



ace insurance

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American Express Cardmember
Credit Protector (CCI) Claim Report Form

IMPORTANT INFORMATION

Please ensure this Form is completed in all Parts applicable to your claim. The Privacy Consent on the back, must be completed for all claims. Supporting documentation required is detailed below each Part.

The issue and acceptance of this Form does not constitute an admission of liability by the Company or a waiver of its rights.

Please attach a copy of your statement of the date of the event you are claiming for.

We will use this to calculate your claim payment.

ACE will credit the insurance claim payouts directly to your Personal Loan. You may wish to consider what direct debit arrangements you have in place. If you wish to stop or start your usual direct debit payments you will need to contact your financial institution and American Express to make the necessary arrangements.

Policy and Claimant Details

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Name of Policyholder [input field]

Name of Claimant: (Mr/Mrs/Miss/Ms) [input field]

Policy Number / Credit Card Number (if applicable) [input field]

Address: [input field]

Telephone: Home: [input field] Business: [input field]

Email: [input field]

Date of Birth: [input field] Occupation: [input field]

Employer: [input field] Contact: [input field]

GST Information

(a) Are you registered for GST Purposes? Yes [checkbox] No [checkbox]

(b) What is your Australian Business Number (ABN)? [input field]

(c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? Yes [checkbox] No [checkbox]

(d) If YES, what percentage of the GST did you claim or are you entitled to claim? [input field] %
(If the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

CLAIM FOR SERIOUS ACCIDENT OR INCOME REPLACEMENT BENEFIT

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?

No

Yes – when?

Have you returned to work full-time?

No

Yes – when?

OR

Have you returned to work part-time?

No

Yes – when?

- If yes, what hours and duties are you working?

Days

Hours

Duties

Is this condition due to injury or illness arising out of your employment?

No

Yes – give details

If injury, how exactly did it occur?

Who is your usual family doctor?

Name

Address

Telephone Number

When did you first get treatment from a medical practitioner for this condition?

Doctor's Name

Address

Telephone Number

When did you first see the medical practitioner?

Have you consulted any other medical practitioner for this condition?

No

Yes

- give details

Doctor's Name

Address

Telephone Number

Period

Did you go to hospital?

No

Yes

- give details

Hospital Name

Address

Date of Admission & Discharge

Number of Days in Hospital

During the 24 hours before the injury, did you drink any alcohol or take any drugs?

No

Yes

- give details

State types & quantities

Have you ever had this or a similar condition in the past?

No Yes – give details

Date(s)

Treatment received

Name of treating Doctors/Specialists

Addresses of Doctors/Specialists
who treated you

What other significant medical or surgical treatment have you received in the past 5 years?

– give details

Date(s)

Nature of the condition(s) treated

Name of treating Doctors/Specialists

Addresses of Doctors/Specialists
who treated you

Are you affected by any other long term or chronic disability?

No Yes – give details

--

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.

No

Yes – give details below

--

Name of insured organisation/employer
& telephone number

Name of Insurer & Telephone No.

Type of cover

Amount claimed per week

per week

Do you have private health insurance?

No

Yes – give details

Do you have ambulance cover?

No

Yes – give details

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Medical Practitioner's Statement to Company

THE POLICYHOLDER IS RESPONSIBLE FOR ANY FEE FOR THIS STATEMENT
THIS FORM SHOULD BE COMPLETED AND RETURNED TO ACE PROMPTLY

Patient's Full Name

Date of Birth

 / /

Height

cms

Weight

kgs

Diagnosis (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 an injury or an illness

Does the patient have any other injury or illness that is contributing to the condition? eg: Osteoporosis

No

Yes – give details

Is condition due to injury or sickness arising out of the patient's employment?

No

Yes – give details

Was the disability sports related?

No

Yes – give 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?

No

Yes – give details

How long have you been the patient's usual doctor/medical practice?

years

Has the patient been hospitalised?

Date of Admission

Date of Discharge

Name of Hospital

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated?

No

Yes – give details

Date performed or anticipated

 / /

Give name of hospital

Did you provide other medical services (including pathology) to the patient?

No

Yes – itemise, give details

Date	/	/	
Date	/	/	

Was the patient referred by you or to you?

No

Yes – give details

Please provide name and address of referring doctor

Name
Address

Date of referral

	/		/	
--	---	--	---	--

Is the patient still disabled?

No – when did the patient return to work?

	/		/	
--	---	--	---	--

Yes – how long will the patient be:

- totally disabled (unable to perform any part of their occupation)

from

	/		/	
--	---	--	---	--

 to

	/		/	
--	---	--	---	--

- partially disabled (able to perform part of their occupation)

from

	/		/	
--	---	--	---	--

 to

	/		/	
--	---	--	---	--

If partially disabled, what duties could the patient perform and for how many hours a week?

Hours per week:

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?

No

Yes – give details

Name of Company and Claim No.

Contact Name and Telephone No.

Remarks

Signature of medical practitioner

Name – print

Qualifications

Address

Telephone Number

	Date	/		/	

CLAIM FOR INVOLUNTARY UNEMPLOYMENT

Note: A Separation Certificate must be attached to your Claim Form

(a) Name and address of last employer	(a) Name:	Phone No.:
	Address:	
(b) Length of employment with above employer	(b) Years	Months
(c) Was this employment permanent, seasonal or for a specified period?	(c) <input type="checkbox"/> Permanent	<input type="checkbox"/> Seasonal <input type="checkbox"/> Specified Period
(d) Date employment ceased	(d) / /	
(e) First day as unemployed	(e) / /	
(f) Reason for ceasing employment	(f)	
(g) Did you voluntarily resign?	(g) <input type="checkbox"/> Yes <input type="checkbox"/> No	
(h) Date registered with Centrelink as unemployed	(h) / /	
(i) Date re-employment commenced	(i) / /	

This Section To Be Completed by Centrelink

I hereby declare that _____ is unemployed and has been registered since _____ with Centrelink and is/is not in receipt of unemployment benefits.

What type of benefit is being paid (i.e. Newstart Allowance etc.)

Is Claimant actually seeking Re-employment? Yes No
If No please advise reason

If not receiving benefits please advise why

Date: _____ / _____ / _____
Centrelink Authorised Representative: _____
Centrelink Official Stamp: _____

Office Contact Details:
Address: _____
Phone: _____ Fax: _____
Contact Name: _____

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CLAIMS FOR LIFE EVENTS

1. PLEASE SELECT THE LIFE EVENT YOU ARE CLAIMING FOR

- (a) MARRIAGE
For this claim to be considered please provide us with a copy of your marriage certificate.
- (b) BIRTH OF YOUR CHILD
For this claim to be considered please provide us with a copy of the birth certificate.
- (c) ADOPTION OF A CHILD(REN)
For this claim to be considered please provide us with a copy of the adoption court orders.
- (d) RELOCATION OF MORE THAN 200km FROM YOUR USUAL PLACE OF DOMESTIC RESIDENCE
For this claim to be considered please provide a copy of your lease agreement.
- (e) CHANGE OF EMPLOYER
For this claim to be considered please provide a "Letter of Employment" from your new employer.
- (f) PURCHASE OF A NEW HOME TO BE YOUR USUAL PLACE OF DOMESTIC RESIDENCE
For this claim to be considered please provide a copy of your "Contract of Sale of Real Estate".
- (g) DIVORCE
For this claim to be considered please provide a copy of your divorce court orders/final decree.

2. THE OUTSTANDING BALANCE OF YOUR AMERICAN EXPRESS CREDIT CARD AMOUNT.

Please attach a copy of your statement at the date of the event you are claiming for.
We will use this to calculate your claim payment.

* Failure to provide the required items may result in delays in processing your claim.

Privacy Consent - Claim Assessment

Protection of My Privacy Acknowledgement and Consents

ACE Insurance Limited (ACE) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principles.

A copy of our Privacy Policy is available on our website at www.aceinsurance.com.au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by ACE, or any third party that ACE provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:

- Any information provided in relation to your claim;
- Any information that is health information or sensitive information, including, without limitation, your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
- Any other personal information that you may provide to ACE or its third party contractors;
- Any information relating to any insurance policy on your life, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- Any other information relating to your income, assets, liabilities and solvency; and
- Any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ACE group, other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. ACE may also disclose your personal information to witnesses in respect to your claim.

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, ACE may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1800 815 675 or email customer.relations@ace-ina.com.

Medical Authority, Declaration and Power of Attorney

I DECLARE THAT,

I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to ACE using and disclosing my personal information pursuant to ACE's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to ACE's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to ACE such personal information (including health information) as ACE in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to ACE in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint ACE to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant

Date

Name of Claimant

Signature of Witness

Date

Name of Witness