PERSONAL ACCIDENT AND ILLNESS CLAIM FORM

Statement and Declaration during Disablement

TAI
a division of Insurance Wholesale Limited
Level 1, 3 Morton Street, Freemans Bay, Auckland 1010
P.O. Box 99 481, Newmarket, Auckland 1149
www.tai.co.nz

Full name of insured:

Date of Birth:

Address:

Occupation:

Email:

Phone:

COMPLETE THIS SECTION FOR AN **ACCIDENT**

1. Date of accident: Time: am ☐ pm ☐

2. Place of accident:

3. Describe fully what happened and what you were doing at the time:

4. Describe nature and extent of injuries:

5. Were you perfectly free from any kind of disease or physical disability at the time of the accident?

6. Give the name and contact details of witness or witnesses of the accident:

COMPLETE THIS SECTION FOR AN **ILLNESS**

7. On what date were you taken ill?:

8. Describe the illness from which you are suffering:

9. Have you ever suffered from the same or similar illness before? YES ☐ NO ☐

If yes, state when:

Name of the medical practitioner who attended you:

COMPLETE THIS SECTION IN **ALL CASES** REQUEST THAT YOUR DOCTOR COMPLETES THE REVERSE OF THIS FORM

10. When did you first obtain medical advice?

11. Is the doctor still attending you? YES ☐ NO ☐ If yes, please provide their name and address:

12. On what date did you cease work?

13. Are you necessarily confined to the house?

14. Are you able to attend to any portion of your usual occupation?

15. On what date do you estimate you will be able to resume the whole of your ordinary or similar occupation?

16. Are you claiming or entitled to claim compensation from the Accident Compensation Corporation or any insurer, company, society, organisation or other source? YES ☐ NO ☐ If yes, give particulars:

General remarks:

I declare that all information contained in this claim form are true and correct.

Signature: Date:

RELEASE OF MEDICAL RECORDS DECLARATION

THE DECLARATION BELOW MUST BE COMPLETED BY THE CLAIMANT BEFORE THE CLAIM CAN BE ASSESSED.

I, , hereby authorise any treatment provider to release any information in relation to my past or present medical condition to Wholesale Insurance Services, PO Box 10027, Wellington 6143.

Signature: Date:

DOCTORS DECLARATION

Doctor's name: Address:

1. What is the nature of the ailment/accident:
2. On what date did the patient first become aware of the ailment?
3. On what date did the patient first obtain medical advice?
4. On what date did the patient cease work?
5. Has the patient ever suffered from this same or similar ailment before? YES ☐ NO ☐
   If yes supply details:
6. On what date do you estimate the patient will be fit for partial duties:
7. On what date do you estimate the patient will be fit for full duties:
8. Prognosis & general remarks relating to current & ongoing treatment required.

Doctor's signature: Date: