Accident & Health
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ABN: 26 053 335 952
AFS Licence No: 238621

# Claim Form
# Department of Veterans' Affairs Voluntary Workers Personal Accident

**Important: Please read before you complete this form**

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. Note: This form can be completed electronically. If completing this form by hand: Please print.
3. The issue of this form is not an admission of liability by AHI.

## 01. Your Details

Compulsory

Policy Number: 5561943

Expiry Date: 03 09 2021

Activity Name

Given Name(s)

Family Name

Date of Birth

Gender: M F Other

Parent or Legal Guardian Name

Residential Address

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

What are you claiming for?

Medical expenses

Other

## 02. Payment Details

Compulsory

Please provide bank and account details for payment

Account Holder's Name

BSB Number (6-Digits)

Account Number

Bank

## 03. Details of Injury

Compulsory

Please provide a description of the incident related to the injury

What were you doing when the accident occurred?

Date and time of accident

How did the accident occur?

Location where accident occurred

What is the nature and extent of your injuries?

## 04. 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

## 05. Declaration

Compulsory

**Dispute Resolution Statement**
AHI underwrite the policy on behalf of Insurance Australia Limited trading as CGU Insurance.

CGU is a subscriber to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute and after talking to AHI, 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 15 business days.

If you still remain dissatisfied after proceeding with the above, our process includes advising you on how to contact the insurance industry's external independent complaints scheme. Access to this scheme is free of charge to you .

**Privacy Declaration**
I/we agree that, by submitting this form, the personal information I/we provide to AHI in this form or otherwise may be collected, held, used and disclosed in the manner set out in the AHI Privacy Policy found at www.ahiinsurance.com.au, including for the processing of this claim.

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 AHI 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 AHI 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

## 06. Patient details

Compulsory

Patients Full Name

Date of Birth

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?

**OR**

When did symptoms become evident?

**Injury**

When did the patient first suffer the injury?

What was the cause of the injury?

**Degree of Disability**

When was patient obliged to cease activity?

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

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# Non-Medical Expenses Notice to Claimants

If you are claiming reimbursement for medical expenses incurred as a direct result of injury, please complete the following claim schedule. If you are claiming the difference in shortfall of a payment from AHI 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, 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, subject to policy limits.
- 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 Doctor or Specialist visits, Medicare refunds 85% of the Scheduled Fee. No-one can reimburse any other amount for these expenses.

Examples

| Medical Services | Amount Charged | Scheduled Fee | Medicare Pays | We Pay | Insured Pays |
|---|---|---|---|---|---|
| Private Hospital Acommodation | $400.00 | $0.00 | $0.00 | $400.00 | $0.00 |
| Private Hospital Doctor Consultation | $92.00 | $62.85 | $47.14 | $0.00 | $44.86 |
| 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 Department of Human Services.

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# Claim Form
# Accident/Injury Expenses

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 AHI.

| | | 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 |
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