Personal Accident Claim Form

FEDERAL INSURANCE TIMOR S.A

OFFICE USE: Policy Number: _____ *Claim Number: _____*

- **WARNING: If you supply any untrue or false information and know that it is not true, Federal Insurance Timor, S.A. (FIT) shall have the right to refuse the claim.**
- **We recommend that you read the Claims section of your policy.**
- **Please answer all the questions on this form. If a question does not apply to your claim, please answer "N/A".**
- **You must not incur any expense (unless it is to minimise the loss), or admit fault, without our permission.**
- **Part G of this form must be signed by the person who has received medical advice for illness or injury.**

PART A: THE INSURED

Name of Insured: _____

Postal Address: _____

Best contact Phone No: _____ Best time to contact: _____

Alternative contact: _____

PART B: THE ILL OR INJURED PERSON

Please answer these questions about the person who suffered the illness or injury.

1. Full name: _____
2. Occupation _____ Date of Birth: _____
3. Is this the "insured" shown in Part A above? Yes ☐ No ☐

If "Yes", go straight to Part C

If "No", what is their connection with the "Insured" shown in Part A? Employee ☐ Spouse ☐ Director ☐ Other ☐

If "Other" please give details: _____

PART C: DETAILS OF ACCIDENT

1. Is this disablement the result of an accident? Yes ☐ No ☐

If "Yes", please complete questions 2 - 7. If the disablement is part of an illness, please go straight to Part D.

2. When did the accident happen? (please give time and date): _____
3. Where did it happen? (please give full address or details of the location): _____

4. What was the injured person doing at the time?

5. Please describe the type and extent of the injuries received:

6. Did the person have any other injury, disease or physical disability at the time of the accident? Yes ☐ No ☐

If "Yes", please give full details: _____

7. Were there any witnesses? Yes ☐ No ☐

If "Yes", please give full details (name, address, contact phone etc.

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PART D: DETAILS OF ILLNESS

1. When was the person first taken ill? (please give date and time) _____
2. What is the illness? _____
3. Has the person had this illness or any similar illness before? Yes ☐ No ☐

If "Yes", please give full details (including date, name of any doctor, details of treatment etc.

_____

_____

PART E: MEDICAL ADVICE

1. On what date was medical advice first obtained? _____
2. What is the name of the doctor who gave this advice? _____

Address _____ Phone _____

3. Is this doctor still providing treatment? Yes ☐ No ☐

If "No", please give details of any other doctor who is now providing treatment.

Name: _____

Address: _____ Phone: _____

4. Has any other doctor or specialist or any other practitioner provided treatment: Yes ☐ No ☐

If "Yes", please give details:

Name: _____

Address: _____ Phone: _____

Type of treatment: _____

PART F: GENERAL DETAILS

Please supply this information about the person who suffered the illness or injury.

1. On what date did the person first stop work because of this injury or illness? _____
2. As a result of this injury or illness, has the person:

(a) been confined at home? Yes ☐ No ☐

If "Yes", when were they first able to leave their home?

_____

(b) had to be hospitalised? Yes ☐ No ☐

If "Yes", please give details

_____

3. Is the person who suffered the illness or injury:

(a) now able to take any part in their business? Yes ☐ No ☐

If "No", when is the person expected to be able to do all of their usual work or fully take part in their business again?

_____

(b) entitled to claim, or currently claiming, any benefit or compensation for this injury or illness under the Accident Compensation Corporation?

Yes ☐ No ☐

If "Yes", please give details

_____

4. Has the person suffered any other illness or injury since this insurance was first arranged? Yes ☐ No ☐

If "Yes", please give details (whether an insurance claim was made or not):

_____

5. Is there any other information which is relevant to this claim? Yes ☐ No ☐

If "Yes", please give details

_____

PART G: AUTHORITY TO RELEASE INFORMATION

This must be signed by the ill or injured person (if this is not possible because of the injury or illness, please contact FIT.
I authorise anyone who has attended or examined me to furnish to FIT or its authorised representative, all information relating to my illness or injury, medical history, consultation, prescriptions or treatment, and copies of any hospital or medical records.
A photocopy of the authorisation shall be sufficient authority.

Full Name: _____

Address: _____

Signature: _____ Date: _____

PART H: DECLARATION AND SIGNATURE

I declare that

1. Material Facts

(a) All information given to FIT in connection with this claim (whether oral or written) is true and correct;

(b) No information relevant to the claim is omitted;

2. Use of Information

(a) My personal information collected by FIT in connection with this claim may be disclosed to other members of the insurance industry;

(b) My personal information held by any other parties in connection with this claim may be disclosed to FIT;

Please note:

- We gather information about you (including your claims history) to consider your claim. The terms of your insurance policy require you to supply this information, and if you refuse to provide it, we may decline your claim.
- This information is held by us and you may access it. It may be passed on to other insurers you deal with.

SIGNED ON BEHALF

OF ALL INSUREDS: _____ Date: _____