

**MULTIPLE DISTRICT 201 of LIONS CLUBS  
INTERNATIONAL Inc.**

**PERSONAL ACCIDENT CLAIM FORM.**

**UNDERWRITER :**

**LLOYDS, One Lime Street, LONDON. EC3M 7HA**

**Instructions to the Club when completing the Claim Form.**

1. Please refer to the Insurance Summary in the Multiple District Directory for details of the coverage provided under this Policy.
1. Please remember that a period of Disablement of less than five (5) days will not be paid. (This is called a Franchise.)
1. In the case of a serious accident, please notify PDG Bob Korotcoff immediately by telephone, facsimile or E-mail.
1. Please report any Claim immediately for any Late Notification could prejudice its outcome and could be an embarrassment to all Parties.
1. Additional Benefits cover is for the amount not recoverable from any Private Health Fund and is subject to the Provisions of the Health Act.
1. **Completed Claim Form is to be returned to:**

***R. N. (Bob) KOROTCOFF, Dip.Fin.Serv. PDG***

***Lions Insurance Programme Consultant***

***AFSL # 278958***

***P O Box 454, BRIGHTON S A 5048***

***Telephone: (08) 8298 1599 Mobile: 0418 831 426***

***Facsimile: (08) 8377 0798 E-mail: insurance@lions.org.au***

INSURED PERSON'S STATEMENT.

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Phone:(w)** \_\_\_\_\_ **(h)** \_\_\_\_\_

**E-mail:** \_\_\_\_\_ **Facsimile:** \_\_\_\_\_

**LIONS CLUB of:** \_\_\_\_\_ **DISTRICT:** \_\_\_\_\_

**Position in Club:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_ **Time of Accident:** \_\_\_\_\_

**Function at which Accident occurred:** \_\_\_\_\_

**How did the Accident occur?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Were you engaged in performing duties at the time of the Accident?** YES / NO.

**Witnesses:** \_\_\_\_\_

\_\_\_\_\_  
**Name and Address of Attending Doctor:** \_\_\_\_\_

**Are you in receipt of an Income from Work?** YES / NO. **If yes,**

**What is your Gross Weekly Wage?** \$ \_\_\_\_\_ **Are you self employed?** YES / NO.

**PLEASE ATTACH A STATEMENT FROM YOUR EMPLOYER SHOWING YOUR GROSS WEEKLY EARNINGS IMMEDIATELY PRIOR TO YOUR INJURY. ALTERNATIVELY, ATTACH A COPY OF YOUR LATEST TAXATION ASSESSMENT NOTICE FROM THE AUSTRALIAN TAX OFFICE.**

I warrant the truth of the foregoing statement and particulars in every respect and that I have not withheld from the Company any material information in connection with this claim.

**SIGNATURE of INJURED PERSON:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**PLEASE HAVE YOUR MEDICAL ATTENDANT COMPLETE THE MEDICAL CERTIFICATE on the next page.**

**Name of Injured Person:** \_\_\_\_\_

**Nature of Injury:** (Please provide sufficient particulars of symptoms to enable a Medical Officer of the Company to comment should the Company wish to consult him.)

\_\_\_\_\_  
\_\_\_\_\_

**Is the Injury consistent with the stated Cause above?** \_\_\_\_\_

**Please state the date you consider incapacity from the injury commenced:**

\_\_\_\_\_

**Have you treated the Injured Person previously for this Complaint? If so, please provide full details:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If the Injured Person is suffering from any Disease irrespective of the present injury or if there are any circumstances which may tend to delay recovery, please give full details:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**When did the Injured Person first consult you in connection with this Injury?**

\_\_\_\_\_

**Are you the Injured Person's usual Medical Attendant? YES / NO. If Yes,**

**for how long have you known him / her?** \_\_\_\_\_

**TEMPORARY TOTAL DISABILITY:** The complete inability of the Injured Person because of this Injury to perform each and every duty pertaining to his / her regular business or occupation.

**If, in your opinion, the Injured Person has been totally disabled as defined above, please quote**

**duration: TOTAL DISABLEMENT From \_\_\_\_\_ to \_\_\_\_\_**

**Expected duration of Injured Person's Total Disablement?** \_\_\_\_\_

**I CERTIFY, that to the best of my knowledge, the foregoing statements are correct.**

**SIGNATURE:** \_\_\_\_\_ **QUALIFICATION:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**Telephone No.** \_\_\_\_\_ **Date:** \_\_\_\_\_

AUTHORITY.

I hereby authorise any Hospital, Physician, or Other Person who attended me, or any Employer, to furnish J U A UNDERWRITING AGENCY PTY LTD, or its Representatives, any and all information in respect of any Sickness or Injury, Medical History, Consultation, Prescriptions, or Treatment, copies of all Hospital or Medical Records and copies of all Records of Employers.

I also agree that a Photostat copy of this Authorisation shall be considered as effective and valid as the Original.

**SIGNATURE of INJURED PERSON:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

LIONS CLUB OFFICIAL CERTIFICATION.

**I certify that LION** \_\_\_\_\_

**\*\* IS A MEMBER IN GOOD STANDING?**

**\*\*WAS A VOLUNTARY WORKER FOR THIS CLUB?**

**\*\* IS AN ACCOMPANYING PARTNER OF A MEMBER OF THIS CLUB?**

And was injured in the circumstances described elsewhere in this Claim Form and is, in my opinion, entitled to Benefits under the Lions Personal Accident Policy.

**SIGNATURE of CLUB OFFICER:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **POSITION in CLUB:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**LIONS CLUB of** \_\_\_\_\_

**CLUB ADDRESS:** \_\_\_\_\_

**HAVE YOU ENCLOSED?**

- 1. IF CLAIMING WEEKLY BENEFITS, STATEMENT OF INCOME?**
- 2. IF CLAIMING ADDITIONAL EXPENSES, ALL RECEIPTS?**