Westpac

Unfit for Work Claim Form

Insert your claim number and/or policy number if known.	
Claim number:	
Policy number:	

Please tick the insurance policy you're claiming on:
☐ Credit Card Repayment Protection
☐ Flexi Loan Repayment Protection
☐ Personal Loan Protection

IMPORTANT INFORMATION

- Please be aware that submitting a claim doesn't stop any direct debit you may have in place to pay your loan or credit card. So if you wish to stop a direct debit, please call 132 032 or visit your nearest branch. You are still responsible for your repayments until your claim is accepted.
- Please ensure you keep a copy of your claim form in case your paperwork doesn't reach us.
- We will always contact you within 5 business days of receiving your claim form, so if you haven't heard from us within 7 days, please call us on 1300 369 989.

Please be assured we're here to help you

Questions?

1300 369 989 (option 2, option 2)

8.45am – 5pm (Sydney time) Monday – Friday

Return this form

Fax 1300 786 606

cciclaims@westpac.com.au

Personal Loan and Credit Card Protection Claims
Westpac General Insurance
GPO BOX 4451, Sydney NSW, 2001

CLAIM REQUIREMENT CHECKLIST

To help us assess your claim promptly, please ensure you can tick ALL the boxes below:

☐ Have you read the important information?
☐ Have you completed all fields in the form?
☐ Have you signed and dated the Privacy Statement and Declaration on page 4?
☐ Has your registered medical practitioner completed and signed the Medical Certificate on page 6?
☐ Have you attached documentation confirming your working hours?
☐ Have you kept a copy of your completed form and documentation?

PERSONAL DETAILS (please print)

Westpac customer number (same as telephone or internet banking number)

Date of birth / /

Title (Mr/Mrs/Miss/Ms)

Name of claimant

Have you previously been or are you known by any other name?

Postal address

Postcode

Home phone ( )

Mobile

Email

EMPLOYMENT DETAILS

Job title

Employer/business name
(If you're a sub-contractor, provide details of the company you were contracted to when you became unfit for work)

Address

Direct manager/payroll contact name | Best contact phone ( ) | Fax

Please provide a detailed description of your usual employment tasks and duties before you became unfit for work

Are you self employed? ..... ☐ Yes ➤ Please provide your ABN ☐ No

GST INFORMATION

Are you registered for GST purposes? ..... ☐ Yes ➤ answer next question ☐ No ➤ skip to next section

If 'Yes', have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on your insurance policy?..... ☐ Yes ➤ answer next question ☐ No ➤ skip to next section

If 'Yes', what percentage of the GST did you claim or are entitled to claim? ..... %
(If the GST paid and your ITC entitlements are the same amount, the answer to this question is 100%)

INJURY OR ILLNESS AND MEDICAL DETAILS

Please note: If you were unemployed at the time of your injury or illness, your claim may not be covered. Please call us on 1300 369 989 (option 2, option 2) to discuss further.

1. What is the injury or illness that caused you to stop working?
(Your claim is unable to be considered without confirmation of the medical condition(s) you are claiming for)

2. How did the injury occur or what caused the illness?

3. When did the injury occur, or when did symptoms for the illness first begin? ..... Date / /

4. When did the injury or illness cause you to stop work?..... Date / /

5. How many hours a week were you working before you ceased work? .....

For your claim to be considered you must attach documentation confirming the number of hours you worked in the 28 days before you stopped working. For example, payslips, invoices, or a letter from your employer or the company you were working for at the time.

6. Has your employment been terminated or have you resigned? ..... ☐ Yes ➤ Date / / ☐ No

If your employment was terminated, please provide the reason for termination

7. Have you returned to work full-time? ☐ Yes ➤ Date / / ☐ No

8. Have you returned to work to modified or light duties?

☐ Yes ➤ Date / / ➤ Hours per day? ➤ Days per week?

Please describe how these differ from your usual duties

☐ No ➤ When do you expect to return to:

- modified or light duties? Date / /
- your normal occupational duties? Date / /
- alternative suitable employment? Date / /

9. Which doctor or medical institution *(e.g. hospital)* did you first seek treatment from for this condition?

Name

Address

Phone ( )

First consultation date for this condition / /

10. Please provide the details of your usual medical practitioner

Name

Address

Phone ( )

11. Have you ever had this or a similar condition in the past? ☐ Yes ☐ No

If 'Yes',

- when were you first diagnosed with this condition? Date / /
- who was your registered medical practitioner at this time?

Name

Address

Phone ( )

**Please note - If you are claiming within the first 180 days after taking out your policy, there may be additional information required to support your claim. Please call 1300 369 989 (option 2, option 2) to discuss further.*

PRIVACY STATEMENT AND DECLARATION

Why we collect your personal information

We* collect personal information (including sensitive information e.g. health information) from you to assess your claim under the policy and, if your claim is accepted, for administration of your claim. We may also use your information to comply with legislative or regulatory requirements in any jurisdiction, to prevent fraud, crime or other activity that may cause harm in relation to our products or services and to help us run our business.

If you do not provide all the information we request, or do not agree to any of the uses or disclosures detailed below, we may be unable to assess or administer your claim.

Collecting and disclosing your personal information

We may disclose your personal information (including sensitive information) to other members of the Westpac Group**, anyone we engage to do something on our behalf such as a service provider and to other third parties, including:

- your employers (past and present);
- any health care provider including medical practitioners, physiotherapists, chiropractors, psychologists and hospitals attended by you or retained by us;
- other insurers, including Workers' Compensation insurers;
- any government agency, including Medicare Australia, Centrelink and the Australian Taxation Office;
- any claims assessor, investigator, legal adviser, financial adviser, superannuation fund, trustee or administrator, auditor, forensic accountant, external dispute resolution body or reinsurer retained by you or us;
- any Federal, State or Territory Police Department or private organisation which investigates fraud; and
- any witness identified by you in this form.

You authorise the above parties, and any other person, to disclose to us and other members of the Westpac Group any personal information (including sensitive information) and/or documentation required by us that they may hold about you which relates to our assessment and administration of your policy or claim. You 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 us upon request.

We may disclose your personal information to an entity which is located outside Australia. Details of the countries where the overseas recipients are likely to be located are in the Westpac Privacy Policy.

Other important information

We are required or authorised to collect personal information from you by certain laws. Details of these laws are in the Westpac Privacy Policy.

The Westpac Privacy Policy is available at westpac.com.au or by calling 132 032. It covers:

- how you can access the personal information we hold about you and ask for it to be corrected;
- how you may complain about a breach of the Australian Privacy Principles, or a registered privacy code and how we will deal with your complaint; and
- how we collect, hold, use and disclose your personal information in more detail.

The Westpac Privacy Policy will be updated from time to time.

If you have provided information about another individual, you must make them aware of that fact and the contents of this privacy statement.

Declaration

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 job loss/unfit for work 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.

DECLARATION – YOU MUST SIGN THIS FOR YOUR CLAIM TO BE ASSESSED

Full name

Date of birth

/ /

Address

Signature

✗

Date

/ /

*"We", "us", "our" means Westpac General Insurance Limited.** "Westpac Group" means Westpac Banking Corporation and its related bodies corporate.

THIRD PARTY AUTHORITY FORM – OPTIONAL

Please complete this section if you wish to provide authority for another person to talk to us about your claim, such as a partner, family member or friend.

I, _____ (claimant's full name)

authorise _____ (authorised person's full name),

who is the claimant's _____ (relationship to claimaint eg mother) of

_____ (authorised person's address)

_____ (authorised person's phone number), born _____ (authorised person's date of birth)

to obtain information about my claim and liaise directly with Westpac General Insurance about this claim.

Claimant's signature

✗

Date

/ /

WHAT TO DO IF YOU HAVE A COMPLAINT

We're constantly striving to provide our customers with the best possible service, and we'll do our best to resolve any complaint you have quickly and fairly.

So if you do have a complaint about your policy, our service, the way the policy was sold to you, or the way your claim is being handled, here's what you should do.

Step 1

We ask that you first contact one of our Consultants to discuss your complaint.

For claims issues: Phone 1300 369 989 Fax 1300 786 606

For any other issues: Phone 1300 369 989 Fax 1300 786 525

If the Consultant is unable to resolve the matter, they'll refer it to a Senior Officer, their Team Leader or Manager. The Senior Officer, Team Leader or Manager will acknowledge your complaint within 2 business days, providing their name and relevant contact details and keep you informed of the progress of your complaint at least every 10 business days.

The Senior Officer, Team Leader or Manager will try to resolve your complaint within 15 business days however, if we consider that further information, assessment or investigation of the complaint is required, we will agree reasonable alternative timeframes with you. If an agreement cannot be reached, we will notify you of your right to take your complaint to the next stage.

The Senior Officer, Team Leader or Manager will respond to your complaint in writing.

Step 2

If you're still not satisfied with the outcome, you may ask for us to refer the dispute to our Internal Dispute Resolution Officer who will review the matter.

The Internal Dispute Resolution Officer's contact details are:

Internal Dispute Resolution Officer
Westpac General Insurance Limited
Mail GPO Box 4451, Sydney NSW 2001
Phone 1300 369 989
Fax 1300 786 606 for claims issues or 1300 786 525 for any other issues

The Internal Dispute Resolution Officer will acknowledge your complaint, providing their name and relevant contact details and keep you informed of the progress of your dispute at least every 10 business days.

The Internal Dispute Resolution Officer will try to resolve your dispute within 15 business days however, if we consider that further information, assessment or investigation of the dispute is required, we will agree reasonable alternative timeframes with you. If an agreement cannot be reached, we will notify you of your right to take your dispute to the Australian Financial Complaints Authority (AFCA).

The Internal Dispute Resolution Officer will respond to your dispute in writing.

Step 3

If you are not satisfied with the decision made or we cannot otherwise reach an agreement, you can refer your matter to AFCA which provides a free independent dispute resolution service for consumers who have a general insurance dispute.

Additionally, if we are unable to resolve your complaint or dispute to your satisfaction within 45 calendar days, we will inform you of the reasons for the delay and that you may take your complaint or dispute to AFCA. The contact details are:

Australian Financial Complaints Authority
Mail: GPO Box 3 Melbourne VIC 3001
Phone: **1800 931 678**
Online: **www.afca.org.au**
Email: **info@afca.org.au**

First things first.

Please note that if you haven't first tried to resolve your complaint with us, the Australian Financial Complaints Authority will direct your complaint to us and we'll provide you with a response under our Internal Dispute Resolution process.

Please Note: Any fees charged by the medical practitioner for completion of this certificate, in terms of the policy, are the patient's responsibility. We cannot attend to your patients claim until this section is fully completed.

Privacy Statement: The personal information we collect from you on this form will be used to process your patient's claim. We may disclose your personal information to other members of the Westpac Group, anyone we engage to do something on our behalf, and other organisations that assist us with our business. Our privacy policy, available at westpac.com.au or by calling 132 032, contains information about how we handle your personal information.

MEDICAL CERTIFICATION – TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

Patient's Full Name:

Date of Birth: / /

Patient's occupation at time of illness or injury:

Are you the patient's usual Practitioner? ☐ Yes ➤ When did you first see the patient? / / ☐ No

To your knowledge, has the patient consulted any other doctors in relation to this injury/illness? ☐ Yes ☐ No

If yes, please provide the doctor's names:

Diagnosis (if no diagnosis, what are the presenting symptoms and what investigations are taking place?):

Date of onset/first symptoms: / /

What date did the patient first consult you for this medical condition? / /

Please advise of any contributing injuries or illnesses.

Has the patient ever had the same or similar medical condition? ☐ Yes ☐ No

If yes, please provide full details including when the injury/illness was first diagnosed:

Please provide the patient's employment capacity for all periods since the date you first treated them, including expected capacity for the foreseeable future:

Capacity for Work	Period From	Period To
Totally unfit for occupational duties	/ /	/ /
Fit for suitable/restricted duties	/ /	/ /

If the patient is fit for suitable/restricted duties, please confirm the hours/days per week and the restrictions:

Hours per day: Days per week: Restrictions:

Please confirm when the patient is expected to return to their normal capacity: / /

If the return to work date is unclear, please provide the expected duration of incapacity from today's date:

Within 3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-18 months ☐ 18-24 months ☐ 24 months+ ☐

If applicable, please confirm if the patient will never return to: usual occupational duties ☐ any type of work ☐

Please explain why this is the case:

REGISTERED MEDICAL PRACTITIONER'S DETAILS

Name (Print):

Qualifications:

Address:

State Postcode

Phone Number: ( )

Fax Number: ( )

Signature

✗

Date / /