

## KIDS' ACCIDENT COVER - CLAIMANT'S CLAIM FORM

Please note that this form must be completed by the parent/guardian and please ensure all questions are answered to avoid any delay in the claim process. If you have any questions please call the HCF Life Claims Team on 1300 423 543 (Select Option 2).

Complete and return email: lifeclaims@hcf.com.au or mail: HCF Life Insurance GPO BOX 4445 Sydney NSW 2001

	<b>DETAILS</b> (PLEASE	USE CAPITAL LETTERS	AND A BLACK PE	N)				
Person injured								
Title	First name					Midd	e initial	
لتتتيا								C (D) 1 1 1 1
Surname								Sex (Please mark "x')
								M F
Date of hirth (DI	D/MM/YYYY) Pa	rent's phone (mobile	)	Parent's phor	e (home)			
Date of birtin (Di	5/11/11/17/10	irent's priorie (mobile	.,	r dicites prior	ic (Horric)			
Unit No.	Street No.	Street name						
Suburb					State	Postcode		
Parent/guardian	email							
Turchity guardian	Ciridii							
		SE CAPITAL LETTERS AI			olicy terms for (	lefinition of Acc	cident)	
What time did th	ne accident occur?	Date of accident	(DD MM YYYY	<b>'</b> )				
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	AM PM							
Where did the ac	ccident occur? Plea	se give precise addres	ss and precise loo	ration				
How did the acci	dent occur? (e ø fe	ll over running riding	etc)					
How did the acci	dent occur? (e.g. fe	ll over, running, riding	etc)					
How did the acci	dent occur? (e.g. fe	ll over, running, riding	etc)					
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Did the injury inv	rolve a broken or fra		ed by your policy	? Yes 🗌		ning the injury		
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Address of the doctor/medical centre/hospital who attended to the above injury:  Address of the doctor/medical centre/hospital who attended to the above injury:  Unit No. Street No. Street No. Street No.  Street No. Street No. Street No.  Street No. Street No.  Street N	Name of the deater/a			a Alaa alaa wa isii wa u			
Privacy collection notice  HCF Life Insurance Company Pty Ltd (HCF Life) collects the information that you provide on this form to assess your insurance claim. If you do not provide this information, HCF Life may be unable to assess or finalise your claim. HCF Life may disclose your information to its related entities and third parties in connection with this purpose. Information about how HCF Life manages personal information is contained in the HCF Privacy Policy, which is available at hcf.com.au/privacy  3 DECLARATION AND CONSENT  (Please read and sign)  I hereby declare that all the above statements are true and complete and that I and any other persons covered by this policy whose personal (including sensitive) information is being disclosed to HCF Life acknowledge the Privacy Collection Notice above and confirm that we are aware of the HCF Privacy Policy, in accordance with which our personal information is dealt with by HCF Life, including requests for access to and correction of and complaints about their personal information and consent to this information being made available to HCF.  I acknowledge that claims will be listed with an insurance industry reference bureau for the purpose of establishing and obtaining an insurance reference.  I authorise and consent to:  i. any doctor, physician or other health care provider, ambulance or hospital;  ii. any employer, accountant or insurer; and  iii. any Government body or agency (including but not limited to the Police of any State or Territory or Centrelink)  supplying to HCF Life upon request or legal direction any information and documents that HCF Life may reasonably require to undertake its assessment of this claim or any related matter. This includes (without limitation) details of any medical test, treatment, medical history or financial details to substantiate my loss of income.  Signature of Parent/Guardian  Date (DD MM YYYY)  **CLAIM PAYMENT INSTRUCTIONS**  (Please complete)  HCF Life pays claim benefits directly to a nominated bank account. Plea	Name of the doctor/n	nedical centre/i	iospitai wno attended t	o the above injury:			
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### The Fire Insurance Company Pty Ltd (MFF Life) collects the information that you provide on this form to assess your insurance claim. If you do not provide this information, HCF Life may be unable to assess or finalise your claim. HCF Life may disclose your information to its related entities and third parties in connection with this purpose. Information about how HCF Life manages personal information is contained in the HCF Privacy Policy, which is available at hcf.com.au/privacy  **BECLARATION AND CONSENT**  (Please read and sign)  I hereby declare that all the above statements are true and complete and that I and any other persons covered by this policy whose personal (including sensitive) information is being disclosed to HCF Life acknowledge the Privacy Collection Notice above and confirm that we are aware of the HCF Privacy Policy, in accordance with which our personal information is dealt with by HCF Life, including requests for access to and correction of and complaints about their personal information and consent to this information being made available to HCF.  I acknowledge that claims will be listed with an insurance industry reference bureau for the purpose of establishing and obtaining an insurance reference.  I authorise and consent to:  i. any doctor, physician or other health care provider, ambulance or hospital;  ii. any employer, accountant or insurer; and  iii. any Government body or agency (including but not limited to the Police of any State or Territory or Centrelink)  supplying to HCF Life upon request or legal direction any information and documents that HCF Life may reasonably require to undertake its assessment of this claim or any related matter. This includes (without limitation) details of any medical test, treatment, medical history or financial details to substantiate my loss of income.  Signature of Parenty/Guardian  Date (DD MM YYYY)  **ACALIM PAYMENT INSTRUCTIONS**  (Please complete)  HCF Life pays claim benefits directly to a nominated bank account. Please advise the follo	Suburb				State	Postcode	
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(Please complete)  HCF Life pays claim benefits directly to a nominated bank account. Please advise the following information:  Account name	X						
BSB No. Account No.	( <b>Please complete</b> ) HCF Life pays claim b			ccount. Please advise the follo	wing informati	on:	
DOD INU. ACCOUNT INO.	PCP No.	\	Jo				
	DOB INO.	Account I	NO.				
If you'd like us to credit the claim benefit directly to the account from which your HCF/HCF Life premiums are deducted please tick this box.   Unfortunately we're unable to credit benefits directly to a credit card account.					HCF Life pre	miums are deducte	ed please tick this box.

## Notes:

The Procedures for submitting a claim form are as follows:

- 1. Completion of the Claim Form by the parent or guardian of the child
- 2. A statement/medical certificate signed by a doctor and, for fractures only, a copy of the X-Ray report In the case of stitches, the number of stitches performed. In the case of severe burns medical confirmation of the severity
- 3. Proof of age (a copy of birth certificate or passport), if this is not already detailed on the doctor's/medical report. Please ensure the claim form is fully completed, and signed to avoid delays in processing the claim.

Any fees incurred for obtaining any of the above, are to be provided at the claimant's expense.

HCF reserves the right to request research evidence supporting the adopted therapeutic approach in certain instances for the condition treated. Information in this form may be shared with the member.

Email: lifeclaims@hcf.com.au Internet: hcf.com.au