Mutual Aid -
Request for Relief – Disablement (Accidental Injury or Illness)

People's Choice Credit Union,
a trading name of Australian Central Credit Union Ltd
ABN 11 087 651 125, acts under its own
Australian Financial Services Licence (AFSL 244310)
and Australian Credit Licence (ACL 244310)
T 13 11 82 peopleschoicecu.com.au

(THE ISSUE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY)

Member No.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other please specify

Member name: First name(s) | Surname

Address:

Suburb | State | Postcode

Date of Birth:

Contact details: Home | Mobile | Business | Email

Disablement Particulars

Accidental Injury / Illness:

If involved in a motor vehicle accident and you were the driver of the vehicle, please provide a copy of the blood alcohol / drug analysis report

Date of Disablement:

Disablement resulted from:

Have you previously suffered from this sickness / injury?:

☐ No ☐ Yes If yes, what date?

Date unable to work: Date resumed work:

Do you receive any other form of income? i.e: Centrelink, Workcover, Income Protection etc.

☐ Yes Provide details:

☐ No Reason i.e. partner works etc.:

Treating Doctor

Name:

Address:

Suburb | State | Postcode

Telephone contact details:

NB: Please ensure the attached Medical Report is completed.

Please retain a copy of the completed form for your records.

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Medical Authority and Declaration

This authority or photocopy of, hereby authorises any hospital or medical practitioner to furnish People's Choice Credit Union, a trading name of Australian Central Credit Union Ltd ("People's Choice") of 60 Light Square, Adelaide SA 5000 with any medical information it requires in relation to my disablement which commenced on:

I (full name) _____

hereby request financial assistance and warrant the truth of the foregoing statements and particulars (including any additional information requested of me) in every respect and declare that I have not or will not abstain from my usual professional/business/occupation, either entirely or partially, longer than absolutely necessary in consequence of the said Disablement and that such Disablement is the sole cause of my financial hardship.

I hereby give consent for People's Choice to contact my Medical Practitioner/s to confirm details of my Mutual Aid Request for Relief. I understand that I may be required to provide additional information to support this Request for Relief.

I voluntarily give this consent and understand all information obtained will be kept confidential.

Member signature: This form must be hand signed with your personal signature _____ Date _____

Third Party Authority to make and receive enquiries in relation to my Mutual Aid – Request for Relief

If you wish to provide authority for another person to discuss your application on your behalf, please complete the authorisation and return with your application.

I (full name) _____ freely give permission for:

Name: _____

Address: _____

_____

Contact Ph. No.: _____

To contact and be contacted to discuss information relating to and about my Mutual Aid - Request for Relief of which this person is aware. I understand that this authorisation shall be valid until my application is finalised, and that I have a right to revoke this authorisation by written notification.

Member signature: This form must be hand signed with your personal signature _____ Date _____

Print Name _____

People's Choice Credit Union Use Only

Loan No: _____ Branch _____

Disbursement date: _____ Cessation date: _____

Repayment: _____ PW / PF / PM

Operator's name Print _____ Date _____

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Mutual Aid - Medical Report

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To be completed by the treating Medical Practitioner or Specialist

Member name:	First name(s)	Surname				
Date of Birth:						
Name of treating Doctor:		Telephone contact details:				
Are you the person's usual Doctor:	☐ No	☐ Yes	How Long		Years	Months
State nature and cause of disablement:						
Date of onset:		Date of diagnosis				
Please provide details of treatment:						

Are there any medical conditions which have a bearing on this current disablement? ☐ No ☐ Yes

If yes, Please provide details:

Has this person ever received a medical diagnosis, treatment, operation or attention for this or similar disablement or related cause? ☐ No ☐ Yes

Please supply the following details:

Date	Nature of Disability

What is your Prognosis?

Incapacity to perform usual occupation for this condition: From To

Reduced capacity to perform usual occupation for this condition: From To

Details:

Signature of Medical Practitioner: This form must be hand signed with your personal signature | Date

Address of Practice

Please retain a copy of the completed form for your records.