



## SECTION 2: INVOLUNTARY UNEMPLOYMENT BENEFIT (cont'd)

### 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there an involuntary unemployment claim pending?        Yes         No

If yes, please provide details of the insurer:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PLEASE PROVIDE DOCUMENTATION THAT SUPPORTS YOUR INVOLUNTARY UNEMPLOYMENT CLAIM.

## SECTION 3: DISABLEMENT BENEFIT

Description of disablement: \_\_\_\_\_

Date which disablement first manifested itself:        /        /

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?        /        /

Were you hospitalised?        Yes         No

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: \_\_\_\_\_

### 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: \_\_\_\_\_

**SECTION 3: DISABLEMENT BENEFIT (cont'd)**

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 disablement 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? / /

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

If yes, please provide details:

\_\_\_\_\_

\_\_\_\_\_

Is there a disablement claim pending? Yes  No

If yes, please provide details of the Insurer:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SECTION 4: MEDICAL QUESTIONNAIRE (to be completed by your Doctor)

### 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: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date:     /     /     

Doctor's stamp:

## SECTION 5: DEATH BENEFIT

### WE REQUIRE A CERTIFICATE OF IDENTITY OF THE DECEASED, THIS SECTION TO BE COMPLETED 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

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SECTION 5: DEATH BENEFIT (cont'd)

Outstanding balance at time of death (including arrears up to two months): \_\_\_\_\_

Total settlement: \_\_\_\_\_

I declare that the deceased is the same person named as the Life Insured, under the Loan Protection Policy issued by YMI Motorcycle Insurance. I authorise YMI 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 6: PRIVACY REQUIREMENTS

Your Privacy is important to Us. You need to read the Privacy Statement below which explains, amongst other things, how We collect, handle, store and disclose Your personal and sensitive information in order for Us to provide and inform You about Our insurance and insurance related Services including Your claim. To do this We may disclose Your personal information to Our service providers and others in accordance with the Privacy Statement below.

## SECTION 7: DECLARATION

- I/ We acknowledge mi-bike Motorcycle Insurance Pty. Ltd. and/or International Insurance Company of Hannover SE – Australian Branch (Inter Hannover) 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 information and answers given above are true in every detail and no information has been withheld or misrepresented.
- I/We undertake to render every assistance in My/Our power in dealing with this matter.

Signature of Insured: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date:        /        /

## SECTION 8: PRIVACY STATEMENT

mi-bike Motorcycle Insurance Pty. Ltd and International Insurance Company of Hannover SE – Australian Branch (Inter Hannover) are committed to protecting Your privacy in accordance with the Privacy Act 1988 (Cth) (Privacy Act) and the Australian Privacy Principles (APPs).

In this section dealing with Privacy, “We”, “Our” and “Us” refers to both Inter Hannover and mi-bike Motorcycle Insurance. This Privacy Statement outlines how We collect, disclose and handle Your personal information (including sensitive information) as defined in the Act.

### Why We collect your personal information

We collect your personal information (including sensitive information) so We can:

- identify You and conduct necessary checks;
- determine what service or products We can provide to You e.g. offer our insurance products;
- issue, manage and administer services and products provided to You or others, including claims investigation, handling and settlement;
- maintain and improve Our services and products e.g. training and development of Our representatives, product and service research and data analysis and business strategy development;
- make special offers of other services and products provided by Us or those we have an association with, that might be of interest to You.

### What happens if You don't give Us Your personal information?

If You choose not to provide Us with the information We have requested, We may not be able to provide You with Our services or products or properly manage and administer services and products provided to You or others and manage claims.

### How We collect Your personal information

Collection can take place by telephone, email, or in writing and through websites (from data You input directly or through cookies and other web analytic tools).

We only use and disclose personal information for the purpose it was collected unless the use or disclosure is destined for another purpose is with your consent, or otherwise permitted by law.

If You provide Us with personal information about another person You must only do so with their consent and agree to make them aware of this privacy notice. To avoid confusion, exchanging details with third parties involved in an accident implies consent and You do not need to take further steps.

### Who We disclose your personal information to

We share Your personal information with third parties for the collection purposes noted above.

The third parties include: Our related companies and Our representatives who provide services for Us, other insurers and reinsurers, Your agents, Our legal, accounting and other professional advisers, data warehouses and consultants, social media and other similar sites and networks, membership, loyalty and rewards programs or partners, providers of medical and non-medical assistance and services, investigators, loss assessors and adjusters, other parties We may be able to claim or recover against, and anyone either of Us appoint to review and handle complaints or disputes and any other parties where permitted or required by law.

We may need to disclose information to persons located overseas. These countries are listed in Our respective Privacy Policies and may change from time to time and as may be notified in Our respective Privacy Policies. If personal information is transferred to countries outside Australia that do not have legislation similar to the Privacy Act, we will take steps to ensure that adequate measures are taken by our clients to protect the personal information before it is transferred.

### More information, access, correction or complaints

For more information about our privacy practices including how we collect, use or disclose information, how to access or seek correction to your information or how to complain in relation to a potential Privacy breach and how such a complaint will be handled, please refer to Our Privacy Policy available at Our respective websites [www.mi-bike.com.au](http://www.mi-bike.com.au) or [www.inter-hannover.com/218887/interhannover-in-australia](http://www.inter-hannover.com/218887/interhannover-in-australia) or by contacting us (our contact details are below).

### Contact us and opting out

By proceeding with Your application or submitting Your claim, You and any other person included on the Policy, consent to this use and these disclosures unless You tell Us otherwise. If You wish to withdraw Your consent, including for things such as receiving information on products and offers by Us or persons We have an association with, please contact Us. If You do not agree to provide Us with the Information, We may not be able to process Your application, administer Your Policy or assess Your claims.



#### mi-bike Motorcycle Insurance

Level 5, 50 Berry Street, North Sydney

P.O Box 6156, North Sydney NSW 2059

Telephone: 1300 652 936 Email: [claims@ymia.com.au](mailto:claims@ymia.com.au) in the first instance.

[www.mi-bike.com.au](http://www.mi-bike.com.au)

This policy is underwritten by International Insurance Company of Hannover SE  
(ABN 58 129 395 544) (AFS Licence No. 458776)