

# QBE Personal Accident / Illness Claim

QBE Pacific Islands



## A. Notes

- It is most important that all questions are answered. If not applicable, write "n/a".
  - The issue of this claim form is not an admission of liability by QBE.
  - If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
  - Any amounts further marked as \* are in the currency of the country in which the policy has been issued.
  - Markets
- Please use the checklist below to indicate the operation in the QBE Pacific Islands region to which you will be submitting your claim.

MARKET	BUSINESS NAME	PLEASE TICK
Fiji	QBE Insurance (Fiji) Limited	<input type="checkbox"/>
Papua New Guinea	QBE Insurance (PNG) Limited	<input type="checkbox"/>
Solomon Islands	QBE Insurance (International) Pty Limited	<input type="checkbox"/>
Vanuatu	QBE Insurance (Vanuatu) Limited	<input type="checkbox"/>

Note: For any other markets please contact the local QBE office.

## 6. Jurisdiction

The content and use of this form or any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by:

- the laws of the country at the QBE office which issues the policy/ies upon which this present claim is made; unless
- the policy/ies refer to the laws of a different country applying, in which case the laws of that country, and in relation to those matters, the parties submit to the exclusive jurisdiction of the courts of that country.

For those policies governed by the laws of the Republic of Vanuatu, the validity, interpretation and effect and the rights and obligations of the parties to such policies shall be governed exclusively by English law as applicable within Vanuatu immediately before 30 July 1980 and shall be exclusively justiciable before the Supreme Court of Vanuatu.

## B. Insured details

Name of insured

Address

Private tel. no  Business tel. no  Mobile tel. no

Fax no  email

Occupation  Policy no

Name of affected party  Age

Address

Tel. no  Mobile tel no

Have you ever previously met with an accident? If "Yes", please give full details below.  Yes  No

Have you ever previously suffered from any illness? If "Yes", please give full details below.  Yes  No

Date	Nature of accident/extent of injuries and/or illness	Duration of disablement
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Have you ever previously claimed under a personal accident or illness policy?  Yes  No

If "Yes", please give particulars including name(s) of insurer(s).

Are you insured against accident or illness with any other company?

Yes  No

If "Yes", please give full details.

Have you received or are you entitled to receive benefits under any workers' compensation act in consequence of this accident? If "Yes", please give full details.

Yes  No

Have you engaged in or attended to your business in any way since this accident occurred?

Yes  No

If "Yes", please give full details.

Are you able to engage in or attend to your business in any way?

Yes  No

a. If "Yes", to what extent?

b. If "No", when do you anticipate that you will be able to engage in or attend to your business in any way?

Are you confined to your bed?

Yes  No

Are you totally disabled?

Yes  No

State name and address of your medical attendant:

Date of last medical attendance

**C. The accident / illness**

1.If accident:

a. Date of accident

Time

b. Place of accident

c. State exactly how the accident occurred?

d. State nature of injuries

e. State name(s) and address(es) of witness(es) to accident:

2.If illness:

a. Nature of illness

b. How long?

c. Please state how long you have been:

i) confined to house: from

/  /

to

/  /

ii) able to get outdoors: from

/  /

to

/  /

d. Please state how long you have been:

i) totally disabled: from

/  /

to

/  /

ii) partially disabled: from

/  /

to

/  /

**D. Signature and declaration**

I/we declare that:

1. The information and answers given above are correct to the best of my/our knowledge and belief.
2. I/we understand the claim may be refused or reduced if information is withheld.
3. I/we authorise QBE to disclose information contained herein to QBE's advisors, reinsurers and to other insurers. I/we authorise QBE to obtain from any other party information that is, in QBE's view relevant to this claim.

Signature of insured

Date

**E. Medical certificate**

To be completed by attending physician.

Are you still attending the insured person?

Yes  No

What are his/her present symptoms?

a. Totally disabled from  /  /  to  /  /  b. Partially disabled from  /  /  to  /  /

If the insured person is still disabled, please state the probable date of their being able to resume a portion of their usual duties?

Date  /  /

How much longer is it probable the person's state of disability will continue?  days  weeks  years

General remarks

I certify that to the best of my knowledge the foregoing statements are correct:

Name:

Address

Doctor's signature

Date

**Fiji**  
**QBE Insurance (Fiji) Limited**

QBE Centre, 33 Victoria Parade  
Suva  
Tel: + 679 331 5455  
Fax: + 679 330 0285  
email: info.fiji@qbe.com  
qbepacific.com

**Papua New Guinea**  
**QBE Insurance (PNG) Limited**

QBE Building, Musgrave Street  
Port Moresby  
Tel: +675 321 2144  
Fax: +675 321 4756  
Email: info.png@qbe.com  
qbepacific.com

**Solomon Islands**  
**QBE Insurance (International) Pty Limited**

Panatina Plaza, Prince Philip  
Highway, Honiara  
Tel: + 677 388 84  
Fax: + 677 388 87  
Email: info.sol@qbe.com  
qbepacific.com

**Vanuatu**  
**QBE Insurance (Vanuatu) Limited**

Level 2, Office 2a - 2c / 2g  
Tana Russet Complex, Port Vila  
Tel: + 678 353 00  
Fax: + 678 355 10  
Email: info.van@qbe.com  
qbepacific.com