BERKSHIRE HATHAWAY SPECIALTY INSURANCE

Accident & Health

GROUP PERSONAL ACCIDENT INSURANCE CLAIM FORM

NOTIFICATION OF A CLAIM OR CIRCUMSTANCE THAT MAY GIVE RISE TO A CLAIM

YOUR INFORMATION

Policy Number:

Policyholder Name: _____

Your Full Name: _____

Full Address:

_____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Telephone Mobile: _____ Telephone Work: _____

Email Address: _____

Policyholder Address: _____ Policyholder Telephone Number: _____

Were you employed by the Policyholder at the time of suffering the Accident or contracting the Sickness? ☐ Yes ☐ No

If no, please provide further details:

ACCIDENT

Location where accident occurred: _____

Date & Time of Accident: _____

Please describe how the injury/accident occurred:

Please advise the extent of your injuries:

Have you previously been treated for serious injury? ☐ Yes ☐ No

If yes, please provide full details including how long you were off work:

Were there any witnesses to the accident? ☐ Yes ☐ No

Witness Name: _____

Witness Address & Contact Details:

SICKNESS

When did the sickness commence? _____

Please describe the nature of the sickness:

Have you previously been treated for this sickness or a similar type of sickness? ☐ Yes ☐ No

If yes, please provide full details including how long you were off work:

PERIOD OFF WORK

Was hospital treatment required? ☐ Yes ☐ No

If yes, complete the following regarding your hospital stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Please provide details of all attending physicians (please attach separate sheet if insufficient space)

Doctor's Name	Address	Telephone Number

Are you entitled to sick leave? ☐ Yes ☐ No

If yes, please advise number of days: _____

Period you have received sick leave from _____ and to _____

When did you stop work? Date: _____ Time: _____

When did you first obtain treatment from a doctor? Date: _____ Time: _____

Name of treating doctor: _____

Address of treating doctor:

Is this doctor still treating you for the injury or sickness? ☐ Yes ☐ No

Is this doctor your regular doctor? ☐ Yes ☐ No

If no, please provide name & address of your regular doctor:

Is there any condition (past or present) affecting your current disability? ☐ Yes ☐ No

If yes, please provide details:

CURRENT STATUS OF DISABILITY

Are you now recovered? ☐ Yes ☐ No

*If yes, when did you return to work? (date)*_____

Are you now partially disabled? ☐ Yes ☐ No

If yes, when did you return to partial duties? (date) _____

Are you now totally disabled? ☐ Yes ☐ No

If no, when do you expect to return to work? (date) _____

OTHER INSURANCE

Have you lodged a claim, or will you make a claim for benefits under the Accident Compensation Act (2001) that may also cover your loss? ☐ Yes ☐ No

If yes, please provide details:

CLAIMING FOR WEEKLY BENEFITS

Are you self-employed? ☐ Yes ☐ No

If yes, confirmation of earnings must be submitted with your claim form (income tax return, profit & loss statement etc.)

If you are employed as a wage earner the section below must be completed by your employer.

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an Injury/Sickness suffered whilst _____ on _____.

The employee has been incapacitated since: _____

And is expected to/did resume duties on: _____

The employee's gross salary, exclusive of bonuses, commission,
allowances etc. at the date of injury/sickness was: $_____ per week

Please specify the pay type: (sick leave, annual leave etc.) _____

If any form of pay was received, please provide full details of pay history:

Name of Company: _____

Company Address: _____

Name of Supervisor or Payroll completing this form: _____

Telephone Number: _____

Email Address: _____

_____ _____

Signature of Supervisor or Payroll Date

AUTHORITY TO GIVE INFORMATION

I/we hereby authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the insurer such information as it may require regarding any injury or illness to me or my physical or mental condition or prognosis, or my employment, to assist in the proof and settlement of my claim. A photocopy of this authority can be acted upon as if it were original.

_____ _____

Signature of Supervisor or Payroll Date

CERTIFICATE OF ATTENDING PHYSICIAN

To be completed by attending physician.

The claimant must obtain, at his/her own expense, the completion of this certificate from a duly qualified and registered medical practitioner. In the event of the medical practitioner being unable to answer from their own personal knowledge any of the following questions, they are requested to state so.

Furnished in connection with the disability of:

Name of Patient: _____

Full Address: _____

Are you the patient's regular physician? ☐ Yes ☐ No

If yes, how long have you known the patient? (years & months)

_____

Has the patient previously suffered from the same or similar injuries/sicknesses? ☐ Yes ☐ No

If yes, provide the date and diagnosis:

Date of first consultation of this condition: _____

In your opinion, how long has this condition been in existence whether treated for same or not?

Present Condition:

Prognosis:

Nature of operation (if any):

Name of physician(s) who previously treated patient for the above condition:

Are the patient's symptoms:

Due exclusively to the accident? ☐ Yes ☐ No

Traceable to disease? ☐ Yes ☐ No

Infirmity or any other cause? ☐ Yes ☐ No

Is there anything in the patient's medical history which may have contributed, directly or indirect, to the injury/illness or which may be likely to retard the patients recovery? ☐ Yes ☐ No

If yes, please provide details:

Is the patient still under your care for this condition? ☐ Yes ☐ No

If no, on what date did you release the patient to perform regular duties?

_____

Dates unfit for work, or unable to perform specific parts of the patient's occupation? *(if uncertain please estimate)*

_____

Have you any reason to suppose that the patient was under the influence of intoxicants or drugs at the time of the accident? ☐ Yes ☐ No

If hospitalised, please provide dates: _____

Name of hospital: _____

Dates patient was totally disabled: _____

In your opinion, probable further disability should not exceed past the following date:

_____

Name of Physician: _____

Full Address: _____

Office Phone Number: _____ Mobile Phone Number: _____

Qualifications:

_____ _____

Signature of Physician Date

PAYEE'S ELECTRONIC FUNDS TRANSFER (EFT) DETAILS AND TAX STATUS:

Following approval of your claim, we will pay your claim directly into your bank account. To enable us to do so, please provide the following details:

Name of Financial Institution: _____

Account Name: _____

Bank Code: _____ Account Number: _____

Bank Swift Code (International Payments): _____

Bank Account Currency (International Payments): _____

Bank Address (International Payments): _____

Please note that we are not liable for any bank processing fees incurred by you.

Is the Payee tax resident in New Zealand? ☐ Yes ☐ No

If not, is the Payee registered for GST? ☐ Yes ☐ No

DECLARATION

I declare that the above statements are true and correct and that I understand that:

- this claim form may collect personal information;
- Berkshire Hathaway Specialty Insurance Company requires this information pursuant to my/our insurance policy ("the policy") and to evaluate this claim;
- the Privacy Act 2020 entitles me/us to have access to, and request correction of, any information retained;
- Berkshire Hathaway Specialty Insurance Company is authorised to collect information relevant to the policy and the claim from third parties; and
- Berkshire Hathaway Specialty Insurance Company may make our personal information available to third parties to administer this claim or when required by law to do so.

Name: _____ Position: _____

Signature: _____ Date: _____

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