

# Personal Accident Voluntary Workers

## Claim Form

Claim Number \_\_\_\_\_  
(office use only)

### How to Get Quick Action on Your Claim Form

Catholic Church Insurance Limited will act on your claim as soon as we receive this form. You can help us to act quickly for you by:

- ◆ Providing an original doctor's certificate. The certificate must show:
  - Name of the voluntary worker
  - Date, nature and extent of injury
- ◆ Providing original itemised accounts or receipts for claimable expenses.
- ◆ Ensuring the declaration on page 4 is completed by your church/school/organisation.

Catholic Church Insurance Limited does not pay for the cost of obtaining documentation to support a claim.

**IMPORTANT: CATHOLIC CHURCH INSURANCE LIMITED IS PROHIBITED BY FEDERAL HEALTH LEGISLATION (INCLUDING THE HEALTH INSURANCE ACT 1973 (Cth)) FROM PAYING ANY MEDICARE REBATE INCLUDING THE MEDICARE GAP**

**STOP**

**For Example:**

A student breaks their arm whilst playing on the school playground

Doctor's Fee	\$100.00
Less Medicare Refund	\$60.00
<b>Medicare Gap</b>	<b>\$40.00</b>

\*The Medicare Gap is NOT claimable under this policy

### Checklist for Voluntary Workers

**Please check**

- |  |   |
|--|---|
| <input type="checkbox"/> That all questions have been answered                   | <input type="checkbox"/> That all supporting documentation is attached                            |
| <input type="checkbox"/> That you have not included any Medicare claimable items | <input type="checkbox"/> That the church/school/organisation has signed the declaration on page 4 |

### Checklist for church/school/organisation

**Please check**

- |  |   |
|--|---|
| <input type="checkbox"/> That all questions have been answered         | <input type="checkbox"/> That the voluntary worker has signed the declaration on page 4           |
| <input type="checkbox"/> That all supporting documentation is attached | <input type="checkbox"/> That the church/school/organisation has signed the declaration on page 4 |

## To be completed by a voluntary worker

### Personal Details

Title  Surname  Given name(s)

#### Address

Postcode

Phone: Work  Home  Mobile  Fax

Voluntary Worker's date of birth (dd/mm/yyyy)

/  /

Email

## Please complete if in paid employment at the time of the accident

Employer's name

Employer's address

Postcode

Your normal weekly wages (excluding overtime)

\$

Your usual occupation

Are you making or entitled to make any other insurance or compensation claim in respect to this disablement

i. sick leave/annual

ii. workers compensation

Description of incident and nature of injury

Declaration signature

Names and address of witness(es)

1. Name

Address



Postcode

2. Name

Address



Postcode

Please advise name and address of the doctor who treated you after the accident and details of treatment given




Have you lodged a claim through private health insurance in relation to this claim?  Yes  No

**If YES, please provide all relevant proof of benefits paid by your health insurer. This Personal Accident Voluntary Workers Policy will pay the difference between the Insured's non-medicare rebate and the cost of the health service.**

If you are totally disabled from attending your normal employment, please give dates of disablement:

 /  /  to  /  / 

**The original certificate from a qualified medical practitioner must be submitted for all periods of disablement claimed.**

Please give details of any weekly payments received during the period of disablement (eg: wages, compensation, social services, etc.)

Description	Weekly payment amount being received
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>

Please detail your non Medicare related costs

Description	Cost amount
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>

## Payment

If you would like the claims settlement to be paid via EFT into your account, please complete your details below:

Account name

Bank

Branch

BSB number

 - 

Account number

## Declaration (Voluntary Worker)

I declare that the information given is true and correct, and that I suffered incapacity and/or expenses in the Accident referred to above.

Voluntary Worker's signature

Date (dd/mm/yyyy)

 /  / 

Church/School/Organisation Name

## Declaration (church/school/organisation)

Policy number

Client number

Do you consider the information on this form to be accurate?  Yes  No

If NO, please comment

Do you wish to make further comment in relation to this claim?

Church/school/organisation signature

Date (dd/mm/yyyy)

 /  / 

Please print name

**Upon completion of the claim form please return to:**

GPO Box 180 Melbourne 3001 or via email to [liabilityclaims@ccinsurance.org.au](mailto:liabilityclaims@ccinsurance.org.au)

## Privacy

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We are committed to protecting your privacy in accordance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles (APPs), which will ensure the privacy and security of your personal information. Our Privacy Policy explains how we collect, use, disclose and handle your personal information as well as your rights to access and correct your personal information and make a complaint for any breach of the APPs. A copy of our Privacy Policy is located on our website at [www.ccinsurance.org.au](http://www.ccinsurance.org.au)

## General Insurance Code of Practice

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CCI is a signatory to the General Insurance Code of Practice. The Code is designed to set minimum standards of practice and service in the insurance industry. Further information about the Code can be obtained from [www.codeofpractice.com.au](http://www.codeofpractice.com.au)

## Complaints and Dispute Resolution

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If you are unhappy with our service, a decision or the process, you may make a complaint in accordance with our complaints handling procedure. Details of our insurance complaints handling procedure can be obtained from our website at [www.ccinsurance.org.au](http://www.ccinsurance.org.au)

### How to Contact Us

Mail	Catholic Church Insurance Limited GPO Box 180 Melbourne 3001
Email	<a href="mailto:claims@ccinsurance.org.au">claims@ccinsurance.org.au</a>
Website	<a href="http://www.ccinsurance.org.au">www.ccinsurance.org.au</a>
Telephone	1300 138 498
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