PERSONAL ACCIDENT INSURANCE CLAIM

Please note that we also require the attached Insurance Certificate to be completed by your usual doctor (if he/she has details) or the doctor who has provided the treatment for your accident. You are responsible for obtaining this certificate and for payment of any fees charged.
The claim form should be completed by the injured person. If you have any questions please call the HCF Life Claims Team on 1300 423 543.

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)

Title

First name

Middle initial

Surname

Sex (Please mark "x')
M ☐ F ☐

Home address
Unit No.

Street No.

Street name

Suburb

State

Postcode

Phone (home)

Phone (work)

Phone (mobile)

Occupation

Date of birth (DD/MM/YYYY)

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 and who was involved (e.g. friends, relatives, work associates, strangers etc)?

State the nature and extent of the injuries (Note: Please refer to your policy terms to see impairments that are covered by your policy)

When did you seek medical advice?
: AM ☐ PM ☐

Date of accident (DD MM YYYY)

Name of doctor, medical practice or hospital:

Address of doctor, medical practice or hospital:
Unit No.

Street No.

Street name

Suburb

State

Postcode

How were you transported from the accident scene to the doctor, medial practice or hospital?

Was the accident reported to the police? Yes ☐ No ☐ If 'Yes', please advise:

When it was reported, name of police officer and contact number of Police station where reported, and Police Event number

Name of your usual doctor/medical centre:

Address of your usual doctor/medical centre:

Unit No. Street No. Street name

Suburb State Postcode

How long have you attended this practice?

Years Months

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 Insured Person X Date (DD MM YYYY)

Signature of Policy Holder 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.

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.

The Hospitals Contribution Fund of Australia Ltd.
ABN 68 000 026 746 AFSL 241 414

HCF Life Insurance Company Pty Ltd.
ABN 37 001 831 250 AFSL 236 806

Head Office: 403 George Street, Sydney, NSW 2000
Telephone: 13 13 34
Postal Address: GPO Box 4445, Sydney NSW 2001
Email: lifeclaims@hcf.com.au
Internet: **hcf.com.au**

PERSONAL ACCIDENT INSURANCE CERTIFICATE OF MEDICAL ATTENDANT

To be completed by a medical attendant.
The policy holder is responsible for any fee for this statement.

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

Membership No.

Policy No.

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

Title

First name

Middle initial

Date of birth (DD/MM/YYYY)

Surname

M ☐ F ☐

2 ACCIDENT DETAILS

Date the accident occurred (DD MM YYYY)

Date the patient first received medical attention for this (DD MM YYYY)

Date the patient came to see you with this condition (DD MM YYYY)

3 INJURY DETAILS

Fractures (if ribs and/or vertebrae involved, advise exact number at question 4.)	Yes ☐	No ☐
Dislocations (requiring surgery under anaesthesia)	Yes ☐	No ☐
Severe Burns (Partial thickness / 2nd degree or Full Thickness / 3rd degree)	Yes ☐	No ☐

4 DESCRIBE NATURE OF INJURIES (DESCRIBE COMPLICATIONS IF ANY)

If severe burns, what percentage of body surface was involved, as measured by the Lund Browder Chart? Please do not include any superficial thickness (or 1st degree) burns

5 DESCRIBE NATURE OF TREATMENT

6 FINAL DIAGNOSIS

Please include copies of all specific tests, x-ray reports, discharge summary, operation report etc.

Does the injury(s) sustained directly relate to the accident? Please provide details:

7 COMMENTS

Please provide any other information that you may feel may be helpful in assessing this claim.

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**

8 DECLARATION

(Please read and sign)

- I declare the information provided to be true and correct.

How HCF Life collects, uses, discloses (which may include obligations to overseas recipients in compliance with its privacy obligations) and keeps and secures personal information including how to opt out from direct marketing, how to request access to a correction of your personal information or how to complain about a privacy breach and how this is handled by HCF Life is explained in the HCF privacy policy. For a copy of this policy, call our member services team on **13 13 34** or go to **hcf.com.au/privacy**

Name (please print)

Qualifications

Signature

X

Date (DD MM YYYY)

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.