



## INDIVIDUAL PERSONAL ACCIDENT APPLICATION FORM

### HOW TO FILL OUT THIS FORM

Please fill out every question neatly and clearly. This will assist us in evaluating your application and if we are unable to read the information you have given us, we may not be able to provide your insurance.

**Full Name of the Insured** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

**Date of Birth** | \_\_\_\_/\_\_\_\_/\_\_\_\_ | **Sex** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**What are your duties of your occupation?** \_\_\_\_\_

\_\_\_\_\_

**Are you an employee or are you self-employed?** \_\_\_\_\_

**Period of Insurance** **From:** | \_\_\_\_/\_\_\_\_/\_\_\_\_ | **To:** | \_\_\_\_/\_\_\_\_/\_\_\_\_ |

### Insured Person's Acknowledgement

a) Have you ever had medical or surgical advice or treatment, or been hospital confined during the past 5 years?

**Yes**  **No**  **If Yes, please provide name and address of Doctors and/or Hospitals**

\_\_\_\_\_

b) Have you ever been declined accident, sickness or life insurance, or been issued such insurance which has been postponed, modified, rated up, cancelled or renewal refused?

**Yes**  **No**  **If Yes, please provide details**

\_\_\_\_\_

c) Have you ever claimed for benefits under any accident or sickness insurance?

**Yes**  **No**  **If Yes, please provide details**

\_\_\_\_\_

d) Will the total amount of your weekly compensation during disablement from this and all other sources exceed your weekly salary or income?

**Yes**  **No**  **If Yes, please provide details**

\_\_\_\_\_

e) Are there any circumstances connected with your occupation or other activities which render you liable to injury or sickness? e.g. Football

**Yes**  **No**  **If Yes, please provide details**

\_\_\_\_\_



f) Are there any reasons that would cause you to consider yourself not presently in good health?

Yes  No  If Yes, please provide details

\_\_\_\_\_

**Are you at present insured under any accident or sickness insurance. If so, please give details:**

Name of Insurer \_\_\_\_\_ Capital Sum Insured \_\_\_\_\_ Weekly Sum Insured \_\_\_\_\_

**Insurance applied for Sum Insured:**

Death & Capital Benefits \_\_\_\_\_ Weekly Accident \_\_\_\_\_ Weekly Sickness \_\_\_\_\_  
(Events 1 – 19)

Benefit Period (Weeks) \_\_\_\_\_ Excess (Days) \_\_\_\_\_

**Scope of Cover – Please select when you would like to be covered:**

a) 24 hours/365 days

b) Working hours only

c) Outside working hours

**Self Employed persons only**

**Do you require cover for Monthly Business Expenses? YES/NO**

If yes, what limit do you require?

\$ \_\_\_\_\_ per month (please note that the Excess applicable is noted above)

**IMPORTANT INFORMATION**

**INSURER**

The Insurer of Your policy are Certain Underwriters at Lloyd’s of London, who are authorised under the Insurance Act 1973 to write Australian Insurance business.

**PRIVACY**

Woodina Underwriting is committed to protecting the privacy of the personal information You provide Us. Woodina Underwriting collects, uses and retains Your personal information in accordance with the National Privacy Principles.

**RENEWAL PROCEDURE**

Before this policy expires we will normally offer renewal by sending a renewal invitation advising the amount payable to renew this policy. It is important that you check the information shown before renewing each year to satisfy yourself that the details are correct.

**DECLARATION**

I/We hereby agree that this Declaration shall be the basis of the contract between me/us and Insurers.

Date \_\_\_\_\_ Signature of Insured \_\_\_\_\_