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Progressive Claim Form

This section is to be completed by the patient / claimant

01. Policy and Personal Information

Policy Number

Claim Number

Name of Insured

Title

Name of Claimant

Date of Birth

Residential Address (cannot be a PO Box)

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

Date of Last Consultation

Doctors' Details

Doctors Name	Address	Telephone Number

Since the Injury / Sickness occurred, have you been able to attend in any way to your business or any occupation? Yes No
If Yes, please give details and extent of work:

What is the present extent of your disablement? Totally Disabled Partially Disabled None at all

If still disabled, indicate approximate length of continuing disability Days Months Years

When do you expect to return to work? Full time Part time

If no longer disabled, have you resumed work?
Yes Date resumed work
No Date to resume work

Have you received or are you entitled to receive benefits from:

a. the Workers' Compensation Act or ordinance? Yes No Entitlement per week.

b. any other source whatsoever? Yes No Entitlement per week.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:
I hereby declare that the foregoing statements in this form are true and correct and that I have not abstained from engaging in or attending in my profession, business or occupation, either totally or partially longer than absolutely necessary as a result of injury or sickness, and that such injury or sickness is the sole and direct cause of my disablement.

I declare that I have not engaged in any other employment nor earned any other income through other employment during my disablement period. I acknowledge that I remain ready to provide further evidence of my claim as may be required.

Signature of claimant

Date

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Medical Certificate

The insured is responsible for completion of this form without expense to the company.
To be completed by the attending medical practitioner.
Important: the medical attendant is respectfully requested to give as much detail as possible in order to assist Our client and avoid the necessity of additional enquires

01. Patient Details

Full Name

Date of Birth

Please give complete diagnosis of this condition

Please give date of first symptoms

Please list current symptoms and objective signs

Please describe the nature of all current treatment (eg surgical, conservative) if any and the date performed

Is the patient still under your care for this condition? Yes No

Is there any complicating factor affecting or extending this condition? Yes No

If Yes, please describe

Is the patient complying with treatment plans? Yes No

How is this evident?

Is the condition Improving Remaining Static Deteriorating

If the condition is static or deteriorating, what further intervention is planned?

What is the current prognosis of the patient's condition?

TEMPORARY TOTAL DISABLEMENT means disablement which entirely prevents you from engaging in your usual occupation or business.

From

To

How long was, or will the patient be continuously totally disabled

TEMPORARY PARTIAL DISABLEMENT means disablement which entirely prevents you from carrying out a substantial part of the duties normally undertaken by you in your usual occupation or business.

From

To

How long was, or will the patient be continuously partially disabled?

What duties could the patient perform and for how many hours a week?

Print Name

Qualification

Signature

Address

Phone

Fax

Date