Claim lodgement process for
Loss of Income Protection – Goonyella Riverside Group Insurance

We hope this flowchart will help you better understand how making a claim works and what we jointly need to do to have the claim assessed ASAP. Cerberos Brokers Pty Ltd (AFSL 260668) are the insurance broker for the CFMEU and they assist in the claims lodgement process. Cerberos act as agent of CFMEU. Cerberos is NOT the Insurer and is NOT liable for any loss or claim. Should you have any questions regarding any part of your claim form or the claims process, please call Cerberos on (07) 3088 2070 business hours or email claims@cerberos.com.au.

Complete all parts of the claim form and include:

- ❑ All doctors certificates
- ❑ Have your doctor complete the Doctors statement (Pages 6 & 7)
- ❑ Include copies of 2 most recent pay-slips
- ❑ Certified Copy of identification e.g. Driver's licence
- ❑ Medicare Form
- ❑ Bank deposit details

Please note there will be delays in receiving your benefit if the above are not included in your claim.

✓ **Step 1.** Obtain a claim form ⇩	Claim forms can be obtained from: • your Union Lodge Representative; • Cerberos Brokers
✓ **Step 2.** Sending your claim form Remember to keep a copy of all your claim documentation & send original claim forms to: Cerberos Brokers Pty Ltd PO Box 1305 SPRING HILL QLD 4004 ⇩	To *speed up* the process for lodgement you can: • scan your completed and signed Claim Form and email it to: claims@cerberos.com.au. • fax your claim form to Cerberos Brokers Pty Ltd (07) 3088 2079 ***Please keep a copy for your own records***
✓ **Step 3.** Your confirmation Cerberos Brokers will confirm receipt of your claim and lodge it with the insurer	Cerberos Brokers will: • ensure you have provided all the information needed by the underwriter; • confirm receipt of your claim; • provide you with the insurer's claim number; • give you a contact number to discuss the progress of your claim.

Insurance Claim Form – Personal Injury or Sickness

To ensure your claim is processed as quickly as possible, please ensure:

1. Completion of Sections A, D & F
2. Sections B & C are completed if your claim relates to Injury, Sickness or Additional Benefits
3. Your most recent payroll slip is included, and have your doctor complete the Doctors Statement
4. Any necessary documentation required to support your claim is attached to this form
5. Your Claim Form is signed.

Please send completed Claim Form and all documentation to:

Claims Department
Cerberos Brokers Pty Ltd
PO Box 1305
SPRING HILL QLD 4004

A — **This section to be completed for all claims**

Personal Information & Policy Details

Mr/Mrs/Miss/Ms	**Surname**		**First Name(s)**			
Date of Birth	_____/ _____/ _____	**Height**		**Weight**		
Residential Address			**State**		**P'Code**	
Postal Address	Write 'as above' if same as residential address					
Telephone	**Private**		**Business**		**Mobile**	
Email Address		Would you like to receive all your correspondence via email? No ❑ Yes ❑				
Occupation						
Employer		**Mine/Pitt/Division:**				
Describe the usual duties of your occupation						
Gross Weekly Income – please attach most recent play slip ***(Only required where income benefits are being claimed.)***						

Banking Details: **BSB:** _____ -_____ **Bank** _____ **Account No.** _____

Account Name_____

B — **This section only to be completed for Injury or Sickness claims**

Injury/Sickness Claims

Please describe the nature of the Injury or Sickness			
If Injury, describe how it occurred			
What date did the Injury occur or Sickness first manifest?			
Are you now, or have you been unable to work?	No ❑ Yes ❑	**Date ceased work**	
Have you returned to work on either a full-time or part-time basis?		Full-time ❑	Part-time ❑
Date resumed working	Full-time:	Part-time:	
If part-time, hours/days working per week			
Current duties			

B	(Section B Continued) This section only to be completed for Injury or Sickness claims

Injury/Sickness Claims Cont'd

Details of your usual doctor

Name	
Address	
Telephone Number	

Details of treatment sought for this injury/sickness

Name of attending doctor			
Address			
Telephone number		**Date treatment first sought**	_____/ _____/ _____
Have you ever suffered from a similar injury/sickness in the past?		No ❑ Yes ❑ (Please provide details)	
Details			

Details of any hospital treatment/admission for this Injury/Sickness

Name of hospital			
Address			
Date of admittance		**Date of discharge**	_____/ _____/ _____

Details of any other Doctors or medical professionals consulting for this Injury/Sickness

Name (s)			
Address			
Date of admittance		**Date of discharge**	_____/ _____/ _____

Details of any alcohol or drugs consumed during the 24 hours prior to the injury

Alcohol (type and quantity)	
Other drugs (type and quantity)	

Details of any medical or surgical treatment or advice received in the last 5 years

Please provide: • Nature of condition • Date(s) condition occurred/manifested • Treatment undertaken • Names and address of treating doctor(s)	

Details of any long term of chronic disability you've suffered

Please provide: • Nature of condition • Treatment undertaken • Name and address of treating doctor(s)	

Insurance Claim Form – Personal Injury or Sickness

C	Complete this Section only if you are claiming for any of the benefits below

Additional Benefits

Please tick the benefits your are claiming:

❑ Income Protection ❑ Funeral Benefit

Not all policies provide all of the benefits shown

Benefit Level (please specify) _____

D	This section to be completed for all claims	

Other Insurance Details

Are you a member of a private health fund?	No ❑ Yes ❑ (Please provide details)
Do you have Ambulance Cover?	No ❑ Yes ❑
Are you claiming Insurance or any Compensation from any other Entity, Insurance or otherwise?	No ❑ Yes ❑ (Please provide details)

Name of Insurer/Entity	
Telephone Number	
Details of Claim made or Benefit expected	
Income Benefit Claimed	
Other Benefits Claimed	

E	Privacy Statement

Privacy Statement

I _____, date of Birth____/_____/_____ hereby authorise any hospital, physician or other person who has attended me, or my union representative to furnish Lloyds of London or their representatives with:

1. All copy hospital and medical reports/ notes;
2. All copy employment records and income tax returns; and
3. All information pertaining to medical history (any sickness or disease or injury, consultation, prescription or treatment), employment history and income tax returns.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant the foregoing particulars are true and correct in every detail and acknowledge that Lloyds of London relies upon the truthfulness of the particulars supplied by me in respect to the claim.

Privacy Consent

I consent to Lloyds of London or their representatives:

a) Collecting and using my personal information for the purpose of administering my claim including investigations, assessing and paying any claim made by me or on my behalf. I acknowledge the collection of this information may be necessary to process my claim.

b) Disclosing my personal information to related entities of Lloyds of London, their staff members located outside Australia, the insured, other insurers and reinsurers, insurance references bureaus, law enforcement agencies, lawyers, assessors, repairs, advisers and the agent of any of these, insurance broker, insurance agent or other intermediary, my employer or Insurance Ombudsman Service for the purpose of administering my claim or providing a report.

SIGNED: ..... DATED: .....

F	This section to be completed for all claims

Declaration & Authorisation

I declare that:

- the information contained in this form and any documents attached, is correct and complete;
- I have not withheld any information that could affect this claim;
- I am the Insured Person or a nominated beneficiary of the Insured Person covered by the Policy;
- I understand and agree to the above Privacy Statement

I authorise:

- Lloyds of London (or its appointed agents) to collect, use and disclose my personal information that amounts to sensitive information under the Act, as is relevant to this claim.
- Any police officer, airline official or other person who has attended me to supply copies of any and all information relevant to any claim to Lloyds of London or its appointed representatives. A photocopy or facsimile of this authority shall be as effective as the original.
- Lloyds of London (or its appointed representatives) to give to, or obtain from, other insurers or insurance reference bureau any information relevant to this claim.

Your Signature		**Date**	
Name (please print)			

G	Union Authorisation & Confirmation

Declaration & Authorisation

I declare that:

- the information supplied in this form and any documents attached, is correct, complete and to the best of my knowledge;
- information that could affect this claim has not been withheld;
- I know the insured Person.

_____ _____

Lodge Rehab Officer Signature **Name of Union Lodge**

_____ _____

Print Full Name **Mobile Number**

I hereby authorise to have the above Union delegate kept informed as to the status of my claim.

I understand that neither the underwriter (nor its appointed representative) or Cerberos (and its representatives) will be held responsible for disclosing any information whatsoever relating to my claim.

_____ _____

Claimant Signature **Date**

Attending Medical Practitioner's Statement

- Any fees in relation to the completion of this form are the responsibility of the claimant.

Patient's Full Name			
Date of Birth			
Height	cms	**Weight**	kgs

What is disabling the patient? (Please provide full description of condition including nature and location of any injury)

Is the condition which is disabling the patient an injury or illness? (please tick)	Injury ❑ Illness ❑

Please provide a copy of any X-Ray or other report(s)

Does the patient have any other condition which may be contributing to the disablement, or prolong recovery?	No ❑ Yes ❑ (Please provide details below)
Details	
Is the condition either caused or exacerbated by the patient participating in any sporting activity?	No ❑ Yes ❑ (Please provide details below)
Details	

Date injury occurred or symptoms first manifested:	
Date you were first consulted for this condition:	
Has the patient ever suffered from the same or a similar condition:	No ❑ Yes ❑ (Please provide details below)
Details	
How long have you been the patient's doctor/medical practitioner?	
Name of patient's usual doctor/practice (if not you)	
Has the patient undergone surgery, or is surgery anticipated?	No ❑ Yes ❑ (Please provide details below)
Details	
Date surgery performed or anticipated: _____/_____/_____	**Name of Hospital:**

Attending Medical Practitioner's Statement cont'd

Has the patient undergone any other tests/services/procedures (including pathology tests)?			No ❑ Yes ❑ (Please provide details below)
Details			
Was the patient referred to you?			No ❑ Yes ❑ (Please provide details below of referring doctor)
Details			
Is the patient still disabled?	No ❑	**When did the patient return to work?** _____/_____/_____	
	Yes ❑	**When do you anticipate the patient being able to return to work?**	
		Full-time: _____/_____/_____	
		Part-time": _____/_____/_____	

If unable to perform all of the usual duties of their occupation, please advise what duties the patient could perform and for how many hours per week?

Has the patient requested medical evidence for the current condition to be issued to any other entity; insurance or otherwise?		No ❑ Yes ❑ (Please provide details below)
Details		

Any other comments relating to the patient's current condition or any other relevant factors affecting the condition of the patient's ability to return to work?

Signature of Medical Practitioner			
Name (please print)			
Qualifications			
Address			
Telephone Number		**Fax Number**	
Email Address			

Australian Government
Department of Human Services

medicare

Request for Medicare claims information

Information about your request

The purpose of this form is to request Medicare claims information for individuals and families.

Any changes to this form must be initialled by the relevant signatory.

You can view, download and print your Medicare claims information for at least the last 3 years by accessing your Medicare Online account through myGov.

This form should only be used to request Medicare claims information which is older than 3 years.

If you are requesting Medicare claims information for a person (other than children under 14 years of age) who cannot consent to the release of their own information (e.g. they have a power of attorney or they are deceased), in addition to completing this form, please provide evidence of your authority to act on their behalf.

Information that may be provided in response to your request will include date of service, item claimed, item description, benefit amount, payment method, relevant dates and provider names and locations.

Filling in this form

- **Please use black or blue pen**
- Print in BLOCK LETTERS
- Mark boxes like this ☐ with a ✓ or ✗
- Where you see a box like this ☐ ▶ ***Go to 5*** skip to the question number shown. You do not need to answer the questions in between.

Returning your form

Check that all required questions are answered and that the form is signed and dated.

If you have indicated that the information requested in this form should be provided to a third party, please return this completed form to that third party.

The third party is responsible for sending this completed form to the email address below.

Email the completed form to:
medicare.disclosure@humanservices.gov.au

or

visit one of our service centres.

For more information

For more information, go to **humanservices.gov.au** or for assistance completing this form call **132 011** Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Note: Call charges may apply.

Details of person making request

1 Medicare card number

☐☐☐☐ – ☐☐☐☐☐ – ☐ Ref no. ☐

2 Name

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

3 Date of birth / /

4 Permanent address

Postcode

5 Postal address (if different to above)

Postcode

6 Daytime phone number

( )

Mobile phone number

Email

@

As we will send your personal information to the email address that you provide, you should be satisfied that the address is appropriate for the receipt of personal information.

Claims information request

7 Indicate the date range(s) for the claims information required.

Medicare claims history for the period

From / / to / /

(insert full date range e.g. 01/05/2014 to 31/05/2015)

8 Are you requesting personal or family claims information?

Personal only ✔ ▶ ***Go to 14***

Family only ☐

Personal and family ☐

Family members aged 14 years and over

9 Are you requesting information about other family members aged 14 years or over?

No ☑ ***Go to 10***

Yes ☐

Complete question 9 if information is required for other family members aged 14 years and over.

Information requested for family members aged 14 years and over, must be accompanied by their signature.

If the other family members are not listed on your Medicare card they will need to submit a separate request.

Family member 1

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

Date of birth

/ /

Would you like us to send your personal information to a third party?

No ☐

Yes ☐ I authorise the Australian Government Department of Human Services to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

Postcode

Family member 1 signature

Date

/ /

Family member 2

Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name

First given name

Second given name

Date of birth

/ /

Would you like us to send your personal information to a third party?

No ☐

Yes ☐ I authorise the Australian Government Department of Human Services to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

Postcode

Family member 2 signature

Date

/ /

If the information relates to more than 2 additional family members aged 14 years and over, attach a separate sheet with details.

Requests for children under 14 years of age

A person with parental responsibility can generally get Medicare or PBS information about a child where the child is under 14 years of age and listed on the same Medicare card as the requesting person.

10 Are you requesting information for a child under 14 years of age?

No ☑ ***Go to 14***

Yes ☐

11 Are you the child's parent or guardian?

No ☐ You may not request this claims information

Yes ☐ If legal guardian, attach supporting documents

Child 1

Family name

First given name

Second given name

Other names child known by (if applicable)

Date of birth / /

Is the child a subject of Family Court orders?

No ☐

Yes ☐ Provide a copy of the current court order.

Is the child listed on more than one Medicare card?

No ☐

Yes ☐ Provide details

Child's other Medicare card number

Ref no.

Child's other address (if applicable)

Postcode

Child 2

Family name

First given name

Second given name

Other names child known by (if applicable)

Date of birth / /

Is the child a subject of Family Court orders?

No ☐

Yes ☐ Provide a copy of the current court order.

Is the child listed on more than one Medicare card?

No ☐

Yes ☐ Provide details

Child's other Medicare card number

Ref no.

Child's other address (if applicable)

Postcode

Child 3

Family name

First given name

Second given name

Other names child known by (if applicable)

Date of birth / /

Is the child a subject of Family Court orders?

No ☐

Yes ☐ Provide a copy of the current court order.

Is the child listed on more than one Medicare card?

No ☐

Yes ☐ Provide details

Child's other Medicare card number

Ref no.

Child's other address (if applicable)

Postcode

If the information relates to more than 3 children under 14 years of age, attach a separate sheet with details.

12 Would you like us to send your child's/children's personal information to a third party?

No ☑ ***Go to 14***

Yes ☐

13 I authorise the Australian Government Department of Human Services to provide my child's/children's personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Postal address

Postcode

Authorisation

14 Would you like us to send your personal information to a third party?

No ☐ ***Go to 16***

Yes ☑

15 I authorise the Australian Government Department of Human Services to provide my personal information requested in this form, to the following organisation or person:

Contact name

Organisation name

Claims Management Australasia Pty Ltd

Postal address

P O Box 6009

Dural Delivery Centre

NSW Postcode 2158

Privacy notice

16 Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for: the purposes of research, or investigation, or where you have agreed, or where it is required or authorised by law.

If you have requested claims history which is older than 5 years, your personal information will be disclosed to the Department of Health so that your request can be processed.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy** or by requesting a copy from the department.

Declaration

17 I declare that:

- I have parental responsibility for each child under 14 years of age for whom I have requested claims information.
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Applicant's signature

Date

/ /