



**SQUASH AUSTRALIA NATIONAL PERSONAL ACCIDENT INSURANCE PROGRAMME  
CLAIM FORM FOR LOSS OF INCOME &/OR RE-IMBURSEMENT OF MEDICAL EXPENSES**

**Correct completion of these forms will assist us to make accurate and faster decisions regarding your claims for benefits. Incomplete claim forms will be returned for completion, leading to assessment delays.**

**IMPORTANT NOTE**

This claim form can be used for making two types of claims. You can use this form to claim for re-imburement of medical expenses and/or you can also use this form to claim for weekly benefits due to the loss of your income where that cover exists under the policy. You should check with your member organisation whether the policy covers you for the loss of your income.

**THERE ARE THREE SECTIONS TO THIS CLAIM FORM.**

**Section One: CLAIMANT CERTIFICATION** is to be completed by the person making the claim (the sick or injured person) and needs to be completed for all claims. There are three pages.

**Section Two: MEDICAL CERTIFICATION** is to be completed by the **registered medical practitioner** who is/or has been involved in treating the person making the claim and needs to be completed for all claims (Any fee incurred for completion of this part of the form is the responsibility of the person making the claim). There is one page.

**Section Three: CLUB / CENTRE CERTIFICATION.**

Once the injured person has completed Section 1 and their treating medical practitioner has completed Section 2, the injured person needs to take the form to an official of their Club or Centre for completion of Section 3. There is one page.

**ALL SECTIONS OF THE CLAIM FORM MUST BE COMPREHENSIVELY COMPLETED BEFORE A CLAIM CAN BE ASSESSED.**

Once the claim form has been completed, signed and dated please send it WITH ALL ATTACHMENTS to:-

MARSH PTY LTD  
GPO Box 1229  
MELBOURNE VIC 3000  
Attn: Kristy Sacco

If you have any inquiries, or if you need assistance with understanding or completing this form, you can contact us on (toll-free) 1300-306-383. Please ensure that you keep copies of all documentation sent to Marsh and / or AFA.

**NOTE: This form is used to initiate a claim – if you continue to be disabled – and you are claiming for loss of income - you will be sent further progress forms for completion and return on a regular basis**

## SECTION 1 CLAIMANT CERTIFICATION

**THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM**

**Policy No:** 5487195      **Name of Squash Club / Centre:** \_\_\_\_\_

### **A. TYPE OF CLAIM**

Which benefit are you claiming for?

- ( ) **Medical expenses**  
( ) **Loss of income**

### **B. YOUR DETAILS**

First names: (Mr/Mrs/Ms) \_\_\_\_\_ Family Name: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medicare Number: \_\_\_\_\_

Your address \_\_\_\_\_ Suburb/town \_\_\_\_\_

Occupation: \_\_\_\_\_ Telephone (H) \_\_\_\_\_ (M) \_\_\_\_\_

### **C. THE INJURY**

1. What is the injury you sustained? \_\_\_\_\_

2. Which part/s of your body were injured? \_\_\_\_\_

3. Describe **fully** how the injury occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Full address at which you were injured? \_\_\_\_\_

5. Were you working, or at work, or travelling to or from work at the time of the injury?

6. What activity were you actually engaged in at the time you were injured? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. When did the injury occur? TIME \_\_\_\_\_ AM/PM      DATE \_\_\_\_/\_\_\_\_/\_\_\_\_      WEEKDAY \_\_\_\_\_

8. Please nominate the name and address of a witness who saw you injure yourself

Name \_\_\_\_\_ Address \_\_\_\_\_ Ph: \_\_\_\_\_

10. Have you **EVER** previously sustained an injury to that part of your body for which you are now making this claim? \_\_\_\_\_

11. If you answered "yes" to question 10 please tell us where you were when it happened, the date and how it occurred?

(Location) \_\_\_\_\_ (Date) \_\_\_\_/\_\_\_\_/\_\_\_\_ (How it occurred) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Which doctor, hospital or medical centre, if any, did you consult **the previous time** you injured this/these parts of your body?

I previously attended \_\_\_\_\_ for injury to this part of my body on \_\_\_\_/\_\_\_\_/\_\_\_\_

13. Was the activity in which you were engaged, at the time you injured yourself, an activity which was sanctioned and scheduled by the insured

Club / Association? \_\_\_\_\_  
\_\_\_\_\_

### **D. DETAILS OF YOUR CLAIM WITH YOUR HEALTH INSURER**

What is the name of your private health fund? \_\_\_\_\_ Membership No: \_\_\_\_\_

What branch of your health fund do you usually deal with? \_\_\_\_\_ Have you made a claim yet? \_\_\_\_\_

**SECTION 1 CLAIMANT CERTIFICATION – CONTINUED**

**THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM**

**E. MEDICAL DETAILS**

1. When did you **first** see a doctor for the injury and who was the doctor you first saw?

The first doctor I saw was \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Were you admitted to hospital? \_\_\_\_\_ If admitted, which hospital were you admitted to? \_\_\_\_\_

3. On what date were you admitted to hospital? \_\_\_\_/\_\_\_\_/\_\_\_\_ On what date were you released \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Is the doctor that you have been seeing for your injury your usual treating doctor? \_\_\_\_\_ If not, how long have you been seeing this current doctor? \_\_\_\_\_

5. Who is your usual treating doctor and what is the address of their practice? \_\_\_\_\_

**F. MEDICAL EXPENSES BEING CLAIMED (Complete only if you are claiming for re-imburement of medical expenses)**

If you are claiming for medical expenses please provide details of the expenses you are claiming reimbursement for and attach original receipts.

Date	Treatment	Provider	Cost	Account Paid ?

**NOTE**

**IF YOU HAVE NOT MADE A CLAIM WITH YOUR PRIVATE HEALTH INSURER, YOU MUST DO SO BEFORE SUBMITTING THIS CLAIM FOR RE-IMBURSEMENT OF MEDICAL EXPENSES**

**G. LOSS OF INCOME BEING CLAIMED – (Complete this section only if you are claiming for loss of income)**

1. In what occupation did you work in the 12 month period before you injured yourself? \_\_\_\_\_

2. How many hours per week did you work before you injured yourself? \_\_\_\_\_

3. What were your duties? \_\_\_\_\_

4. Were you self-employed or an employee? \_\_\_\_\_

5. Did the injury cause you to fully cease work? \_\_\_\_\_ If so, on what date did you fully cease work? \_\_\_\_/\_\_\_\_/\_\_\_\_

6. For how long were you fully off work due to the injury? \_\_\_\_\_

7. On what date did you first return to work? \_\_\_\_/\_\_\_\_/\_\_\_\_

8. If you have not yet returned to work, when do you expect that you will return to work? \_\_\_\_\_

**IMPORTANT !**

**IF YOU ARE CLAIMING FOR LOSS OF INCOME YOU MUST ATTACH PROOF OF YOUR INCOME FOR THE FULL TWELVE MONTHS BEFORE YOUR DATE OF INJURY**

Acceptable proof of income is a full copy of your taxation return and assessment for the twelve month period prior to the date of the injury

**SECTION 1 - CLAIMANT CERTIFICATION – CONTINUED**

**THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE INJURED PERSON MAKING THE CLAIM**

**H. DECLARATION AND INFORMATION AUTHORITIES**

I understand that AFA Pty Ltd may need to access, collect and disclose information about me in order to be able to assess my claim for benefits. In order to do so, I (insert your full name here) \_\_\_\_\_ of (your address) \_\_\_\_\_

hereby authorize AFA Pty Ltd to collect and disclose information about me from and to any health insurance provider, any hospital, physician, medical practice, any medical services provider, any medical therapy provider, investigators, insurance reference bureau, with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, copies of accounts. I also agree to allow access to records relating to my injury created or held by the association, university or institution at which I sustained my injury.

In providing or obtaining information about me, I understand that AFA Pty Ltd will use that information in the assessment of my claim, and that If I do not provide, or permit access to this information my claim may not be able to be assessed by AFA Pty Ltd.

AFA Pty Ltd may also collect and disclose information about me to:-

- Its relevant staff and contractors and confidential service vendors involved in delivering services on behalf of AFA Pty Ltd/Australian Family Assurance Ltd.
- An agent or broker who collects the claim form from me, or who otherwise assists in facilitating the assessment of my claim
- Its re-insurers, or re-insurance brokers (which may include re-insurers or re-insurance brokers located outside Australia)
- Its legal service providers such as legal firms, or to accountants, actuaries, providers of medico-legal services, loss adjusters, auditors, Insurance Enquiries and Complaints Ltd (IEC Ltd) and claims management consultants.

By completing and returning this form to AFA Pty Ltd, I agree to AFA Pty Ltd collecting additional information from the parties specified above in connection with the assessment of my claim and agree to AFA Pty Ltd using and disclosing my information as set out above.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. The expenses which I have claimed relate solely to the injury I sustained which is the subject of this claim. I agree that if I have made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

Signed \_\_\_\_\_

Dated \_\_\_\_/\_\_\_\_/\_\_\_\_

Signed \_\_\_\_\_

Dated \_\_\_\_/\_\_\_\_/\_\_\_\_

(Signature of Parent or Guardian if claimant under 18 years)

## SECTION 2 MEDICAL CERTIFICATION

**THIS PART OF THE CLAIM FORM MUST BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER WHO IS CERTIFYING THAT THE INJURED PERSON IS, OR WAS, INJURED AND/OR DISABLED FROM WORKING/OR NEEDED MEDICAL CARE.**

**PLEASE NOTE THAT ANY FEE INCURRED FOR THE COMPLETION OF THIS MEDICAL CERTIFICATION FORM IS THE RESPONSIBILITY OF THE PATIENT**

### PATIENT'S DETAILS

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. How long has the patient been known at your practice? \_\_\_\_\_ years
2. Are you the patient's primary treating physician at your practice? \_\_\_\_\_
3. What do you understand the patient's occupation to be? \_\_\_\_\_
4. What is the medical diagnosis disabling the patient? \_\_\_\_\_  
\_\_\_\_\_
5. When did the patient **first** consult you in regard to this period of disability? \_\_\_\_/\_\_\_\_/\_\_\_\_
6. **Was there any previous history of this or of a similar injury?** \_\_\_\_\_ If so, please provide full details of the dates and the nature of the previous history of injury \_\_\_\_\_  
\_\_\_\_\_
7. If the patient sustained an injury, what were the circumstances of the injury?  
\_\_\_\_\_
8. On what date did the injury/accident occur? \_\_\_\_/\_\_\_\_/\_\_\_\_

### SPECIFICS OF DISABILITY

	YES	NO	FROM WHAT DATE	TO WHAT DATE
Has the patient been <b><u>ENTIRELY PREVENTED</u></b> from engaging in their occupation by the medical condition?	( )	( )	____/____/____	____/____/____
Has the patient <b><u>ONLY BEEN PARTIALLY PREVENTED</u></b> from engaging in their occupation?	( )	( )	____/____/____	____/____/____
Is the patient now capable of a return to <b><u>FULL TIME</u></b> duties?	( )	( )	____/____/____	
Is the patient now capable of a return to <b><u>PARTIAL DUTIES?</u></b>	( )	( )	____/____/____	

1. If the patient is not yet capable of returning to work, what is currently preventing them from doing so? \_\_\_\_\_  
\_\_\_\_\_
2. Please list here details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis

TEST	CONDUCTED ON	CONDUCTED BY	RESULT
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

9. What is the current regime of medical treatment given or required? (medication, therapies, surgery etc)  
\_\_\_\_\_  
\_\_\_\_\_

### DOCTOR'S DECLARATION

The information provided in this medical certification is a truthful, comprehensive and frank account of the patient's medical condition, medical history and level of disability. I understand that if I have provided any false or misleading information in this medical certification, or if I have deliberately omitted information from this medical certification which has been requested and which I am able to give, it may result in a report to the Medical Registration Board or further action by the insurer, including civil action to recover compensation paid to the claimant in circumstances where reliance was placed on the accuracy and genuineness of the information I have provided.

Signed \_\_\_\_\_ Dated \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name: \_\_\_\_\_ Qualifications \_\_\_\_\_  
Address \_\_\_\_\_ Telephone No: \_\_\_\_\_

