LOAN REPAYMENT WAIVER

CLAIM FORM: ACCIDENT & INJURY, REDUNDANCY

Section 1: Customer's Claim Information					
Mr/Mrs/Miss/Ms				DOB	/ /
Given Names:				Surname:	
Address:					
Phone: Home ☎		Work		Mobile	
Employer:					
Contact person:				Contact phone:	
Physical Address:					
Postal Address:					

Section 2: Accident & Sickness – only complete if you suffered an accident or injury			
Date of accident or illness	/ /		
Nature of injury or illness			
How did accident / injury occur? Brief description			
Date & time you ceased work	/ /		
Employer:			
Have you been able to work since your accident / illness?	Yes ☐ No ☐		
If yes, provide details			
Doctor's Name:			
Have you lodged an ACC claim?	Yes ☐ No ☐		
If yes, what is the Claim #:		ACC branch:	
Have you previously suffered the same injury / illness?	Yes ☐ No ☐		
If yes, provide details			

Section 3: Redundancy – only complete if you were made redundant			
Date made redundant	/ /		
Employer:			
Have you started a new job?	Yes ☐ No ☐	If yes, date you started	/ /
New Employer name and address:			

Section 4: Customer Declaration			
Full Name:			
Signature	✗	Date:	/ /

Privacy Act 2020. Please note that:

1. This claim form collects personal information about the Customer.
2. The information is being collected to allow Pacific Finance to evaluate the claim.
3. You may have access to, and request correction of this information subject to the provisions of the Privacy Act 2020.

In addition:

1. I agree to meet any costs including, but not limited to, medical expenses associated with obtaining information relevant to my claim.
2. I authorise Pacific Finance Limited to disclose and use personal information it has obtained in connection with this claim to other persons to whom this personal information may be relevant.

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Section 5: TREATING DOCTORS DETAILS – only ask your doctor to complete this page if you suffered an accident or injury			
Doctor's Name:			
Practice Name:			
Address:			
Section 6: Patient's Information			
Given Names:		Surname:	
Date first consulted about the accident or illness	/ /		
Has the patient suffered the same injury / illness previously?	Yes ☐ No ☐		
If yes, provide details			
Date patient became aware of injury / illness	/ /		
Has been a patient since (date):	/ /		
Do you consider the injury / illness to be drug / alcohol related?	Yes ☐ No ☐		
If yes, provide details			
Doctor's Name:			
Is the patient fit to work?	Yes ☐ No ☐		
If yes, is he/she fully or partially fit? Provide details		If no, date estimated to be fit for work?	/ /
Section 7: Treating Doctor's Declaration			
Full Name:			
Signature	x	Date:	/ /

1. I confirm that I am a registered medical practitioner of the Practice stated in Section 3 located at the Address stated in Section 3;
2. I declare that the above information is true and correct and that I have disclosed all relevant information;
3. I understand the payments under this claim will be made to the Pacific Finance Limited.

Please attach a copy of the patient's Medical Certificate with this statement