_\_\_\_\_

### SECTION 2: GENERAL MEDICAL INFORMATION

Date of first examination or treatment by medical attendant for this occurrence: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name and Address of doctor who first attended you: \_\_\_\_\_

Name and Address of usual medical attendant: \_\_\_\_\_

Name and Address of the medical attendant now treating you: \_\_\_\_\_

Name and Address of other medical attendants for any accident or illness in the last 5 years: \_\_\_\_\_

Have you engaged in or attended to your usual profession, business or occupation since the date of accident or the date upon which the illness became evident (even if only in a reduced capacity)?  YES  NO

State dates between which you were confined: To Bed: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

To House: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### SECTION 3: ILLNESS

What is the nature of the illness? \_\_\_\_\_

When did it first become evident? \_\_\_\_\_

Have you ever suffered from or sought treatment for the illness in respect of which you are now claiming?  YES  NO

If YES, give details including date you last sought treatment: \_\_\_\_\_

Period for which you are claiming: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## SECTION 4: ACCIDENT

When did the accident occur: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

State exactly how the accident occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nature and extent of injuries: (if a limb or an eye, state whether left or right) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and address of all witnesses of the accident

Witness #1 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Witness #2 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Witness #3 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Witness #4 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Have you suffered from or sought treatment previously for the disability in respect of which you are now claiming:  YES  NO

If YES, give details including date you last sought treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Period for which you are claiming: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## PLEASE NOTE

1. If you are claiming for an accident or an illness, then Section 5 must be completed by your Medical Attendant. You are also reminded that any charge for completion of that Report must be borne by you as per the terms of your policy.
2. Your signature is required in Section 7 of this form before lodgement.

**SECTION 5: MEDICAL ATTENDANT'S REPORT** (TO BE COMPLETED BY TREATING DOCTOR)

1. Name of Claimant: \_\_\_\_\_

2. Occupation: \_\_\_\_\_

3. Are you the Claimant's usual medical attendant? \_\_\_\_\_

4. State the exact nature and extent of injuries sustained or all illness/disabilities suffered by the Claimant: \_\_\_\_\_  
\_\_\_\_\_

5. What organs are affected (state whether mild or severe)? \_\_\_\_\_  
\_\_\_\_\_

6. On what date did you first attend the Claimant in connection with his/her present disablement? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

7. Was there any external and visible sign of injury?  YES  NO

If YES, give details: \_\_\_\_\_

8. In your opinion would the symptoms have been evident to the Claimant for any length of time? \_\_\_\_\_  
\_\_\_\_\_

9. State period that the claimant:

a) will be totally unable to attend his/her usual occupation or business: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

b) has been totally unable to attend his/her usual occupation or business: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

10. When did he/she or at what date do you expect that the Claimant will be able to resume:

a) some part of his/her work? From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

b) the whole part? From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

11. Has the treatment or medicine prescribed by you been adhered to by the Claimant:  YES  NO

12. Are you aware of the claimant previously suffering from this condition:  YES  NO

If YES please provide FULL details: \_\_\_\_\_  
\_\_\_\_\_

13. Has the Claimant previously suffered from any illness which would have contributed to or would have accelerated the occurrence of the Claimant's current medical

condition:  YES  NO

If YES please provide FULL details: \_\_\_\_\_  
\_\_\_\_\_

**GENERAL REMARKS**

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Qualifications: \_\_\_\_\_

Address: \_\_\_\_\_ P/Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## SECTION 6: UNEMPLOYMENT

Name and Address of last employer: Name: \_\_\_\_\_

Address: \_\_\_\_\_ P/Code: \_\_\_\_\_

Was this employment Permanent, Seasonal, Casual, Contract of Service or of a specific period? \_\_\_\_\_

Date employment Commenced: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date employment Ceased: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Period employed: \_\_\_\_\_

Hours worked per week: \_\_\_\_\_

Reason for termination: \_\_\_\_\_

Did you voluntarily resign? \_\_\_\_\_

Date you registered with Commonwealth Employment Service as Unemployed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date re-employment commenced: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Office of Commonwealth Employment Service where you registered as Unemployed: \_\_\_\_\_

Period for which you are claiming: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Attach a copy of separation certificate from your employer and certificates from the Commonwealth Employment Service for the period that you were registered as Unemployed.**

## SECTION 7: DECLARATION AND SIGNATURE OF INSURED

- I hereby declare that the information I have submitted in relation to this claim is true and correct in every particular;
- In the event that this claim references any Accident, Injury or Illness, I authorise all Medical Professionals to supply Eric Insurance Limited (Eric) with my complete medical history including fully detailed medical reports, clinical notes, examination findings, and full details of any period of incapacity that may have arisen from the condition for which treatment was sought;
- I agree to provide any information that is requested by Eric that it deems is relevant to assessing this claim; and
- I acknowledge that Eric may provide, and obtain from, other insurers and/or the Insurance Reference Bureaux personal information relating to this claim as well as claims I have previously lodged, in accordance with Eric's Privacy policy. I understand that I may request a copy of Eric's Privacy policy at any time or obtain it from Eric's website.

Signature of Insured: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Print Name: \_\_\_\_\_

(A photocopy of this authority has the same effect as the original)

### RETURNING INSTRUCTIONS:

Please complete and return this form to the Postal Address below, together with all documentation requested:

Eric Insurance

PO Box 9106 Scoresby VIC 3179

[claims@ericinsurance.com.au](mailto:claims@ericinsurance.com.au)

### CLAIM ENQUIRIES:

Eric Insurance claims officers are available to assist you with any queries relating to your claim. Please contact our Australia wide phone service on Free Call 1800 99 99 77 for assistance. If you have an unresolved complaint or dispute, you should first speak with our Operations Manager.

If you are not able to resolve your concerns with the Operations Manager, you should ask that your query be referred to Eric's Internal Disputes Department.



Eric Insurance  
Customer Service 1800 999 977  
Email: [claims@ericinsurance.com.au](mailto:claims@ericinsurance.com.au)