Group personal accident   
(volunteers) claim form

### IMPORTANT

* + - Please complete the Policy Details Section and any of the following sections which relate to your claim.
    - Please ensure that this form is signed and that all questions are answered fully.
    - To avoid delay in processing your claim, please ensure that all you provide all necessary documentation specified in the section relevant to your claim Claims may be subject to an excess as described in your Policy.
    - Please send this form and all documentation to:

Email: [claims@vmia.vic.gov.au](mailto:claims@vmia.vic.gov.au)

or mail to:

Claims Department  
Victorian Managed Insurance Authority   
PO Box 18409, Collins St East, Melbourne VIC 8003

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| Policy and claimant details – Complete for all claims | |
| **INSURED**  Policy / Certificate number | Expiry date:      /     / |
| Contact person: | |
| Address: | |
| Telephone: | Date of birth:      /     / |
| Fax: | |
| Email: | |
| Employer’s name: | |
| Occupation: | |
| Usual duties: | |
| What are your gross weekly earnings? $ | |
| What are you claiming for? (e.g. Temporary Total Disablement): | |

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| Electronic Funds Transfer Details | |
| Following VMIA approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details: | |
| Name of financial institution: | |
| Account name: | |
| BSB number: | Account number: |

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| Incident details |
| Please advise of nature of incident: |
| When did the incident occur?      /     / |
| Did the incident cause you to stop work? Yes  No  When:      /     / |
| Have you returned to work full-time? Yes  No  When:      /     /  OR  Have you returned to work part-time? Yes  No  When:      /     /  If Yes, what hours and duties are you working?       Days       Hours  Duties: |
| Is this condition due to injury arising out of your employment? Yes  No  Provide details:  How exactly did it occur? |
| When did you first get treatment from a Medical Practitioner for this condition?  Doctor's name:  Address:  Telephone:  When did you first see the Medical Practitioner?      /     /  Treatment provided/received:  If you have received treatment from a Medical Practitioner, please attach any relevant medical reports. |

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| Other insurance details |
| Do you have private insurance? Yes  No  If yes, please advise:  Name of fund:  Membership number: |
| Do you have ambulance cover? Yes  No  If yes, please provide details: |

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| CLAIMS FOR ADDITIONAL BENEFITS FOR INJURY | |
| NOT ALL POLICIES PROVIDE THESE BENEFITS. PLEASE ONLY COMPLETE IF APPLICABLE.  Are you claiming for:-  homecare or income replacement after major surgery for cancer  childminding or income replacement after a child's accident  home tuition fees after a child's accident  medical expenses not covered by Medicare  damage to personal property  Give details, specifying each item: | |
| **ITEM** | **AMOUNT** |
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| PLEASE ATTACH INVOICES OR OTHER EVIDENCE OF THE EXPENSES YOU HAVE INCURRED OR RECEIPTS FOR DAMAGED PROPERTY | |

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| 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.  Yes  No |
| Name of insured organisation/employer:  Telephone: |
| Name of insurer:  Telephone: |
| Type of cover: |
| Amount claimed per week:       per week |
| Do you have private health insurance? Yes  No  Give details: |
| Do you have ambulance cover? Yes  No  Give details: |

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| TO BE COMPLETED BY YOUR EMPLOYER |
| If Self Employed please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earnings. |
| Name of employer: |
| This is to certify that                                of  has been unable to attend his/her occupation as a result of Injury from      /     /  His/Her average Gross Weekly Salary at the time of this accident was A$  He/She has been employed since      /     /  His/Her Sick Leave Entitlement at the time of this accident was                 days  Has a claim for Worker's Compensation been lodged? Yes  No  In case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission?  Yes  No  Employer / Supervisor name (please print):  Employer / Supervisor signature: ………………………………………………………..  Telephone:                 Dated:      /     / |

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| Privacy Consent - Claim assessment |
| **Protection of My Privacy**  **Acknowledgement and Consents**  VMIA 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.vmia.vic.gov.au](http://www.vmia.vic.gov.au/)  Your personal information will be used by us or any third party that we provide 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 VMIA 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);     - Any other information relating to your income, assets, liabilities and solvency; and     - Any information from third parties who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.   To process your claim we 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 VMIA, 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).  We 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 insurers, our reinsurers, and government agencies including the police (where we are compelled by law). These third parties may be located outside Australia. VMIA may also disclose your personal information to witnesses in relation to your claim.  If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, we may not be able to process or assess your claim. |

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| Medical Authority, Declaration and Power of Attorney |
| I DECLARE THAT,  I understand that by investigating my claim or by accepting proofs of my claim, VMIA has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.  I agree to VMIA using and disclosing my personal information pursuant to VMIA'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 VMIA's privacy officer.  I authorise any person or entity, including but not limited to the Parties referred to above, to provide to VMIA such personal information (including health information) as VMIA in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.  I will use my best endeavours to render all reasonable assistance and co-operation to VMIA 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 VMIA 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 giving effect to this Privacy Consent and Medical Authority.  Signature of claimant: ……………………………………………… Dated:      /     /  Name of claimant (please print):  Signature of witness: ………………………………………………. Dated:      /     /  Name of witness (please print): |

Any personal information you provide directly (or provided by a health service under s141 of the Health Services Act 1988, or a third party such as a government body) in this Form is being collected by the VMIA for the purpose of administering VMIA’s functions, under s6 of the Victorian Managed Insurance Authority Act 1996 (Vic), namely to provide insurance, risk advisory and claims handling services. Any personal information you provide will be treated according to the requirements of the Privacy and Data Protection Act 2014 (Vic), the Information Privacy Principles, the Victorian Protective Data Security Standards, the Health Records Act 2001 (Vic) and the Health Privacy Principles. VMIA will not act or engage in any practice that contravenes these provisions. Information will be handled in line with VMIA's Privacy Policy. You have the right to access and correct your personal information. Requests for access should be sent to the Privacy Officer, VMIA, PO Box 18409, Collins Street East, VIC 8003 or privacy@vmia.vic.gov.au