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

Privacy Act 1993. 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 may request correction of this information subject to the provisions of the Privacy Act 1993.

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 3: TREATING DOCTORS DETAILS			
Doctor's Name:			
Practice Name:			
Address:			

Section 4: Customer's Information			
Given Names:		Surname:	
Date first consulted about the accident or illness	/ /		
Has the Customer suffered the same injury / illness previously?	Yes ☐ No ☐		
If yes, provide details			
Date Customer became aware of injury / illness	/ /		
Customer has been a patient of mine since (date):	/ /		
Do you consider the injury / illness to be drug / alchol related?	Yes ☐ No ☐		
If yes, provide details			
Doctor's Name:			
Is the customer fit to work?	Yes ☐ No ☐	If no, date estimated to be fit for work?	/ /
If yes, is he/she fully or partially fit? Provide details			

Section 5: Treating Doctor's Declaration			
Full Name:			
Signature	✗	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 Customer's Medical Certificate with this statement