Accident / Injury Report

1. Please complete this form **USING BLACK INK** and write within the boxes in **CAPITAL LETTERS**. Mark appropriate answer boxes with a **CROSS**. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE.**
2. Please complete all details that are relevant to you on all pages of this form.
3. Read the declaration and sign all the relevant signature panels.
4. See Important Information for all details relating to how you are covered.

SECTION A: Your details

Bupa membership number

Surname

First name

Initial Title

Date of birth (D D M M Y Y Y Y)

Sex (M/F)

Residential address

Postcode

Email

Mail address (if different from residential address)

Postcode

Home phone (including area code)

Work phone (including area code)

Mobile

Full name of person(s) injured

Date of birth (D D M M Y Y Y Y)

SECTION B: Accident and injury details

1. Particulars of accident or injury

Was the injury the result of an accident?

X Yes (please complete questions 2 to 7)

X No (please complete questions 2a and 2b)

2. Details of accident/injury/condition

a. Date and time of the onset of accident/injury/condition (D D M M Y Y Y Y) : AM PM

b. Describe how the accident/injury/condition occurred

c. Place of accident/injury

d. Describe the nature of injury sustained and when the symptoms first appeared

e. Name and addresses of any witnesses

f. Did you seek immediate medical attention within 72 hours?

X Yes. If yes, please provide details of the treating practitioner.

X No

g. Please attach a copy of the doctor/hospital/police report or claim form which was completed at the time of your accident/injury (if available).

3. Are you entitled to claim

a. Workers' Compensation^	X Yes (go to question 4)	X No*
b. Third Party damages from persons liable?	X Yes (go to question 5)	X No*
c. Damages for persons liable at law, e.g. Public Risk?	X Yes (go to question 6)	X No*

*If you answered 'No' to all of the questions above, go to the declaration. ^If you have claimed under Workers' Compensation or Third Party and have been refused, please attach a certified copy of the official letter of refusal with written confirmation that no appeal will be lodged.

4. Workers' Compensation (*to be completed if work-related*)

a. Did the accident/injury happen at work, or going to and from work?

X Yes – Provide name and address of employer

X No

Work cover claim number

Continued on next page.

SECTION B: Accident and injury details *continued*

b. Do you intend to claim Workers' Compensation?

X Yes X No – give reasons (*e.g. self employed*)

Insurer details and address

Postcode

5. Third Party Insurance (*to be completed if a motor accident*)

a. Name of driver of your vehicle (if applicable)

b. Name of owner of your vehicle (if applicable)

c. Was another vehicle involved?

X Yes X No

d. Name and address of the negligent party

e. Do you intend to claim against the Third Party?

X Yes X No – give reasons

TAC/CTP claim number

Insurer details and address

Postcode

6. Damages/Compensation (*e.g. public liability*)

Do you intend to claim damages from any other party?

X Yes X No – give reasons

7. Are you being represented by a lawyer or any other party in relation to this claim?

X Yes – give details X No

Surname

First Name

Address

Postcode

Phone number (including area code)

Email address

SECTION C: Declaration

I understand that Bupa might require more information before processing my claim. I authorise Bupa to contact any necessary persons including insurance companies if additional information is required (including providing medical reports) to establish my eligibility for Benefits.

I understand that Bupa may pay a Benefit if: the customer/dependant is entitled to claim damages/compensation, the customer/dependant agrees to pursue the claim, and the customer/dependant signs an Acknowledgement and Undertaking agreeing to pursue legal action and repay Treatment expenses paid by Bupa in the event of the claim for compensation/damages, however described, being successful.

I understand that a Benefit is not payable if: the customer/dependant refuses to pursue a claim without adequate cause or the customer/dependant has been successful in a claim for compensation or damages and has received a settlement including payments by way of ex-gratia and/or non-disclosed settlement. Any Benefits paid in these circumstances must be refunded to Bupa.

Policyholder's signature | Date D D M M Y Y Y Y | Witnessed by | Date D D M M Y Y Y Y

Just before you send

X Check that you have signed all the signature boxes relevant to your application, including the declaration above.
PLEASE DO NOT STAPLE.

Please mail your application to us to:

Bupa Health Insurance GPO Box 4338 MELBOURNE VIC 3001

Alternatively, you can drop by a Bupa Health Insurance store.

If you would like any assistance, please call us on **134 135.**

Bupa HI Pty Ltd ABN 81 000 057 590

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