

# Unemployment or Unfit for Work Claim

<b>Office Only</b>	
Claim No:	
Policy No:	

## IMPORTANT INFORMATION

- Please ensure all relevant sections are fully completed. An incomplete claim form may result in a delay in the assessment of your claim.
- If your claim is for an injury or illness, ensure that your doctor completes page 8 of this form. Any fees charged by your medical practitioner for completion of this form, in terms of policy, are your responsibility.
- A separate claim form needs to be completed for each new claim.
- We suggest you keep a photocopy of the completed claim form for your records.

**Please return this completed form to Personal Loan and Credit Card Protection Claims**  
**Westpac General Insurance Limited**  
**GPO Box 4451, Sydney NSW 2001 OR Fax to: 1300 786 606**  
 If you have any queries or need any help in completing this form, please telephone our office on 1300 369 989.  
 8.45am – 5.00pm Monday to Friday (Sydney time)

**Please tick (✓) the type of claim this relates to:**     **Unemployment**     **Injury/Illness**

What is/are your Loan Account and/or Credit Card Account number(s) you are claiming for?


## PERSONAL DETAILS (please print)

**1** Title: Mr  Mrs  Ms  Miss       Given names

Surname

Date of birth  /  /       Home phone number  (    )      Mobile phone number

**2** Have you or are you known by any other names?  
 Yes  Provide other name(s)  ▶ **Go to 3**  
 No  ▶ **Go to 3**

**3** What is your residential address?  
  
State Postcode

Is this residential address to be used for all your banking needs?..... Yes  No

**4** What is your postal address? (if same as residential, write 'AS ABOVE')  
  
State Postcode

Is this postal address to be used for all your banking needs? ..... Yes  No

**5** What was your occupation at the time of injury, illness or becoming unemployed?

**6** Describe your duties/tasks performed on a daily basis at the time your injury, illness or unemployment occurred.

**7** Are you or any person, business or entity that paid your premium, registered for Goods and Services Tax (GST)? (if you or any person, business or entity that paid your premium are an individual who is not carrying on a business or enterprise you should tick **NO**)

Yes  Were you or any person, business or entity that paid your premium, entitled to claim any input tax credits on the premium paid for the period in which the event giving rise to this claim occurred?

Yes  What percentage of the GST charged on the premium were you or any person, business or entity that paid your premium, entitled to receive as an input tax credit?

%

No  **Go to 8**

No  **Go to 8**

## INJURY/ACCIDENT DETAILS

**8** Does your claim relate to an **injury**?

Yes  When did the injury happen?

Date  /  /  Time  am / pm **Go to 9**

No  **Go to 11**

**9** How did your injury happen and where did it occur? If the injury occurred at work, please provide a copy of the injury/incident report.

**10** Please describe your injury (eg. broken leg) and then go to **question 13**

**Go to 13**

## ILLNESS DETAILS

**11** Does your claim relate to an **illness**?

Yes  What is your illness?

**Go to 12**

No  **Go to 22**

**12** When did symptoms of your illness first commence?

/  /  **Go to 13**

## MEDICAL INFORMATION

**13** When were you first treated by a medical practitioner for this current injury or illness?

/  /

**14** Please provide details of all doctors who have previously and are currently treating you for this injury or illness.

Dates from	Dates to	Name of doctor	Address	Phone no.	Fax no.	Type of doctor

15 When did you stop working as a result of this injury or illness?

/ /

16 Has your employment been terminated?

Yes

Does the date you were terminated differ to the date in your answer to question 15?

Yes  what date were you terminated

/ /

Go to 17

No  Go to 17

No  Go to 17

17 Have you returned to work or attempted any work since this injury or illness occurred?

Yes

Please provide details including the exact date you returned to work or the period you attempted to work and whether you returned to full or partial duties.

(Empty text box for details) ▶ Go to 18

No  Go to 18

18 If you have attempted work unsuccessfully or have not returned to work, when do you expect to return to work in the same capacity you were working prior to your injury or illness?

/ /

19 How many hours were you working each week prior to your injury or illness?

(Empty text box for hours)

- Please attach copies of documentation to confirm the number of hours worked in the month leading up to your injury or illness (eg. payslips, invoices, letter from the company you were working for at the time)
- Attaching this information will speed up consideration of your claim.

20 Are you self employed?

Yes  Go to 22

No  Go to 21

21 What is the name, address, phone and fax number of your employer(s) at the time your injury or illness occurred?

Employer Name	Address	Phone no.	Fax no.

## UNEMPLOYMENT DETAILS

**22** Does your claim relate to unemployment?

Yes  When did you become unemployed?  
 Date  **Go to 23**

No  **Go to 23** Please skip Q23 – 32 and read the subsequent sections as well as sign the declaration.

**23** Were you self-employed or a sub-contractor?

Yes  Please provide your ABN no. (if applicable)

**and;**

Please provide details of why your employment ceased

**Go to 24**

**If you were self employed or in a business partnership, you must provide documentation which satisfies us of your loss of employment. This can include, for example, a letter from your accountant confirming the business has ceased trading, and/or a letter from the person you were contracting with confirming that your employment has ceased, the reason for your employment ceasing and the person's name and contact details.**

No  Please provide the name, address, phone number and fax number of your employer(s) at the time of you becoming unemployed.

Employer Name	Address	Phone no.	Fax no.

**You must attach a copy of your Employment Separation Certificate from your relevant previous employer. If you are unable to provide the certificate, you may instead provide a letter from that employer confirming your period of employment, reason for employment ceasing and the employer's name and contact details.**

**24** Did you voluntarily resign/cease employment voluntarily?

Yes  Please provide the reason for your resignation.

**Go to 25**

No  **Go to 25**

**25** Was your employment of a seasonal nature?

Yes  **Go to 26**

No  **Go to 27**

**26** Did your employment cease as a result of the season ending?

Yes  **Go to 27**

No  Please provide the reason for your employment ceasing.

**Go to 27**

**27** Was your employment contract work?

Yes  **Go to 28**

No  **Go to 30**

**28** Did your employment cease due to the end of your own contract?

Yes  Please provide full details.

**Go to 29**

No  **Go to 29**

**29** Did your employment cease due to the completion of the contract of the company/person who employed you?

Yes  Please provide the name, address and telephone number of the company/person who employed you.

▶ Go to <b>30</b>

No  ▶ Go to **30**

**30** Was your employment casual, part-time or for a specified period of time?

Yes  Please provide details.

▶ Go to <b>31</b>

No  ▶ Go to **31**

**31** What was the duration of your employment?

Commenced employment

Finished employment

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

**32** Have you recommenced work?

Yes  On what date did you recommence work?

/	/	/
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▶ Please read the subsequent sections as well as sign the declaration.

No  ▶ Please read the subsequent sections as well as sign the declaration.

## WHAT TO DO IF YOU HAVE A COMPLAINT

If you have a complaint about any aspect of our service or the way your claim is handled, we will do our best to resolve it for you quickly and fairly. We will keep you informed of the progress of our response to your complaint.

### Step 1

We ask that you contact one of our Claims Officers on:

Telephone: 1 300 369 989 or by Fax: 1 300 786 606.

If they are unable to resolve the matter, they will refer it to their Team Leader.

### Step 2

If, after the Team Leader has considered the issue, and you are not satisfied with the outcome, you may contact our Personal Loan and Credit Card Protection Operations Manager, who will arrange for the matter to be reviewed by our Head of Personal Loan and Credit Card Protection (*who has the authority to make a determination on any complaint*) in accordance with our internal dispute resolution process.

The contact details are:

Operations Manager Personal Loan and Credit Card Protection Westpac General Insurance Limited GPO Box 4451 Sydney NSW 2001 Telephone: 1 300 369 989 Fax: 1 300 786 606
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When responding we will advise you of the availability of alternative external and independent dispute resolution facilities to which you can refer your case if you consider we have not dealt with it in a fair and proper manner.

If we are unable to resolve your complaint to your satisfaction within 45 days, you can take the complaint or dispute to the Financial Ombudsman Service Limited.

## PRIVACY CONSENT AND DECLARATION

I authorise and agree that Westpac General Insurance Limited ABN 99 003 719 319 ("WGIL"), any other member of the Westpac Group\* and third parties such as any claim investigator retained by WGIL to investigate my claim, my employers (past and present) and loan collection agencies and any provider of credit covered by my policy (the 'Parties') may exchange with each other any information about me, excluding health or other sensitive information, but 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;
- details of my employment, including position, period of employment, remuneration, hours worked, duties performed and reasons for ceasing employment; and
- details regarding my loan or credit card account and any information required by WGIL, as applicable, including balance owing, monthly repayments and the status of the account, to enable assessment and ongoing management of my claim(s), and payment of my claim(s).

I agree that any information referred to above can be used by the Parties and any Service Provider (as defined below) for assessing my claim(s) and for administration of my policy, planning, product development and research purposes.

I understand that 'my health information' includes information or an opinion about:

- my health or disability; and
- any health service which has been or will be provided to me.

I understand that 'The Health Record Holders' include:

- any medical practitioner or other health care professional (e.g. physiotherapists, chiropractors, psychologists etc); and
- any hospital or other health service provider, including paramedical service providers;
- attended by me or retained by WGIL.

If my claim is for an accident or illness, I agree that WGIL may exchange my personal and / or health information , for the purpose of assessing my claim, with:

- any claim investigator retained by WGIL to investigate my claim;
- the Health Record Holders; and
- the Health Insurance Commission.

I agree that WGIL may provide copies of my claim form, other relevant personal information and any medical reports about me in WGIL's possession, to any independent medical specialist who examines me in connection with my claim, for the purpose of assisting with the assessment of my claim. I authorise medical practitioners and any other health service provider to provide my health information to WGIL upon request.

If WGIL engages anyone (a 'Service Provider') to do something on its behalf (for example technology providers and loan servicing companies) then I agree WGIL and the Service Provider may exchange with each other any information referred to in this declaration.

WGIL might give any information referred to above to entities other than the Parties, the Service Providers, the Health Record Holders and the Health Insurance Commission 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 the Westpac Group hold about me (sometimes there will be a reason why that is not possible, in which case I will be told why).

I authorise any other person to release any information and /or documentation required by WGIL in relation to my claim upon request, and I agree that a copy of this declaration will be sufficient authorisation to any person or organisation, including medical practitioners and other health service providers, to provide information and documentation to WGIL upon request.

I hereby declare that:

- I am the person referred to in the statements in this document.
- the statements in this document are true in every respect;
- I acknowledge that the policy benefit for total disablement /unemployment will be paid to my loan/ credit card account; and
- I have read, understand and agree to the consents and acknowledgements above relating to my privacy.

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. WGIL may be unable to assess my claim.

Full name:
Address:
Date of birth:            /            /

Signature

Date

\* The Westpac Group means Westpac Banking Corporation and its related bodies corporate, which include WGIL, Westpac Life Insurance Services Limited and Westpac Financial Services Limited.

\*\* To find out what sort of personal information members of the Westpac Group have about you, or to make a request for access, please telephone 132 032.

**OPTIONAL – ONLY COMPLETE IF REQUIRED**

**If you require us to liaise with another person regarding your claim,  
please complete the following authority.**

**Authority To Release Information About My Claim**

I, \_\_\_\_\_ (*claimant's full name*)

authorise \_\_\_\_\_ (*authorised person's full name*)

of \_\_\_\_\_ (*authorised person's address*)

\_\_\_\_\_ (*authorised person's contact phone number*)

\_\_\_\_\_ (*authorised person's date of birth*)

Relationship to claimant (*eg. husband, wife*) \_\_\_\_\_

**Note**

- This authority only relates to this claim.
- This authority relates to Westpac General Insurance only (*if you require other areas of Westpac to liaise with a 3rd party, please contact the relevant area*).
- This authority will remain in force until we receive a written request from you cancelling it.
- **I agree to the above**

Claimant Signature

Date

# MEDICAL CERTIFICATE

## To be completed by your medical practitioner

**1** What is the name of your patient?

**2** What was your patient's occupation, business or profession at the time they became unfit for work?

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

**4** On what date did you first attend the patient in connection with this injury or illness?

**5** Please advise the exact nature and extent of the injuries or illness.

**6** General remarks (please provide any additional information relevant to the injuries or illness).

**7** To your knowledge, has the patient previously suffered from this injury or illness?  
 Yes  Please provide full details including when the injury or illness was first diagnosed.

No  **Go to 8**

**8** To your knowledge has the patient consulted any other doctors in relation to this injury or illness?

Yes  Please provide the doctor's name(s).


No  **Go to 9**

**9** Please advise the period the patient is/has been unfit for his/her usual occupation due to this injury/illness.

From  To

**10** When do you expect the patient will be fit to return to work?

Some part of their work  Full time duties

**11** What is your Name (the Medical Practitioner)?

**12** Please specify your qualifications?

**13** What is your address?  
  
  
State                  Postcode

**14** What is your phone and fax number  
 Phone number  Fax number

**15** Medical Practitioner's Signature  Date

**Please note, we cannot attend to your patients claim until this section is fully completed.**

**Any fees charged by the medical practitioner for completion of this certificate, in terms of the policy, are the patient's responsibility.**