HCF 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 _____

Surname _____

Sex (Please mark 'X') M ☐ F ☐

Home address:

Unit No. _____ Street No. _____ Street name _____

Suburb _____ State _____ Postcode _____

Phone - home _____ _____ Phone - work _____ _____ Mobile _____

Occupation _____ Date of birth (DD MM YYYY) _____

2 Accident details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN) (Note: Please refer to policy terms for definition of an 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

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 _____

Surname _____

Sex (Please mark 'X') M ☐ F ☐

Address of first witness

Unit No. _____ Street No. _____ Street name _____

Suburb _____ State _____ Postcode _____

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 (Note: Please refer to your policy terms to see impairments that are covered by your policy)

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, Medial 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

HCF LIFE Personal Accident Insuranceclaim

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

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 Insured person 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.

HCF LIFE 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 send to:
HCF Life Insurance
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 ☐

2 Accident details

Date the accident occurred condition (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, ECG reports, blood etc.

Does the injury(s) sustained directly relate to the accident? Yes ☐ No ☐
Please provide details

HCF LIFE 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

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)

HCF Life 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.

HCF Life Insurance Company Pty Limited. ABN 37 001 831 250 AFSL 236 806
Head Office: 403 George Street, Sydney, NSW 2000

Telephone: 02 9290 0444. Fax: 02 9262 4165.
Postal Address: GPO Box 4445, Sydney NSW 2001