SUZUKI MOTORCYCLE LOAN PROTECTION INSURANCE CLAIM FORM

PO BOX 6156, NORTH SYDNEY 2060 PHONE: 1300 279 565 E-MAIL: CUSTOMERSERVICE@SUZUKIINSURANCE.COM.AU

- Please ensure that all questions are answered in full in as much details as possible
- We ask that you return this completed claim form with all the requested information to the above address

Please complete ALL the sections that apply to you claim

If you have been UNEMPLOYED	**complete Sections 1, 2, 3, 4 & 9**
If you have had an ILLNESS	**complete Sections 1, 5, 6, 7 & 9**
If you have had an ACCIDENT	**complete Sections 1, 5, 6, 7 & 9**
In the case of DEATH	**complete Sections 1, 8, 9 & 10**

Policy Number: Insured From: / / Insured To: / /

SECTION 1: GENERAL INFORMATION

Name: Surname: Date of Birth: / /

Address:

Postcode:

Email:

Phone: Mobile:

Name of Employer:

Occupation:

Address:

Postcode:

Email:

Phone: Fax:

Date Employed: From: / / To: / /

Finance Company: Finance Contract Reference No:

Total Outstanding Amount: Monthly Repayment:

Monthly, Weekly or Fortnightly Payment Date: / /

SECTION 2: UNEMPLOYMENT STATEMENT (To be completed by Your Employer)

Company Name:

Name of Employer:

Address:

Postcode:

Email:

Phone: Mobile:

Type of Employment: Full time ☐ Part time ☐ Contract ☐

Date of Employment Commencement: / / Date of Termination of Employment: / /

Period of Employment: Hours worked per week:

Reason for Termination:

SECTION 3: CENTRELINK/JOB AGENCY CERTIFICATE

Are you registered as a job seeker? Yes ☐ No ☐

If you are receiving job search allowance or unemployment benefits please complete the following:

This is to certify that (Full Name):

Of (address):

Postcode:

Was registered as being unemployed on (date): / / Allowance benefit of $ Per (week/fortnight)

Was granted from (date): / / And have been paid to (date): / /

Signature of Authorised Officer: Branch Stamp: Date: / /

If you are not receiving job search allowance/unemployment benefits, please advise the reason why:

SECTION 4: EMPLOYERS DECLARATION

Name of Employee:

Date Employed: From: / / To: / /

Employment Basis: Full time ☐ Part time ☐ Contract ☐

Reason for Termination of Employment:

Signature: Name:

Position: Date: / /

SECTION 5: INJURY OR ILLNESS

Description of injury or illness:

Date which illness or injury first manifested itself: / / Last working day: / /

Describe the circumstances leading up to your injury, or the nature of the symptoms of your illness:

When did you first consult a health care professional about the injury or illness? / /

Name of Doctor or hospital at time of injury or illness:

Address:

Postcode:

Phone:

Name of usual medical doctor (if different from above): Time as patient:

Address:

Postcode:

Phone:

SECTION 5: INJURY OR ILLNESS (continued)

Please provide the names, addresses and contact telephone numbers of any other doctors, hospitals or medical professionals, who treated you or who were consulted in relation to your injury or illness.

Name: Phone:

Address:

Postcode:

Name: Phone:

Address:

Postcode:

Name: Phone:

Address:

Postcode:

Name: Phone:

Address:

Postcode:

Name: Phone:

Address:

Postcode:

Are you claiming for workers compensation? Yes ☐ No ☐

If yes, what is the name of the insurer? Phone:

Address:

Postcode:

Was the injury a result of a motor vehicle accident? Yes ☐ No ☐

If yes, did the police attend? Yes ☐ No ☐ If yes, please provide a Police Report.

When did you return to work? / / Or When do you expect to return to work? / /

SECTION 6: MEDICAL HISTORY

Name of your usual Doctor: How long have you been a patient?

Address:

Postcode:

Phone: Fax:

Reason for consultations with usual Doctor

Reason for Consult:

Date: / /

Reason for Consult:

Date: / /

Reason for Consult:

Date: / /

Reason for Consult:

Date: / /

SECTION 6: MEDICAL HISTORY (continued)

Other Doctors / Hospital attended in the past 5 years

Name of Doctor /Hospital: Date: / /

Reason for Consult:

Name of Doctor /Hospital: Date: / /

Reason for Consult:

Name of Doctor /Hospital: Date: / /

Reason for Consult:

Name of Doctor /Hospital: Date: / /

Reason for Consult:

Details of any prescribed drugs or medication in the past 5 years:

Are you currently receiving any treatment or on any regular medication for any condition? Yes ☐ No ☐

If yes, please provide details of both the condition and the treatment/medication:

Has there been any condition suffered by you, which is the same or similar to the condition you suffer from now? Yes ☐ No ☐

No If yes, please provide details:

If you consulted a Doctor, please provide the following details:

Name of Doctor: Date Consulted: / /

Address:

Postcode:

Was there a period of disablement? Yes ☐ No ☐

If yes, please provide details:

Has there been any major condition suffered by you in relation to this disability? e.g. leg injury with associated knee injury Yes ☐ No ☐

If yes, please provide details of the complaint:

Period of Disability: From: / / To: / /

SECTION 7: MEDICAL CERTIFICATE

Doctors Details

Name of attending Doctor: Phone:

Insureds Name: Date of Birth: / /

Insured Occupation:

Are you the Insureds usual medical attendant? Yes ☐ No ☐ If yes, for how long?

Nature of illness / injury:

Have you treated the Insured for this condition previously? Yes ☐ No ☐

If yes, please provide details:

If the treatment includes any prescribed medication, please provide details:

Are there any medical conditions which have a bearing on this illness/injury? Yes ☐ No ☐

If yes, please provide details:

Has there ever been any medical diagnosis, treatment, operation or attention for this or similar disablement? Yes ☐ No ☐

If yes, please provide details:

Nature:

Date: / /

Nature:

Date: / /

Nature:

Date: / /

SECTION 8: CERTIFICATE OF IDENTITY OF DECEASED BY NEXT OF KIN

Given names of Deceased: Surname of Deceased:

Date of Birth: / / Place of Birth:

Age at Death:

Cause of Death:

Insured Occupation:

Deceased regular Doctor:

Doctors Address:

Postcode:

Was a Specialist ever consulted? Yes ☐ No ☐

Please provide details:

I declare that the deceased is the same person named as the Life Insured, under the Loan Protection Policy issued by Suzuki Motorcycle Insurance. I authorise Suzuki Motorcycle Insurance to obtain any and all information from any hospital, institution or medical practitioner who has treated or examined the deceased.

Signed: Date: / /

Name: Relationship to the Deceased:

Address:

Postcode:

SECTION 9: CLAIM ESTIMATE

Is there an Unemployment/Disablement claim pending? Yes ☐ No ☐

If yes, please provide of details of the Insurer:

Outstanding Balance at time of death: $ Total Settlement: $

Any Arrears: $

SECTION 10: CERTIFICATE

I heareby certify that the answers above are correct and true to the best of my knowledge.

Name of Lender: Phone:

Date: / / Relationship to the Insured:

SECTION 11: REGULAR MEDICAL ATTENDANTS STATEMENT

To be completed by a medical professional/attendant authorised to provide this information and validate this claim.

Are you the deceaseds regular/usual medical attendant? Yes ☐ No ☐

If yes, date that you assumed this position: / /

Cause of Death:

Date of first Treatment: / / Date of Onset Symptoms: / /

Are you aware of any other information that would assist with the assessment of this claim? Yes ☐ No ☐

If yes, please provide further details:

Signature: Date: / /

Qualifications: Phone:

Address of Practice:

Postcode:

PRIVACY STATEMENT

We are committed to protecting your privacy. We will only use the personal information you have provided us in settling this claim, and any claim made against you in respect of this claim.

DECLARATION

I/we acknowledge Suzuki Motorcycle Insurance and/or NM Insurance Pty Ltd (ABN 34 100 6330 38 AFSL 227186) may give to, or obtain from, other insurers and/or Insurance/Financial Bureau, state Licensing, Parts or Service Providers, personal information in relation to this claim or my insurance in general. I/we hereby declare that the foregoing particulars to be true and correct and I/we undertake to render every assistance in my/our power in dealing with this matter.

Signature of the Insured: Date: / /

Name:

nminsurance

NM Insurance Pty Ltd

ABN 34 100 633 038 AFSL 227186

Level 5, 50 Berry Street North Sydney NSW 2060

Phone: 1300 279 565

Email: customerservice@nminsurance.com.au

www.nminsurance.com.au

www.suzukiinsurance.com.au