HCF Accident or incident information

We have recently received a claim from you. To help us process it as quickly as possible, we need some more detailed information about what happened. Please complete this form and return it to us as soon as you can.
Please use CAPITAL LETTERS and a black pen.

When you have completed this form, please scan and email it to **incident@hcf.com.au** or fax it to **02 9279 3549**.

HCF Membership number

Name of patient

Date of Accident/incident (DD MM YYYY)

Please describe how the Accident (as defined on page 2) or incident occurred, what happened?

Time

. ☐ AM ☐ PM

Location

1. Was the patient admitted to hospital? ☐ Yes ☐ No
2. Was this hospital treatment a direct result of the damage or injury? ☐ Yes ☐ No
3. Was the patient admitted into the accident and emergency department? ☐ Yes ☐ No
4. Was the damage or injury caused during the course of:
   - employment or professional duties. Please complete sections A and D.
   - any transport or motor vehicle incident. Please complete sections B and D.
   - an event that may result in a compensation claim not related to work or a vehicle incident. In other words, you believe that someone else was at fault. Please complete sections C and D.
   - None of the above. Please complete section D only.

Section A Workers compensation

What is the name of the patient's employer?

Address of employer

Unit No. Street No. Street name

Suburb State Postcode

Patient's solicitor's name

Law firm name

Patient's solicitor's address

Unit No. Street No. Street name

Suburb State Postcode Phone

Please provide the patient's employer's insurance company details

Name of insurer

Insurer's address

Unit No. Street No. Street name

Suburb State Postcode

Phone

Contact name

Section B Transport Accident or incident

Did the Accident or incident involve

☐ motor vehicle ☐ bus ☐ train ☐ motorbike/scooter ☐ bicycle ☐ other

Do you think that someone else was at fault and you wish to make a third party claim? ☐ Yes ☐ No ☐ Don't know

Please complete these details if you wish to make a third party claim

Patient's solicitor's name

Law firm name

Patient's solicitor's address

Unit No. Street No. Street name

Suburb State Postcode Phone

Please provide insurance details for the person/s you believe are at fault, if you have them

Insurer name Phone

Section C Other compensation claim

If the Accident or incident was not work or transport related, but you believe that another person or organisation is at fault, please complete this section.

Patient's solicitor's name

Law firm name

Patient's solicitor's address

Unit No. Street No. Street name

Suburb State Postcode Phone

Please provide insurance details for the person/s you believe are at fault, if you have them

Insurer name Phone

Section D Declaration

This declaration must be completed by the policyholder or the partner listed on the policy.

I declare the information provided by me to be true and complete.

Signature X

Date (DD MM YYYY)

What is an Accident?

Accident means an unforeseen event, occurring by chance and caused by an external force or object, which results in involuntary injury to the body requiring immediate treatment from a registered practitioner. This definition excludes unforeseen conditions attributable to medical causes.

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