HCF

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

Membership No.

Policy No.

1 CLAIMANT'S DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Person injured

Title

First name

Middle initial

Surname

Sex (Please mark "x")

M ☐ F ☐

Date of birth (DD/MM/YYYY)

Parent's phone (mobile)

Parent's phone (home)

Unit No.

Street No.

Street name

Suburb

State

Postcode

Parent/guardian email

@ . .

2 ACCIDENT DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN) (Note: refer to Policy terms for definition of Accident)

What time did the accident occur?

: AM ☐ PM ☐

Date of accident (DD MM YYYY)

Where did the accident occur? Please give precise address and precise location

How did the accident occur? (e.g. fell over, running, riding etc)

Did the injury involve a broken or fractured bone(s) covered by your policy? Yes ☐ No ☐

If yes, please give full details and provide a copy of the x-ray report or hospital discharge report confirming the injury:

Did the injury involve more than 3 stitches or sutures not as a result of surgery? Yes ☐ No ☐

If yes, please give full details of how many and provide hospital discharge report or medical report from doctor confirming details:

Did your injury involve severe burns? Yes ☐ No ☐ If yes, confirm severity: Partial thickness (2nd degree) ☐ Full thickness (3rd degree) ☐

Please provide hospital discharge or other medical report confirming this.

Is the accident a result of Racing or Professional Sport? (Refer to PDS for definitions) Yes ☐ No ☐

For policies that commenced after 2 February 2022

Did the injury involve overnight hospital admission as a result of a listed impairment? Yes ☐ No ☐ If yes, how many nights?

Name of your usual doctor/medical centre

Address of your usual doctor/medical centre

Unit No.

Street No.

Street name

Suburb

State

Postcode

HCF

Name 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 name

Suburb | State | Postcode

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

X

Date (DD MM YYYY)

4 CLAIM PAYMENT INSTRUCTIONS

(Please complete)

HCF Life pays claim benefits directly to a nominated bank account. Please advise the following information:

Account name

BSB No. | Account 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.

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.