CLAIM FORM

# Premature Birth and Miscarriage Benefit Claim Form

EXTF214

If claiming for income protection, please use the Protect Injury & Sickness claim form only

Call ATC for assistance on 1800 994 694

1. **You** complete Section A.

2. Your **Treating Doctor** completes Section B.

3. Attach medical evidence provided by your **Treating Doctor**.

4. Check all questions have been answered (including by selecting either 'Yes' or 'No' wherever this option is given) and each Section has been signed and dated.

   **Your claim will be delayed if we have to return your claim form to you because it is incomplete.**

5. **Before submitting this form, please tick each applicable box below**

   - ◯ Section A has been fully completed by the claimant
   - ◯ The claimant has signed the Privacy, Authority and Declaration on Section A
   - ◯ Section B has been fully completed and signed by the claimant's medical practitioner
   - ◯ **The following documents have been attached:** Any medical evidence including blood or urine test results or ultrasounds

6. Send, or fax, or scan and email, or deliver your completed form in person to:

   Post: ATC Insurance Solutions Pty Ltd
   Level 4, 451 Little Bourke Street, Melbourne Vic 3000
   Fax: (03) 9867 5540
   Email: claims@atcis.com.au

# SECTION A ➲ Claimant's Statement

**All questions to be completed in full by the claimant.**

**Protect number (if known)** _____

Union member Yes ◯ No ◯ Union name_____ Membership no._____

Surname_____ Given names_____

Date of birth _____/_____/_____

Street address_____

Suburb_____ State_____ Postcode_____

Contact telephone_____ Email_____

Name of employer_____

**Postal address (If different from above)**

Street address_____

Suburb_____ State_____ Postcode_____

**Electronic Funds Transfer**

Please provide your banking details so any claim benefits can be transferred directly in to your account.

Bank name_____ Bank branch_____

Account name_____BSB _____–_____ Account no._____

## Injury Statement

1. Date of injury_____/_____/_____ Time of injury_____ am_____ pm_____

   Date of first medical treatment _____/_____/_____

2. Describe the accident that caused the injury _____

   _____

   _____

3. Where did the accident occur?_____

   _____

4. Did the accident occur at work, including during a meal-break or authorised recess? Yes ◯ No ◯


**ATC Insurance Solutions Pty Ltd** Telephone 1800 994 694 (ATC Claims) Fax 03 9867 5540 Email claims@atcis.com.au Web www.atcis.com.au

## Privacy Act

In this statement "we", "us" and "our" means Lloyd's and ATC Insurance Solutions (ATC) as its agent.

We are bound by the requirements of the *Privacy Act 1988* (Cth), the Privacy Amendment *(Private Sector) Act 2000* (Cth) and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. This sets out standards on the collection, use, disclosure and handling of personal information.

Our Privacy Policy is available at www.atcis.com.au or by calling us on the number below.

We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties (and/or collect additional personal information about you from them) who assist us in providing the above services and some of these are likely to be overseas recipients in the United Kingdom. These parties which include our related entities, distributors, agents, insurers, claims investigators, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Medicare Australia and Centrelink will only use the personal information for the purposes we provided it to them for (unless otherwise required by law).

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information and request correction if required. You may also opt out of receiving materials sent by us by contacting ATC on (03) 9258 1700 or write to us at the address given on page 1.

## Authority

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to ATC or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Workers' Compensation claims, claims with any other insurer or any leave benefits and payments, to be released to ATC. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

**Complete if applicable.**

Name_____ Date of birth_____/_____/_____ Relationship_____

Telephone number _____ Email_____

## Declaration

**I declare that:**

**a. the claim I am making for injury or sickness IS NOT WORK-RELATED and if my injury or sickness is work-related, I have disclosed this clearly in my answers in this section, and**

**b. my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.**

Signature _____

Name (print) _____ Date _____/_____/_____

## SECTION B ➲ Medical Practitioner's Statement

Claimant's full name_____

Date of birth _____/_____/_____

**1.** Did the claimant suffer an injury causing miscarriage or premature birth? Yes ◯ No ◯

**2a.** Date of injury_____/_____/_____ **2b.** Time of injury_____ am_____ pm_____

Ġÿ On what date did the claimant first consult you for the injury?_____/_____/_____

4ÿ Describe the incident that resulted in the injury _____

_____

_____

_____

_____

5ÿ How many weeks gestation was the claimant at the time of the injury causing miscarriage/premature birth?

_____

6ÿ What tests were performed to confirm the claimant's pregnancy (e.g urine or blood test)?

_____

_____

7ÿ If the claimant suffered a miscarriage, what tests were performed to confirm the miscarriage (e.g ultrasound or blood test)?

_____

_____

8ÿ <u>Important:</u> Copies of the test results/reports mentioned in questions 6 & 7 above MUST be provided to the patient in order for their claim to be assessed. Please tick the appropriate boxes below confirming the documents you have provided:

- Blood test(s) Yes ◯ No ◯
- Urine test(s) Yes ◯ No ◯
- Ultrasound or other imaging Yes ◯ No ◯

**I hereby certify that I am a registered medical practitioner and that I have personally examined the above-named claimant.**

Name_____

Qualification_____ Provider no._____

Telephone_____ Fax _____ Email_____

Address _____

Suburb _____State_____Postcode_____

Signature _____ Date_____/_____/_____

AFFIX STAMP HERE



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