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ACCIDENT & HEALTH INTERNATIONAL

Claim Form

SPORT / VOLUNTARY WORKERS

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. **Please answer all questions and provide all relevant documentation to avoid delays with your claim. We are unable to process any claims until all information requested on this form is provided.**
2. **Please note that Sections 1, 2, 3, 4, 6, 7 & 8 are compulsory.**
3. **Note: This form can be completed electronically. If completing this form by hand: Please print.**
4. **The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Limited.**

SECTION ONE: YOUR DETAILS - COMPULSORY

Policy Number

Expiry Date

Association / Team Name:

Type of Sport / Activity

Occupation

Given Name(s)

Family Name

Date of Birth

Gender ☐ Male ☐ Female

Parent or Legal Guardian Name

Residential Address

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

What are you claiming for? ☐ Medical Expenses ☐ Weekly Benefits (if insured) ☐ Other

SECTION TWO: PAYMENT DETAILS - COMPULSORY

Please tick preferred method of Payment for refund.

☐ Cheque

Payee

☐ Direct/EFT Payment

Account Holder's Name

BSB Number (6-Digits)

Account Number

Bank

SECTION THREE: DETAILS OF INJURY - COMPULSORY

Date of Injury

Time

AM / PM

Location where injury occurred

What is the injury?

How did the injury occur?

Was this an authorised sporting or association activity? ☐ Yes ☐ No

SECTION FOUR: MEDICAL QUESTIONS - COMPULSORY

When did you first see a doctor for this condition? Date

Have you previously suffered from the same or a similar injury? Yes No Date

Are there or do you envisage any complications? Yes No Give Details

Do you have other private health cover? Yes No Type of Cover

Please note that if you have private health insurance you must first make a claim on them.

Name of initial medical attendant

Phone number of initial medical attendant

Name of regular medical attendant

Phone number of regular medical attendant

Is there anything in your medical history which may have contributed directly or indirectly, to the injury or which may be likely to retard your recovery?

Yes No Give Details

Nature of operation / hospitalisation (if any) to

If you are unable to go to school or work, when do you expect to be able to return?

SECTION FIVE: LOSS OF INCOME - TO BE COMPLETED ONLY IF CLAIMING LOSS OF INCOME

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

IF SELF EMPLOYED PLEASE INDICATE BY TICKING THE BOX

Confirmation of earnings MUST be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

IF EMPLOYED AS A WAGE EARNER TO BE COMPLETED BY YOUR EMPLOYER (or attach Pay Slip)

I hereby certify that has been unable to attend his/her usual occupation with the company as a result of an

Injury / Illness suffered whilst on the

He / She has been incapacitated since

and is expected to/did resume duties on

His / Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was $ per week.

Name of Company

Has been employed since

Address

Signature of Supervisor or Paymaster

Date

Telephone Number

Name (Please Print)

SECTION SIX: CLUB / ASSOCIATION DECLARATION - COMPULSORY

I hereby certify that whilst participating / playing in an authrorised club activity

Name

was injured on Date ☐☐ ☐☐ ☐☐☐☐ .

Name of Club / Association

Name of Secretary / Officer Bearer

Signature of Secretary / Officer Bearer

Date ☐☐ ☐☐ ☐☐☐☐

Telephone Number

SECTION SEVEN: DECLARATION - COMPULSORY

Dispute Resolution Statement

Accident & Health International Underwriting Pty Ltd is an agent for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd staff you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within fifteen (15) working days.

If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme.

Access to the Dispute Resolution scheme is free of charge to you.

Privacy

The Privacy Act 1988 requires us to tell you that on behalf of the Insurer we collect your personal information and sensitive information in order to calculate your loss and entitlements, determine our liability, compile data and handle claims.

When handling claims we may have to disclose and request your personal and other information to and from third parties such as other insurers, reinsurers, loss adjusters, medical attendants, external claims data collectors, investigators and agents, to the Insurance Reference Services (IRS), or other parties as required by law.

You have the right to seek access to your personal information and to correct it at any time. Please contact Accident & Health and advise us of the changes.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:

I/We certify that the information given in this form is truthful accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We acknowledge that I/We have read and understood the Privacy Act 1998 information referred to above and consent to the collection, storage and use and disclosure of personal and sensitive information of all persons affected by this claim, with their consent. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information then Accident & Health will be unable to process my/our claim.

Authority:

I authorise any hospital and/or physician who has treated me to provide Accident & Health International with copies of medical records or of my past medical history, as requested.

Signature of Claimant / Parent / Legal Guardian

Date ☐☐ ☐☐ ☐☐☐☐

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MEDICAL CERTIFICATE

THE CLAIMANT MUST OBTAIN AT OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES.

IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRES

SECTION EIGHT: TO BE COMPLETED ONLY IF CLAIMING FOR LOSS OF INCOME AND/OR MEDICAL EXPENSES

Patient's Full Name

Please give complete diagnosis of this condition

HISTORY

When did the patient first receive medical treatment?

Is there a previous history of this or a similar condition? ☐ Yes ☐ No

If Yes, please provide details

How long have you known the patient? ☐☐ Days ☐☐ Months ☐☐ Years

Are you the regular general practitioner? ☐ Yes ☐ No If not, please advise who is?

SICKNESS

When was sickness first contracted?

When did symptoms become evident?

OR

INJURY

When did the patient first suffer the injury?

What was the cause of the injury?

DEGREE OF DISABILITY

When was patient obliged to cease work?

Date

When was / will the patient be / able to return to:

Some Duties?

Full Duties?

TREATMENT OF PRESENT CONDITION

When were you consulted?

Initially

Most recently

Was patient confined to hospital? ☐ Yes ☐ No

From

To

If Yes, please advise Name and Address of hospital

What other surgical or medical procedures are possibly contemplated?

Are there any underlying conditions affecting recovery from the current conditions? ☐ Yes ☐ No

If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Print Name:

Qualification:

Signature:

Address:

Phone:

Fax

Date

Accident & Health International
Underwriting Pty Limited

Accident and Health

11/2013

MEDICAL EXPENSES INCURRED WITHIN AUSTRALIA

Information for Personal Injury Claims

If you are claiming reimbursement for medical expenses incurred as a direct result of injury, please read the following information carefully. Please also refer to your Policy document for any other additional terms of reimbursement.

If you are claiming the difference or shortfall of a payment from Accident & Health, you must first seek reimbursement from your Private Health fund (if applicable) and submit the accounts with your claim. Specifically for reimbursement of Medical Expenses that are subject to Medicare, the following information should be noted.

We advise that Your Policy will cover non-Medicare Medical Expenses to the amount stated in the Policy (after the deduction of any excess) for injuries which occur during insured activities. The policy will cover fees incurred as a result of injury including, but not limited to fees paid to nurses, hospitals, chiropractors, osteopaths and physiotherapists. Please note that you are expected to settle accounts first and then seek reimbursement.

We advise that this company must comply with Federal legislation that limits the benefits that General Insurers, Health Funds (and others) are legally allowed to insure. As a General Insurer we are *prohibited* from reimbursing medical expenses that are covered by the Medicare Scheme.

We can pay:

- ✓ Theatre Fees & Accommodation Fees in a hospital where the Insured Person is a *private* patient in a public or private hospital, subject to policy limits.
- ✓ Medical expenses which are not covered by Medicare.

We cannot pay:

- × Any *out of hospital or outpatient* expenses which have a Medicare component.
- × Any amounts above the Scheduled Fee, or "gap" fees related to Medicare services
- × When you are a *public* patient in a private or public hospital. Everything is covered by Medicare in this circumstance.
- × Specifically, for out of hospital Doctor or Specialist visits, Medicare refunds 85% of the Scheduled Fee. No-one can reimburse any other amount for these expenses.
- × Pharmaceuticals items that are subject to the Pharmaceutical Benefits Scheme (PBS), or Pharmaceutical items that cost less than the yearly indexed PBS amount.

Examples

Medical Service	Amount Charged	Scheduled Fee	Medicare Pays	We Pay	Insured Pays
Private Hospital Accommodation	$400.00	$0.00	$0.00	$400.00	$0.00
Hospital Doctor Consultation	$100.00	$80.00	$60.00	$0.00	$40.00
GP Consultation **out of hospital** (no bulk billing)	$100.00	$80.00	$68.00	Nil	$32.00

Please note that where a Private Health Fund has reimbursed any in-hospital amount then no further reimbursement is available.

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ACCIDENT / INJURY EXPENSES

Policy Number *(If known)*

Name

Reimbursement is calculated as follows:

A – D in the case of no Medicare component
Please note: Federal Legislation prohibits General Insurers from contributing to out of pocket expenses against Medicare eligible services.
Please note: in the case of a "Medicare gap" being paid by your Health Fund, no further benefit is claimable from Accident & Health International.

		A	B	C	D	Office Use Only	
Date Expense Incurred	**Item Description**	**Fee Charged**	**Scheduled Fee**	**Medicare Benefits**	**Health Fund Benefit**	**Amount Payable by AHI**	**Details**
Totals							