

ACCIDENT & HEALTH INTERNATIONAL

Claim Form

SPORT / VOLUNTARY WORKERS

Sydney
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AFS Licence No: 238621
Email: claims@acchealth.com.au
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IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. **Please answer all questions and provide all relevant documentation to avoid delays with your claim.** We are unable to process any claims until all information requested on this form is provided.
2. Please note that Sections 1, 2, 3, 4, 6, 7 & 8 are compulsory.
3. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Limited.

SECTION ONE: YOUR DETAILS - COMPULSORY

Policy Number	Expiry Date	Association / Team Name:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Type of Sport / Activity	Occupation		
<input type="text"/>	<input type="text"/>		
Given Name(s)	Family Name		
<input type="text"/>	<input type="text"/>		
Date of Birth	Gender	Parent or Legal Guardian Name	
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	
Residential Address	Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address	Daytime Contact Number	Alternative Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
What are you claiming for?	<input type="checkbox"/> Medical Expenses	<input type="checkbox"/> Weekly Benefits (if insured)	<input type="checkbox"/> Other <input type="text"/>

SECTION TWO: PAYMENT DETAILS - COMPULSORY

Please tick preferred method of Payment for refund.

<input type="checkbox"/> Cheque	Payee		
	<input type="text"/>		
<input type="checkbox"/> Direct/EFT Payment	Account Holder's Name		
	<input type="text"/>		
BSB Number	(6-Digits)	Account Number	Bank
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION THREE: DETAILS OF INJURY - COMPULSORY

Date of Injury	Time	AM / PM	Location where injury occurred
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
What is the injury?			
<input type="text"/>			
How did the injury occur?			
<input type="text"/>			

Was this an authorised sporting or association activity? Yes No

SECTION FOUR: MEDICAL QUESTIONS - COMPULSORY

When did you first see a doctor for this condition? Date

Have you previously suffered from the same or a similar injury? Yes No Date

Are there or do you envisage any complications? Yes No Give Details

Do you have other private health cover? Yes No Type of Cover

Please note that if you have private health insurance you must first make a claim on them.

Name of initial medical attendant Phone number of initial medical attendant

Name of regular medical attendant Phone number of regular medical attendant

Is there anything in your medical history which may have contributed directly or indirectly, to the injury or which may be likely to retard your recovery?

Yes No Give Details

Nature of operation / hospitalisation (if any) to

If you are unable to go to school or work, when do you expect to be able to return?

SECTION FIVE: LOSS OF INCOME - TO BE COMPLETED ONLY IF CLAIMING LOSS OF INCOME

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

IF SELF EMPLOYED PLEASE INDICATE BY TICKING THE BOX

Confirmation of earnings MUST be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

IF EMPLOYED AS A WAGE EARNER TO BE COMPLETED BY YOUR EMPLOYER (or attach Pay Slip)

I hereby certify that has been unable to attend his/her usual occupation with the company as a result of an

Injury / Illness suffered whilst on the

He / She has been incapacitated since

and is expected to/did resume duties on

His / Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was \$ per week.

Name of Company Has been employed since

Address

Signature of Supervisor or Paymaster Date

Telephone Number
Name (Please Print)

SECTION SIX: CLUB / ASSOCIATION DECLARATION - COMPULSORY

I hereby certify that whilst participating / playing in an authorised club activity

Name

was injured on ^{Date}

Name of Club / Association

Name of Secretary / Officer Bearer

Signature of Secretary / Officer Bearer

Date

Telephone Number

SECTION SEVEN: DECLARATION - COMPULSORY

Dispute Resolution Statement

Accident & Health International Underwriting Pty Ltd is an agent for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within fifteen (15) working days.

If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme.

Access to the Dispute Resolution scheme is free of charge to you.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:

I/We certify that the information given in this form is truthful, accurate and complete.

No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We agree that, by submitting this form, the personal information I/We provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in our [Privacy Policy](#) including for the processing of this claim.

Authority:

I authorise any hospital and/or physician who has treated me to provide Accident & Health International with copies of medical records or of my past medical history, as requested.

Signature of Claimant / Parent / Legal Guardian

Date

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MEDICAL CERTIFICATE

THE CLAIMANT MUST OBTAIN AT OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES.

IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRES

SECTION EIGHT: TO BE COMPLETED ONLY IF CLAIMING FOR LOSS OF INCOME AND/OR MEDICAL EXPENSES

Patient's Full Name

Please give complete diagnosis of this condition

HISTORY

When did the patient first receive medical treatment?

Is there a previous history of this or a similar condition?

 Yes No

If Yes, please provide details

How long have you known the patient?

 Days Months Years

Are you the regular general practitioner?

 Yes No If not, please advise who is?

SICKNESS

When was sickness first contracted?

When did symptoms become evident?

INJURY

When did the patient first suffer the injury?

OR

What was the cause of the injury?

DEGREE OF DISABILITY

When was patient obliged to cease work?

Date

When was / will the patient be / able to return to:

Some Duties?

Full Duties?

TREATMENT OF PRESENT CONDITION

When were you consulted?

Initially

Most recently

Was patient confined to hospital?

 Yes
 No

From

To

If Yes, please advise Name and Address of hospital

What other surgical or medical procedures are possibly contemplated?

Are there any underlying conditions affecting recovery from the current conditions?

 Yes No

If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Print Name:

Qualification:

Signature:

Address:

Phone:

Fax

Date



NON-MEDICARE MEDICAL EXPENSES

NOTICE TO CLAIMANTS

If you are claiming reimbursement for expenses incurred as a direct result of injury, please complete the following claim schedule. If you are claiming the difference or shortfall of a payment from Accident & Health, you must first seek reimbursement from your Private Health fund (if applicable) and submit the accounts with your claim. For reimbursement relating to Medical Expenses, please read the following information carefully:

We advise that Your Policy will cover non-Medicare Medical Expenses to the amount stated in the Policy (after the deduction of any excess) for injuries which occur during insured activities. The policy will cover fees incurred as a result of injury including, but not limited to fees paid to nurses, chemists, hospitals, chiropractors, osteopaths and physiotherapists. **Please note that you are expected to settle accounts first and then seek reimbursement.**

We advise that this company must comply with Federal legislation that limits the benefits that General Insurers, Health Funds (and others) are legally allowed to insure. As a General Insurer we are prohibited from reimbursing medical expenses that are covered by the Medicare Scheme.

We can pay:

- ✓ 100% of Theatre Fees & Accommodation Fees in a hospital where the Insured Person is a private patient in a public or private hospital.
- ✓ Any other medical expenses which are not covered by Medicare.

We cannot pay:

- ✗ Any out of hospital or outpatient expenses which have a Medicare component.
- ✗ Any amounts above the Scheduled Fee, or “gap” fees related to Medicare services
- ✗ When you are a public patient in a private or public hospital. Everything is covered by Medicare in this circumstance.
- ✗ Specifically, for out of hospital physician or specialist Doctor visits, Medicare refunds 85% of the Scheduled Fee. No-one can reimburse any other amount for these expenses.

Examples

Medical Service	Amount Charged	Scheduled Fee	Medicare Pays	We Pay	Insured Pays
Private Hospital Accommodation	\$400.00	\$0.00	\$0.00	\$400.00	\$0.00
Hospital Doctor Consultation	\$92.00	\$62.85	\$53.45	\$0.00	\$29.15
GP Consultation out of hospital (no bulk billing)	\$36.00	\$24.50	\$20.85	\$0.00	\$15.15

Please note that where a Private Health Fund has reimbursed the “gap”, no further reimbursement is available.

Further information on these limitations should be available from the Health Insurance Commission.

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ACCIDENT / INJURY EXPENSES

Policy Number (if known)

Name

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Reimbursement is calculated as follows:

A – D in the case of no Medicare component

Please note: Federal Legislation prohibits General Insurers from contributing to out of pocket expenses against Medicare eligible services.

Please note: in the case of a “Medicare gap” being paid by your Health Fund, no further benefit is claimable from Accident & Health International.

		A	B	C	D	Office Use Only	
Date Expense Incurred	Item Description	Fee Charged	Scheduled Fee	Medicare Benefits	Health Fund Benefit	Amount Payable by AHI	Details
Totals							