CBHS HEALTH

CBHS Health Fund Limited ABN 87 087 648 717

Please send this claim form and any additional information:
By Post: CBHS Health Fund Limited
Locked Bag 5014, Parramatta NSW 2124
Fax: 02 9843 7676 **Email:** claims@cbhs.com.au

Accident/Injury/Condition form

SECTION A – PARTICULARS OF ACCIDENT/INJURY/CONDITION

1. Customer details

Member No.

Surname

Given name

Street number

Suburb/Town

State/Territory Postcode

Telephone ( )

2. Patient details

(if different to customers)

Title Mr Mrs Miss Ms Dr

Surname

Given names

Telephone ( )

3. The nature of your condition

4. Is your treatment related to an accident/injury/condition?

(Including domestic, sporting, vehicle or employment)

No *Go to Section B – Signature* **Yes**

5. Details of accident/injury/condition

Date of accident / injury / condition / /

Place of accident / injury / condition

Describe how the accident / injury / condition occurred

When did you first seek treatment from a Health Care Provider for matters related to this accident?

Date / /

Name of Provider

Type of Provider

6. Please answer the following questions:

Does your accident / injury / condition relate to the nature of your employment? **No** **Yes**

Did the accident/injury/condition occur whilst at work? **No** **Yes**

Did your accident/injury/condition occur whilst involved in sporting activities or training? **No** **Yes**

You may be entitled to lodge a claim with Work Cover and all relevant treatment and claims should be forwarded to your employer's Insurance Company or, in the event of a motor vehicle accident, sent to Third Party Insurance company.

***Note:** If the Insurance Company has rejected your claim please provide CBHS Health with a copy of the document which will enable CBHS Health to correctly assess your claim.*

SECTION B – SIGNATURE

7. I acknowledge that I must give all relevant information as requested by CBHS Health. I declare that the above statement to be true and correct.

Telephone ( )

Signature

✗

Date / /