# Accident and Health Insurance

**Claim Form**

**Policy and Personal Information**

Policy Number:

Insured Company Name:

Contact Name:

Address:

Telephone Number:       Mobile Number:

Email Address:

Date of Birth:

|  |  |  |
| --- | --- | --- |
| Gender | Male [ ]  | Female [ ]  |

Occupation/Trade/Activity:

Usual Activities:

**Accident Details**

Date of Accident:       Time:       [ ]  am [ ]  pm

Address of Accident:

Please describe the circumstances of the Accident and Injury as fully as possible (if insufficient space, please attach a separate sheet):

|  |  |  |  |
| --- | --- | --- | --- |
| Did the injury cause you to stop work? | Yes [ ]  | No [ ]  | If yes, when:       |
| Have you returned to work full time? | Yes [ ]  | No [ ]  | If yes, when:       |
| Have you returned to work part time? | Yes [ ]  | No [ ]  | If yes, when:       |
| If yes, what duties and hours are you working? | Hours:       Duties:        |

**General Information**

|  |  |  |
| --- | --- | --- |
| Were there any witnesses to the accident? | Yes [ ]  | No [ ]  |

**Witness no. 1**

Full Name:

Address:

Telephone Number:       Mobile Number:

**Witness no. 2**

Full Name:

Address:

Telephone Number:       Mobile Number:

|  |  |  |
| --- | --- | --- |
| Have you ever been treated for this or a similar injury in the past? | Yes [ ]  | No [ ]  |
| **If yes**, please give details:        |

|  |  |  |
| --- | --- | --- |
| Have you had any other significant or surgical treatment in the past 5 years? | Yes [ ]  | No [ ]  |
| **If yes**, please give full details:        |

|  |  |  |
| --- | --- | --- |
| Are you affected by another other long term or chronic disability? | Yes [ ]  | No [ ]  |
| **If yes**, please give full details:        |

**Medical Information**

|  |
| --- |
| Who is your usual doctor? |
| Name: |        |
| Address: |        |
| Telephone number:  |        |

|  |  |  |
| --- | --- | --- |
| Have you received treatment from a medical practitioner for this injury? | Yes [ ]  | No [ ]  |
| Name: |        |
| Address: |        |
| Telephone number:  |        |
| When did you first see this practitioner? |         |

|  |  |  |
| --- | --- | --- |
| Have you consulted any other medical practitioner for this injury? | Yes [ ]  | No [ ]  |
| Name: |        |
| Address: |        |
| Telephone number:  |        |
| Period: |        |

|  |  |  |
| --- | --- | --- |
| Did you go to hospital? | Yes [ ]  | No [ ]  |
| Hospital Name: |        |
| Address: |        |
| Date of Admission: |        |
| Date of Discharge: |        |
| Number of days in hospital: |        |

|  |  |  |
| --- | --- | --- |
| During the 24 hours before the injury, did you drink alcohol or take any drugs? | Yes [ ]  | No [ ]  |
| **If yes**, please give full details:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| Have you made a previous injury claim against any insurance company?  | Yes [ ]  | No [ ]  |
| **If yes**, please give details:         |

|  |  |  |
| --- | --- | --- |
| Do you hold any other insurance under which a claim for this Incident may be made? | Yes [ ]  | No [ ]  |
| **If yes**, please give full details:         |

|  |  |  |
| --- | --- | --- |
| Do you have private health insurance? | Yes [ ]  | No [ ]  |

|  |  |  |
| --- | --- | --- |
| Do you have ambulance cover? | Yes [ ]  | No [ ]  |

**Declaration *Please read carefully before signing***

I declare that the particulars stated above and documents provided in support of this claim are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sicknesses shall be forfeited.

I further agree that any Professional person, Medical Practitioner or Hospital Authority who has been or may hereafter be consulted by me relative to the injury or illness is hereby authorised and directed by me to divulge at any time Keystone Underwriting Pty Ltd, the Underwriters of this Policy, their legal representatives or Loss Adjusters, any information or history they may have acquired with regard to any injury or illness.

Signed: Dated:

By:

Please return your completed claim form to your broker or:

Keystone Underwriting Australia Pty Ltd

104/266-268 Bay Road

Cheltenham, VIC 3192

Phone: 1300 946 530

Email claims@ksua.com.au

Keystone Underwriting Australia Pty Ltd is not an insurer under your policy. The insurer(s) are those underwriters shown under “Security” in your schedule. Please note that, in accepting this claim form, Keystone Underwriting Australia Pty Ltd is acting as an agent of the insurer(s) and not as your agent.