Aviation & Marine Underwriting Agency Limited
trading as
WHOLESALE INSURANCE SERVICES
for personal product lines

PERSONAL ACCIDENT AND ILLNESS CLAIM FORM

Insured Person Details:

Full Name ……………………………………………………………………………………………………..……………

Address……………………………………………………………………………………………………….………………………

……

Age ……………………..………… Telephone ………………………………… Occupation ………………………………

Bank account number for benefit payments ……………………………………………………………………..……………

Bank name and Branch ……………………………………………………………………………………..……………

Complete this section for an ACCIDENT:

1. Date of accident ………………………………………………………..

2. Time ………………………………………………………..

3. Place of accident ………………………………………………………..

4. Describe fully what happened and what you were doing at the time ……………………………………………..

5. Describe nature and extent of injuries ……………………………………………………………………………..

………

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

………..

7. Give the name and address of witness or witnesses of the accident ……………………………………………..

………..

Complete this section for an ILLNESS:

8. On what date were you taken ill? ……………………………………………………………………………..

9. Describe the illness from which you are suffering ……………………………………………………………..

10. Have you ever suffered from the same or similar illness before? **YES / NO**

If so, state when: also the name of the medical practitioner who attended you ………………………………..

………..

Complete this section in all cases and request doctor complete a Personal Accident and Illness Medical Certificate:

11. When did you first obtain medical advice? …………………………………………………………………………..

12. Is the doctor still attending you? **YES/NO**

If so, please provide their name and address ……………………………...……………………………..

13. On what date did you cease work? …………………………………………………………………………..

14. Are you necessarily confined to the house? **YES/NO**

If not, on what date were you first able to get out of doors? ……………………………..…………………..

15. Are you able to attend to any portion of your business affairs? **YES/NO**

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

……..

17. Are you claiming or entitled to claim compensation from the Accident Compensation Commission or any company, society, organisation or other source? **YES/NO**

If so, give particulars ……………………………………………………………………………………………..

General Remarks? …………………………………………………………………………………………….

……..

……..

I do hereby declare the foregoing particulars to be true and correct.

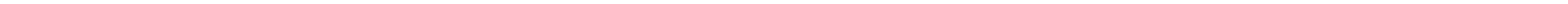
Signed …………………………………………………… Dated ………………………………………………………..

The declaration below must be completed by the claimant BEFORE the claim can be assessed.

RELEASE OF MEDICAL RECORDS DECLARATION

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.

Signed …………………………………………………… Dated ………………………………………………………..



AVIATION & MARINE UNDERWRITING AGENCY LIMITED
Trading As WHOLESALE INSURANCE SERVICES
P.O. BOX 74 344, GREENLANE, AUCKLAND 1546
PHONE: 0800 622 7747 **FACSIMILE:** (09) 377 8208
EMAIL: healthadmin@gbtpa.co.nz **WEBSITE:** www.aviationmarine.co.nz