Bar Cover

Barristers' Sickness &Accident Fund Pty Ltd ACN 000 381 617
as Trustee for the Barristers' Sickness & Accident Fund 1961 ABN 78 600 371 397
T: (02) 9413 8481 F: (02) 9413 8483 E: office@bsaf.com.au W; www.bsaf.com.au
DX 23403 Lindfield Suite 18, 12 Tryon Rd Lindfield NSW 2070 PO Box 42 Lindfield NSW 2070

Part 1 - Personal Injury or Illness Claim Form

Completed form must be accompanied by the signed Certificate of Medical Practitioner (Part 2)

Name in full:_____

Private Address:_____

Private Telephone No._____Present Age_____Years.

1. (a) State nature of illness or injury_____

_____

(b) In the case of an injury, state when and where the accident causing the injury took place and how it happened. It is necessary that the fullest details be given.

_____

_____

Date:_____Time:_____a.m./p.m.

Place:_____

(c) Give names and addresses of any witnesses of the accident.

_____

_____

2. (a) Have you ever suffered from the same or a similar complaint before?

_____

(b) If so, state when and how often; also the names of the doctors who attended you.

_____

_____

3. (a) State the first day you were attended by a doctor and the name of the doctor.

_____

(b) Is that doctor your usual medical attendant?_____

4. (a) Have you, as a result of the injury or illness, been totally disabled from working as a barrister?

If so, say for how long you have been totally disabled.

From_____to_____inclusive.

(b) State why the illness/injury has led you to being totally disabled.

_____

(c) If you have suffered an injury, as opposed to an illness, have you been partially disabled from working as a barrister? If so say for how long and why you have been partially disabled.

_____

(d) Was any part of the period of your disablement a period when you were not working as a barrister for any reason other than accident or illness? If so, please identify that period.

_____

(e) During the period of your disablement, were there any weekdays on which you were not intending to engage in, or attend to, the profession of barrister? If so, please identify those days.

_____

5. (a) Are you still totally incapable of attending to your practice? **Yes** **No**

(b) If you have not fully resumed it to what date were you unable to do so in a material degree?

_____

6. If now able to attend to any portion whatever of your practice state when you commenced so to do.

_____

7. At the time your accident occurred or your illness was contracted were you a practising barrister? **Yes** **No**

8. (a) Have you any other insurance under which you are entitled to claim in respect of the injury or illness upon which this claim is based? **Yes** **No**

If "Yes", please state:

(b) Amount insured per week_____

(c) If the insurance covers medical expenses_____

9. Does your weekly benefit claimed exceed the average gross weekly income earned by you from the practice of the profession of barrister over the 12 months prior to your disablement? **Yes** **No**

If "Yes", please provide details of those average gross earnings and reasons as to why the Fund should cover you for the excess.

10. For GST purposes, are you entitled to full input tax credits in respect of the premium paid to us? **Yes** **No**

11. **For Direct payment please provide your BANKING DETAILS:** Bank Name _____

Account name_____ BSB and Account number _____

I HEREBY WARRANT the truth of the foregoing statements.

Signature of the Insured:_____ Date:_____

NB Please return the <u>original</u> signed Certificate of your Medical Practitioner with this form.

<u>OFFICE USE ONLY</u>

<u>APPROVED</u>

From: _____ To :_____ (inclusive)

Date Approved: _____ Director _____

Bar Cover

Barristers' Sickness &Accident Fund Pty Ltd ACN 000 381 617
as Trustee for the Barristers' Sickness & Accident Fund 1961 ABN 78 600 371 397
T: (02) 9413 8481 F: (02) 9413 8483 E: office@bsaf.com.au W; www.bsaf.com.au
DX 23403 Lindfield Suite 18, 12 Tryon Rd Lindfield NSW 2070 PO Box 42 Lindfield NSW 2070

Part 2 - Certificate of Medical Practitioner

This original Certificate must be returned with the completed claim form.

1. (a) Name of Claimant: _____

2. (a) Nature of illness or injury. N.B. - Give sufficient particulars of symptoms to enable a medical officer of the Company to comment should the Company wish to consult him.

_____
_____
_____

(b) So far as you are aware, how did the injury arise?

_____
_____

3. Please state the date upon which the injury or illness commenced.

_____

4. When did the Claimant first consult you in connection with this illness or injury?

_____

5. Present Condition: (State as clearly as possible)

_____
_____
_____

6. Are you the usual Medical Attendant? If so, how long have you known the Claimant?

_____

7. Has the Claimant previously suffered from this complaint? If so, please state when.

_____

8. Is the Claimant suffering from any disease irrespective of the present illness or injury or are there any other circumstances which may tend to delay recovery? If so, please give particulars.

_____
_____
_____

9. (a) If the Claimant is in your opinion totally disabled from engaging in or attending to the profession of practising as a barrister (eg work in court, office or chambers work) please state:

Date of commencement of total disablement _____

Probable future duration _____

(b) If recovered, state date of recovery _____

10. (a) If the Claimant is in your opinion partially disabled from engaging or attending to the profession of practising as a barrister, please state:

Date of commencement of partial disablement _____

Probable future duration _____

(b) If recovered, state date of recovery _____

11. Is it probable that the claimant will be further incapacitated so as to be unable to attend to their practice by reason of the accident, injury or condition the subject of this claim?

_____

12. General Remarks: _____

_____

_____

_____

_____

I CERTIFY that to the best of my belief the foregoing statements are correct.

Name: _____

Signature: _____

Address: _____

_____

Qualifications: _____

_____

Date: _____