ACCIDENT OR INCIDENT INFORMATION

We have recently received a claim from you. To help us process it as quickly as possible, we need some more detailed information about what happened. Please complete this form and return it to us as soon as you can. Please use CAPITAL LETTERS and a black pen.

When you have completed this form, please scan and email it to **incidentform@hcf.com.au** or fax it to **02 9279 3549**.

HCF Membership No. 3 54 7 9 6 2 4

1 ACCIDENT OR INCIDENT DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Name of patient

R A Y M O N D G E O R G E J O H N M O R R I S O N

Date of Accident/incident (DD MM YYYY)

2 4 0 2 2 0 2 2

Please describe how the accident or incident occurred, what happened?

Whilst at work, I was trying to move a roll of Chicken wire. As I moved to the right my foot stayed on the floor, as I went down I heard 2 massive pops. After getting an ambulance and taken to hospital, I had an X-Ray and they didn't see any breaks. So put me in a cam boot and told me to just take it easy and off I go. After seeing a Physio and my GP I eventually got an Ultra Sound and found Full thickness tears to AITFL and the ATFL. As well as a moderate sprain to the CTFL. I got diagnosed with CRPS on the 3 Nov 2022

Time

0 9 . 3 0 X AM ☐ PM

Location

NATEIS CONTRACTING 113 DALISON AVENUE WATTLEUP WA 6166

1. Was the damage or injury caused during the course of:
   - employment or professional duties. **Please complete sections 2 and 5**.
   - any transport or motor vehicle incident. **Please complete sections 3 and 5**.
   - an event that may result in a compensation claim not related to work or a vehicle incident. In other words, you believe that someone else was at fault. **Please complete sections 4 and 5**.
   - none of the above. **Please complete the questions below (if relevant) and section 5**.

For members with Accident Only cover or claiming Accident Safeguard (as defined on next page).

2. Was the patient admitted to hospital? ☐ Yes ☐ No
3. Was this hospital treatment a direct result of the damage or injury? ☐ Yes ☐ No
4. Did the patient attend the accident and emergency department? ☐ Yes ☐ No If yes, include date attended:

Date (DD MM YYYY)

Name of the hospital where patient attended accident and emergency department. Please provide documentary proof of attendance.

2 WORKERS COMPENSATION (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

What is the name of the patient's employer?

N A T E I S C O N T R A C T I N G

Address of employer

1 1 3 D A L I S O N A V E N U E

Suburb

W A T T L E U P

State

W A

Postcode

6 1 6 6

Patient's solicitor's name

J O A C H I M A Z Z O P A R D I

Law firm name

S T E P H E N B R O W N E

Patient's solicitor's address

L E V E L 6, 5 2 4 H A Y S T R E E T,

Suburb

P E R T H

State

W A

Postcode

6 0 0 0

Please provide the patient's employer's insurance company details

Name of insurer

Q B E

Insurer's address

Level 18/200 S T G E O R G E S T E R R A C E

Suburb

P E R T H

State

WA

Postcode

6 0 0 0

Phone

1 3 3 7 2 3

Contact name

3 TRANSPORT ACCIDENT OR INCIDENT (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Did the Accident or incident involve:

☐ motor vehicle ☐ bus ☐ train ☐ motorbike/scooter ☐ bicycle ☐ other

Do you think that someone else was at fault and you wish to make a third party claim? ☐ Yes ☐ No ☐ Don't know

Please complete these details if you wish to make a third party claim

Patient's solicitor's name

Law firm name

Patient's solicitor's address

Suburb

State

Postcode

Please provide insurance details for the person/s you believe are at fault, if you have them

Insurer name

Phone

4 OTHER COMPENSATION CLAIM (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

If the Accident or incident was not work or transport related, but you believe that another person or organisation is at fault, please complete this section.

Patient's solicitor's name

Law firm name

Patient's solicitor's address

Suburb

State

Postcode

Please provide insurance details for the person/s you believe are at fault, if you have them

Insurer name

Phone

5 DECLARATION (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

This declaration must be completed by the policyholder or the partner listed on the policy.

I declare the information provided to be true and complete.

Signature of the policyholder or partner listed on policy

X

Date (DD MM YYYY)

0 8 0 7 2 0 2 5

INFORMATION TO NOTE

OUR DEFINITION OF AN ACCIDENT

Accident means an unforeseen event, occurring by chance and caused by an external force or object, which results in involuntary injury to the body requiring immediate treatment from a registered practitioner. This definition excludes unforeseen conditions attributable to medical causes.

WHAT IS ACCIDENT SAFEGUARD?

Accident Safeguard is a feature on some Hospital Covers which permits Excluded Services or Minimum Benefit Services to be treated as Covered Services when Treatment is directly the result of an Accident that occurs after joining. Excludes Treatment for elective cosmetic surgery, podiatric surgery by an accredited podiatrist and services not covered by Medicare. Conditions apply. See **hcf.com.au/accident-safeguard** to find out more. To check if your cover includes Accident Safeguard, login to the member section of our website **hcf.com.au/members**

Privacy: HCF collects, uses, discloses, keeps and secures personal information in accordance with the HCF privacy policy. For a copy of this please call member services on **13 13 34** or visit **hcf.com.au**

The Hospitals Contribution Fund of Australia Limited.
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HCF Life Insurance Company Pty Limited.
ABN 37 001 831 250 AFSL 236 806

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