

HCF LIFE 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 enquiries please telephone the HCF Life Claims Team on 1300 423 543.

Complete and send to:
HCF Life Insurance
Company Pty Ltd
GPO Box 4445,
Sydney, NSW 2001

HCF Membership No.

Policy No.

1 Claimant's details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title	First name	Middle initial
<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	Sex (Please mark 'X')	
<input type="text"/>	M <input type="checkbox"/> F <input type="checkbox"/>	+
Home address:		
Unit No.	Street No.	Street name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone - home	Phone - work	Mobile
<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	Date of birth (DD MM YYYY)	
<input type="text"/>	<input type="text"/>	

2 Accident details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

What time did the accident occur? Date of accident (DD MM YYYY)

<input type="text"/>	:	AM <input type="checkbox"/> PM <input type="checkbox"/>	<input type="text"/>
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Where did the accident occur? Please give precise address and precise location

Please provide full details and circumstances of the events leading up to, and how the accident happened

Name of first witness		
Title	First name	Middle initial
<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	Sex (Please mark 'X')	
<input type="text"/>	M <input type="checkbox"/> F <input type="checkbox"/>	
Address of first witness		
Unit No.	Street No.	Street name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>

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Name of second witness
Title First name Middle initial

Surname Sex (Please mark 'X')
M F

Address of first witness
Unit No. Street No. Street name
Suburb State Postcode

State the nature and extent of the injuries

When did you seek medical advice?
Time : 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, Medical Practice or Hospital?

Was the accident reported to the police? Yes No

If yes, please advise:

When was it reported?

Name of police officer

Police station where reported

The Police Event number

Complete and send to:
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Sydney, NSW 2001

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

Were you under the influence of any:

(a) Drugs, not prescribed by a Doctor? Yes No (b) Alcohol? Yes No

3 Declaration and consent (Please read and sign)

I hereby declare that all the above statements are true and complete and that I and all persons covered by this claim whose personal (including sensitive) information is being disclosed to HCF Life are aware of the HCF Privacy Policy (available on the HCF website at hcf.com.au, in HCF branches or by calling 13 13 34), in accordance with which all personal information is dealt (including requests for access to and correction of and complaints about 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:

- i. any treating doctor, physician or other health care provider, ambulance or hospital
- ii. any employer, accountant or any insurer
- iii. the Police Department of any State or Territory or Centrelink

to supply upon request to HCF Life or any legal tribunal details of any medical test, treatment, medical history or financial details to substantiate my loss of income that it might reasonably request.

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. To allow us to do this please advise the following information:

Financial institution name

Branch

Account name

BSB No.

Account No.

If you would 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 are 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.

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

Complete and send to:
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Company Pty Ltd**
GPO Box 4445,
Sydney, NSW 2001

HCF Membership No. Policy No.

1 Patient's details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title First name Middle initial +

Surname Date of birth (DD MM YYYY) Sex (Please mark 'X')
M F

Parent's contact number - mobile Parent's contact number - home

2 Accident details

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

Burns (2nd or 3rd degree) Yes No

4 Describe nature of injuries (describe complications if any)

If burns, did the burn suffered by the patient involve:

27% or more of the body's surface Yes No

18% or more of the body's surface Yes No

9% or more of the body's surface Yes No

5% or more of the body's surface Yes No

5 Describe nature of treatment

6 Final diagnosis

Please include copies of all specific tests, x-ray reports, ECG reports, blood etc.

Does the injury(s) sustained directly relate to the accident? Yes No

If yes, please provide details

To be completed by a medical attendant
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7 Comments

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

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)

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