



CLAIM FORM FOR LOSS OF INCOME &/OR RE-IMBURSEMENT OF MEDICAL EXPENSES UNDER UNIVERSITY OR SPORTING ASSOCIATION POLICIES

Correct completion of these forms will assist us to make accurate and faster decisions regarding our customers' 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, ASSOCIATION CERTIFICATION.

Once the injured person has completed section 1 and their treating medical practitioner has completed section 2, the injured persons needs to take the form to an official of the organisation, which is insured under the policy. (eg, Association Secretary/Association Administration Officer/University Administration Officer) and that official must complete 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, along WITH ATTACHMENTS, to:-

AFA CLAIMS DEPARTMENT
PO Box 761
Balgowlah NSW 2093

If you have any inquiries, or if you need assistance with understanding or completing this form, you can contact us on (toll-free) 1300-728 -997. Please ensure that you keep copies of all documentation sent to 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: _____ Name of University or Association: _____

A. TYPE OF CLAIM

Which benefit are you claiming for?

- () **Medical expenses**
() **Loss of income** (Note: - check with your member organisation that you have this cover)

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 organisation? _____

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

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:-

- It's 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
- It's re-insurers, or re-insurance brokers (which may include re-insurers or re-insurance brokers located outside Australia)
- It's 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 ____/____/____

Signature of Parent or Guardian if claimant under 18 years old _____

Dated ____/____/____

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 ENTIRELY PREVENTED from engaging in their occupation by the medical condition?	()	()	____/____/____	____/____/____
Has the patient ONLY BEEN PARTIALLY PREVENTED from engaging in their occupation?	()	()	____/____/____	____/____/____
Is the patient now capable of a return to FULL TIME duties?	()	()	____/____/____	
Is the patient now capable of a return to PARTIAL DUTIES ?	()	()	____/____/____	

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: _____

SECTION 3 - ASSOCIATION CERTIFICATION

THIS PAGE OF THE CLAIM FORM NEEDS TO BE COMPLETED BY AN OFFICIAL OF THE INSURED ORGANISATION (EG, AN ASSOCIATION SECRETARY/ASSOCIATION ADMINISTRATION OFFICER/UNIVERSITY MEMBER SERVICES OFFICER)

THIS OFFICIAL MUST ATTACH DOCUMENTARY PROOF THAT THE INJURED PERSON WAS A FINANCIAL MEMBER OF THE INSURED ORGANISATION AT THE TIME OF THE INJURY

1. What is the full name of the insured organisation? _____ Ph: _____

2. What is the official postal address of the insured organisation? _____
_____ State _____ Postcode _____

3. What is the full name and date of birth of the injured member?

First name: _____ Surname: _____ Date of Birth: ____/____/____

4. On what date did the member of the insured organisation injure themselves? ____/____/____

5. What was the member of the organisation actually doing at the time they injured themselves? _____

6. What injury was caused to the member of the organisation? _____

7. Was the activity in which the member of the organisation was participating; at the time they injured themselves, an officially authorized and sanctioned activity of the insured organisation? _____

8. What was the officially authorized and sanctioned activity in which the member was participating when they injured themselves?

9. At what venue did the member injure themselves (address) _____

10. What is the injured person's membership/student number of the insured organisation? _____

11. If the injured person is a university student, are they a student from overseas? _____

12. Was the member a fully financial member of the insured organisation at the date they injured themselves? _____

13. Please provide the dates of membership of the injured person with the insured organisation here:

Membership dates of the injured person are from ____/____/____ to ____/____/____

Declaration: I, _____ am the _____
(full name) (title of office bearer)
of the _____ . I declare that the information provided in this
(name of organisation)
certification is true, correct and complete to the best of my knowledge and ability.

Signed _____

Dated: _____

NOTE: THE OFFICIAL OF THE ORGANISATION WHO COMPLETES THIS PAGE OF THE CLAIM FORM MUST ATTACH DOCUMENTARY PROOF THAT THE INJURED PERSON WAS A FINANCIAL MEMBER OF THE INSURED ORGANISATION AT THE DATE THE MEMBER WAS INJURED.