ACCIDENT AND INJURY FORM

TEACHERS HEALTH

UPDATED AUGUST 2021

CHECKLIST

- If the accident/injury/condition occurred in your home and there's no right to recover compensation or damages from another person or organisation, briefly describe how the accident/injury/condition happened (Question 4). In this case, the appropriate response to the remaining questions should be N/A (Not Applicable).
- If the cause of the accident/injury/condition could be attributed to another person or organisation, or if it could be claimable from another source (such as Travel Insurance, CTP Green Slip, Workers Compensation, Dust Diseases Board, Third Party or Public Liability), you'll need to answer all questions.
- Submit your claim with all declarations signed and accounts or receipts attached.
- Leaving a section blank or without the required information may delay your claim being processed.

A. YOUR DETAILS

1. Member number ☐☐☐☐☐☐☐☐ Date of birth DD / MM / YYYY

   Patient's given names ____ Surname ____

   Treatment by ____ From DD / MM / YYYY

2. Date of accident/injury/condition DD / MM / YYYY Time HH : MM ◯ am ◯ pm

3. Place of accident/injury/condition ____

4. How did the accident/injury/condition happen? Note: In the case of a hernia repair, please give the date of onset if not caused by an accident.

5. Did the accident/injury/condition involve a motor vehicle? ◯ Yes ◯ No

   If yes, state whether the patient was a passenger, the driver or a pedestrian

   Does the patient have any entitlement to claim Third Party Insurance? ◯ Yes ◯ No

   Give the name and address of the vehicle owner, name and address of the insurance company and the TAC/CTP claim number

   If not entitled to claim against Third Party Insurance, please state the reasons why. If a claim has been denied, please attach a copy of the advice denying liability

6. Did the accident/injury/condition happen at work or going to or from work? ◯ Yes ◯ No

At the time of the accident/injury/condition was the patient: ◯ Employed ◯ Self-employed ◯ Unemployed ◯ Other

If employed or self-employed, please state name and address of the organisation or business.

Is the patient entitled to claim Workers Compensation? ◯ Yes ◯ No

If no, please state reasons. If a claim has been denied, a copy of the advice denying liability must be attached.

7. Is any action being taken, or is there any intention or entitlement to take action, to recover any hospital, medical or general treatment (ancillary) expenses in respect of this injury, from any other source? ◯ Yes ◯ No

8. If you have answered "Yes" to question 5, 6, or 7, please supply the details of your solicitor or anyone else who may be acting on your behalf.

Name

Address

Suburb/town State Postcode

Phone

Email

B. DECLARATION

I understand that Teachers Health (the Fund) may require additional information before processing my benefits claim, including to determine whether the claim may be subject to compensation. Accordingly, I authorise the Fund to contact any of the persons or organisations, including insurance companies and any solicitor or agent acting on my, or their, behalf in relation to the accident/injury/condition, disclosed in this form and, in making such contact, the Fund may disclose information relating to the accident/injury/condition or the benefits claim (including this Accident and Injury Form). I also authorise the Fund to contact any health care provider to provide any information as necessary to the Fund to determine the appropriate benefits for the benefits claim.

I understand that under the Fund Rules, the Fund is not required to pay benefits where there is an entitlement to compensation or damages from another source (the Claim). In the event that the Fund agrees to make payment for any hospital, medical or general treatment expenses in respect of the accident/injury/condition disclosed in this form, I irrevocably agree:

- to pursue the Claim promptly and diligently;
- keep the Fund updated on the status of the Claim
- not to prejudice the Fund's right to recover benefits paid from the other party where another person or organisation including insurance company, has agreed to compensate me; inform the Fund of any settlement or determination for the Claim;
- to ensure that any benefits paid by the Fund relating to the Claim are included in the Claim;
- to promptly repay any benefit payments made by the Fund in the event the Claim is successful, including by way of ex-gratia or non-disclosed settlements.

Signature

Name

Date D D / M M / Y Y Y Y

Witnessed by

Signature

Name

Date D D / M M / Y Y Y Y

WHAT NEXT? Once the form is completed, please attach receipts and send to **GPO Box 9812, Sydney NSW 2001** or **accidentform@teachershealth.com.au**

Privacy Policy: Teachers Health respects your privacy and is committed to managing and protecting your personal and health-related information in accordance with relevant legislation in Australia. If you would like to find out more about Teachers Health's privacy policy, visit teachershealth.com.au/privacy. Teachers Federation Health Ltd ABN 86 097 030 414 trading as Teachers Health. A Registered Private Health Insurer.