CORPORATE
SERVICES
NETWORK

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SYDNEY NSW 2001

Pilot Personal Accident

Accidental Death & Disablement

Claim Form

CORPORATE SERVICES NETWORK

SECTION A
INSURED / CLAIMANT

Section 1: Policy and personal information

Policy number:				
Insured surname:				
Insured first name:				
Contact numbers:	Daytime contact number:		Alternative number:	
Address:	*Note: we do not accept post office boxes as your address.*			
Date of Birth:				

Section 2: Claimant details (if other than above)

Surname:				
First name:				
Address:	*Note: we do not accept post office boxes as your address.*			
Contact numbers:	Daytime contact number:		Alternative number:	
Email address:				

What is your relationship to the insured? (Please tick).

- ☐ Spouse
- ☐ Defacto Spouse
- ☐ Son or Daughter
- ☐ Sibling
- ☐ Employer
- ☐ Executor of the estate
- ☐ Solicitor acting on behalf of the estate

Section 3: Accident details

3.1. Type of loss / claim (please tick)

☐ Accidental Death ☐ Accidental Permanent Total Disablement

3.2. Please provide exact date and time of the accident.

Date and Time of Accident:	Date:	/ /	Location of Accident:	
	Time:			

3.3. Was the activity at the time of the accident piloting or travelling as a passenger or crew member in an aircraft? (please tick)

☐ No ☐ Yes **>** Please provide details of aircraft (fixed or rotary wing)

3.4. Please describe how the accident occurred?

3.5. Were there any witnesses to the accident? (please tick)

☐ No ☐ Yes **>** Please supply name(s) and contact details.

3.6. Is there a Police report? (please tick)

☐ No ☐ Yes **>** Please attach copies.

3.7. What were the injuries sustained (body part injured, injury type) / If applicable, the cause of death insofar as this is known?

3.8. Have you ever injured the same body part in the past? (please tick)

☐ No ☐ Yes **>** Please provide details.

3.9. Have you made a claim against any other party in respect of this event? If yes, please provide details.

Name of other party / Insurance company:

Description of claim:

Section 4: Treatment

4.1. Was hospital treatment required? (please tick)

☐ No ☐ Yes **>** Please provide dates admitted/discharged, hospital name, address and attending physicians.

4.2. Please provide the name and address of usual General Practitioner.

4.3. Please give details of all attending Physicians, including names, address and telephone numbers.

4.4. If applicable, please give the full name and address of the Coroner who will be conducting the inquest and planned date inquest will be held:

Is there any condition (past or present) affecting your current disability?

☐ No ☐ Yes **>** Please provide details.

Section 5: Employment and education

To be completed only if claim is for Permanent Total Disablement

5.1. What level of education do you have (Primary, Secondary, Tertiary)?

5.2. What qualifications or certificates do you have?

5.3. Please list all previous jobs you have held prior to becoming a commercial aviation pilot.

Employer	Job Title	Duties

5.4. Have you worked in any capacity since stopping work? (please tick)

☐ No ☐ Yes **>** Please supply name of business, type of work, full or part time and dates of employment.

5.5. Have you applied for any jobs since stopping work? (please tick)

☐ No ☐ Yes **>** Please supply name of business(s), type of work, date of application and if you were offered employment.

5.6. Are you attending any rehabilitation programmes or have you commenced any studies to help a return to work?

☐ No ☐ Yes **>** Please supply full details below.

Section 6: Payment details

Following approval of the claim, payment will be made to the appropriate person(s). Please provide bank details for us to accelerate the claims payment process by direct transfer. If we decide that the benefit payment is due to more than one person, the details provided below should be for the person nominated to receive payment on behalf of the relevant parties.

Name of bank account holder:		Bank name:	
Account no:		BSB number:	

Section 7: Documentation

Below is a list of documentation required to process your claim. In certain circumstances, additional information may be required.

- Claim form fully completed.
- Copies of any other documentation such as copies of police reports, accident reports, report by workers compensation investigators or insurers, or any other such authority?

For Accidental Death (in addition to above):

- Certified copy of the Death Certificate / Post-Mortem Report / Burial Certificate.
- Certified copy of the Birth Certificate.
- If death was reported to the Coroner, please attach a copy of the report.
- Certified letter of Administration / Distribution Order

Privacy Authority

Corporate Services Network (CSN)

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.csnet.com.au and send to privacy@csnet.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN'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 CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to CSN 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 if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.

I appoint CSN 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 to give effect to this Privacy Consent and Medical Authority.

Signature of Insured / Claimant	Name of Insured / Claimant	Date
		/ /

Signature of Witness (any adult person)	Name of Witness	Date
		/ /

A copy of this claim form should be retained for your records

SECTION B
PHYSICIAN MEDICAL REPORT

To be completed only if claim is for Permanent Total Disablement.

This form is to be completed by the patients attending Physician, any fee charged to complete this medical report will be the responsibility of the claimant.

Patient details

Surname:	
First name:	
Usual occupation:	
Date of Birth:	

History

How long have you known the patient in a professional capacity?

	Days		Months		Years

Are you the regular attending Physician?

☐ Yes ☐ No **>** Please advise who is below.

Accident and injury details

Date of injury: / /

Date the patient first consulted you for this injury: / /

Please describe the circumstances of the accident and how it occurred?

Did the accident result in any of the following? (please tick)

- ☐ Permanent Paraplegia or Quadriplegia
- ☐ Permanent and incurable paralysis of all limbs
- ☐ Permanent loss of sight of one / both eyes
- ☐ Permanent and incurable insanity
- ☐ Permanent loss of use of lens of both eyes
- ☐ Permanent loss of use of lens of one eye
- ☐ Permanent loss of use of hearing of both ears
- ☐ Permanent loss of use of hearing of one ear

Permanent loss of use of the following? (please tick)

- ☐ Four fingers and thumb of either hand
- ☐ Four fingers of either hand
- ☐ Toes of either foot / all – one foot
- ☐ Toes of either foot / great – both joints

- [ ] Thumb of either hand, both joints
- [ ] Thumb of either hand / one joint
- [ ] Fingers of either hand / three joints
- [ ] Fingers of either hand / two joints
- [ ] Fingers of either hand / one joint
- [ ] Toes of either foot / great – one joint
- [ ] Toes of either foot / other than great toe – each toe

Other conditions? (please tick)

- [ ] Third degree burns and/or resultant disfigurement which covers more than thirty percent (30%) of the entire external body
- [ ] Second degree burns and/ or resultant disfigurement which covers more than thirty percent (30%) of the entire external body
- [ ] Fractured leg or patella with established non-union
- [ ] Shortening of leg by at least five centimetres
- [ ] Other **>** (please specify below)

Is the disability due solely to this accident? (please tick)

☐ No ☐ Yes

Any sign of a pre-existing injury that may have contributed or aggravated either directly or indirectly to this injury? (please tick)

☐ No ☐ Yes **>** Please provide details (nature and cause of injury).

Is there any reason or evidence to suggest the use of alcohol or drugs directly or indirectly contributed to the patient's accident?

☐ No ☐ Yes **>** Please provide details and include BAC reading if taken.

Treatment of injury

Have you referred the patient to other specialist services or treatment?

☐ No ☐ Yes **>** Please provide details and a telephone contact number.

What surgical or medical procedures are possibly contemplated?

A copy of this claim form should be retained for your records

What is the current prognosis?

Any other comments regarding your assessment of the injury?

Declaration of Physician

By signing the declaration below, you confirm and agree to the following:

A. You are a currently registered medical practitioner.
B. You have personally examined the patient.
C. The information provided and supplied herein is true and accurate to the best of your knowledge and belief.

Signature of Physician	Name of Physician	Date
		/ /