CBHS

Health Cover for the CommBank Family

Please send this form and any additional information:
By Post: CBHS Health Fund Limited
Locked Bag 5014, Parramatta NSW 2124
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 customer)

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

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.

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

***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 the above statement to be true and correct.

Telephone

Signature

✗

Date / /