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
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 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 / /