ACCIDENT AND INJURY FORM

UNI HEALTH

UPDATED AUGUST 2021

CHECKLIST

- If the accident or injury occurred in your own home and there is no right to recover compensation or damages from another person or organisation, briefly describe how the accident, injury or 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 or condition could be attributed to some other 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 will need to answer all of the questions.
- Submit your claim ensuring that all declarations are signed and that the accounts or receipts are attached.
- Leaving a section blank or without the required information may delay the processing of your claim.

A. YOUR DETAILS

1. Member number ☐☐☐☐☐☐☐☐ Date of birth D D / M M / Y Y Y Y

   Patient's given names _____ Surname _____

   Treatment by _____ From D D / M M / Y Y Y Y

2. Date of accident/injury/condition D D / M M / Y Y Y Y Time H H : M M ◯ 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

   Against whom? (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, state reasons. If a claim has been denied, a copy of the advice denying liability must be attached.

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 UniHealth (Fund) may require additional information before processing my benefits claim. Accordingly, I authorise the Fund to contact any of the persons or organisations 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. I also authorise the Fund to contact any health care provider to provide any information as necessary to the Fund for determining 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 ("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 (a benefit may not be payable if I do not pursue a Claim without providing adequate cause);
- keep the Fund updated on the status of the Claim;
- 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.

		Witnessed by	
Signature		Signature	
Name		Name	
Date	D D / M M / Y Y Y Y	Date	D D / M M / Y Y Y Y

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