



# injury or sickness supplementary report

Wesfarmers General Insurance Limited, ABN 24 000 036 279, AFS Licence No. 241461, trading as Lumley Insurance  
Level 2, 99 Melbourne Street, South Brisbane, QLD 4101 or GPO Box 524 Brisbane, QLD 4001  
Freecall 1300 651 654 Fax 07 3307 4880

CLAIM NUMBER

How to continue to get quick action on your claim - You can help us act quickly for you, if you:

1. Print your answers to questions.
2. Make sure you answer all of the questions.

This form should be completed in FULL and forwarded to:

Wesfarmers General Insurance Limited  
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Freecall 1300 651 654 Fax 07 3307 4880

Please answer ALL relevant questions concerning the patient and tick (✓) boxes where applicable

Full name

Postal address  Postcode

Phone number (w)  Phone number (h)  Mobile

Date of Birth (dd/mm/yyyy)  Occupation

1. In your own words, describe your disabling injury or sickness

2. a. Are you still unable to work? Yes  No   
If you are unable to work, what is preventing you from doing so?

b. Are you fit for alternative duties? Yes  No   
If yes, please indicate what type of duties you consider yourself suitable for.

If not, please indicate why.

3. a. When do you anticipate you may be fit enough to return to full time work?

b. Have you retired, been made redundant or terminated from your occupation? Yes  No

If **YES**, when

Please provide reasons for retirement, redundancy, or termination.

4. On what dates since your last statement did you receive treatment from a doctor?

 /  /   /  /   /  / 

5. Name, address and phone number of attending doctor

6. Please give as much detail as possible on the type of treatment received (e.g. tablets, further tests, physiotherapy, limb in plaster, still in hospital, rest, operation pending, etc.)

7. Hospitalisation during disablement

Hospital

Location

From  /  /

To  /  /

8. Please add any additional comments you wish to make below.

9. All the information that I/we have given in this claim form is true and complete. I/We authorise you to ask my/our medical practitioner or any person for information that you need to act on this claim. I agree that a photocopy of this authorisation shall be considered to be effective and valid as the original.

Signature of Claimant

Date (dd/mm/yyyy)