HCF

THE HOSPITALS CONTRIBUTION FUND OF AUSTRALIA LIMITED
ABN 68 000 026 746. A Registered Health Benefits Organisation.
HCF House, 403 George Street, Sydney 2000. Correspondence: GPO Box 4242, Sydney NSW 2001.
Telephone: Business (61 2) 9290 0444, Information 13 13 34. Facsimile: (61 2) 9279 3549.
E-mail: service@hcf.com.au Internet: www.hcf.com.au

ACCIDENT DETAILS

Date / / Membership Number

Name of Patient Date of Treatment / /

We have received your claim for benefit for the above named patient. The details provided indicate the treatment may have been the result of an accident or injury. Before your benefit entitlement can be assessed we require further information. As your claim cannot be processed without this information, please return this form as soon as possible.

Was this claim for benefit the result of an accident or injury (including any sporting injuries or hernias)? ☐ **Yes** ☐ **No**

If **Yes** complete the relevant details including sections 1, 2 or 3 below, sign the declaration in section 4 and return this form to HCF.

If **No** proceed to Section 4, sign the declaration and return this form to HCF.

If **Yes** describe how the Accident/Injury occurred.

Date Time Place

- **In the case of Hernia please provide the above details regarding the date and place of onset if not caused by an accident.**

WORKERS COMPENSATION

1. Did the Accident/Injury happen at work, or going to or from work? ☐ Yes ☐ No

IF YES:
(A) State Name and Address of Employer

(B) Are you entitled to claim Worker's Compensation? ☐ Yes ☐ No

IF NO, state reasons

TRANSPORT ACCIDENT

2. Was the Accident/Injury the result of a motor accident? ☐ Yes ☐ No

IF YES
(A) Are you entitled to claim against Third Party Insurance? ☐ Yes ☐ No

IF NO, state reasons

OTHER COMPENSATION – e.g. Personal Injury

3. Are you entitled to claim against any other form of Insurance? ☐ Yes ☐ No

IF YES, please give details

If a claim for compensation has been denied, a copy of this advice is required.

If you answered yes to any of the above questions, please provide the following details:

Solicitors name and address

Insurance Company

DECLARATION

4. I declare the above statements to be true and correct.

Signed Date / /

HCF9352 v.1-04