Voluntary Workers Group Personal Accident

Claim Form

2024 02

Important: Please read before you complete this form

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. Please note that Sections 1, 2, 5, 6, 7 & 8 are COMPULSORY.
3. Note: This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by Batch Underwriting.

Batch

Accident & Health

01. POLICY AND PERSONAL INFORMATION

ALL QUESTIONS REQUIRE COMPLETION

POLICY NUMBER

EXPIRY DATE

ASSOCIATION / TEAM NAME

TYPE OF SPORTS / ACTIVITY

OCCUPATION

TITLE

GIVEN NAME(S)

M F Other

FAMILY NAME

DATE OF BIRTH

RESIDENTIAL ADDRESS (CANNOT BE A PO BOX)

SUBURB

STATE

POSTCODE

EMAIL ADDRESS

DAYTIME CONTACT NUMBER

ALTERNATIVE NUMBER

What are you claiming for? Weekly Benefits (if insured) Medical Expenses Other

02. PAYMENT DETAILS

COMPULSORY

Please provide bank and account details for payment

ACCOUNT HOLDERS NAME

BSB NUMBER (6 DIGITS)

ACCOUNT NUMBER

BANK

(Alternatively supply a deposit slip noting the following information)

03. DETAILS OF INJURY

COMPULSORY

DATE OF INJURY

TIME

AM/PM

LOCATION WHERE INJURY OCCURED

What is the injury?

How did the injury occur?

Was this an authorised sporting or association activity? Yes No

04. MEDICAL QUESTIONS

COMPULSORY

When did you first obtain treatment from doctor? DATE

Is this doctor still treating you for the injury / illness? Yes ☐ No ☐ DATE

Are there or do you envisage any complications? Yes ☐ No ☐ GIVE DETAILS

Do you have other private health cover? Yes ☐ No ☐ TYPE OF COVER

Please note that if you have private health insurance you must first make a claim on them.

NAME OF INITIAL MEDICAL ATTENDANT

PHONE NUMBER OF INITIAL MEDICAL ATTENDANT

NAME OF REGULAR MEDICAL ATTENDANT

PHONE NUMBER OF REGULAR MEDICAL ATTENDANT

Is there anything in your medical history which may have contributed directly or indirectly, to the injury or which may be likely to retard your recovery? Yes ☐ No ☐

Give details

Nature of operation / hospitalisation (if any)

from to

If you are unable to go to school or work, when do you expect to be able to return?

05. LOSS OF INCOME

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

1. If self employed please indicate by ticking the box ☐ Confirmation of earnings MUST be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

2. If employed as a wage earner the following is to be completed by your employer (or attach Pay History Report from the employer for the 12 month period immediately preceding the injury or sickness).

I hereby certify that has been unable to attend his/her usual occupation with the company as a result of an

Injury / Illness suffered whilst on the

He/She has been incapacitated since and is expected to/did resume duties on

His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was $ Per week

During the period of incapacity he/she received $ from to

Please specify type of pay

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

NAME OF COMPANY

HAS BEEN EMPLOYED SINCE

ADDRESS

SIGNATURE OF SUPERVISOR OR PAYMASTER

DATE

NAME (PLEASE PRINT)

TELEPHONE NUMBER

06. CLUB/ASSOCIATION DECLARATION

COMPULSORY

NAME

NAME OF SECRETARY / OFFICE BEARER

I hereby certify that whilst particpating / playing in an authorised club activity

Was injured on

DATE

SIGNATURE OF SECRETARY / OFFICE BEARER

DATE

TELEPHONE NUMBER

07. DECLARATION

COMPULSORY

I/We declare that to the best of my knowledge and belief, the information provided on this claim form and in any attached documentation is true and correct and that I/We have not withheld any relevant information.

I/We consent to Proclaim and/or its agent using the personal information I/We have provided for the purpose of processing my claim.

I/We understand that if I/We choose not to provide the required details, this is my/our choice; however, Proclaim and/or its agent may not be able to process my/our claim.

I/We consent to Proclaim and/or its agent disclosing my/our personal information to other insurers, an insurance reference service, claims adjusters, lawyers and other consultants or as required by law.

I/We also consent to Proclaim and/or its agent disclosing my/our personal information to and/or collecting additional information about me/us, from investigators or legal advisors.

I/We also consent and authorise any hospital and/or physician who has treated me to provide Proclaim and/or its agent with copies of medical records or of my past medical history, as requested.

I/We acknowledge that I/We have read and understood the Privacy Statement found at www.batchunderwriting.com and consent to the collection, storage, use and disclosure of personal and sensitive information to all persons affected by this claim.

I/We acknowledge that if I/We do not agree to the collection of this personal information then Proclaim and/or its agent will be unable to process my/our claim.

SIGNATURE OF CLAIMANT / PARENT / LEGAL GUARDIAN

DATE

08. MEDICAL CERTIFICATE

This section must be fully completed by attending doctor - any fee for completion of this section is the responsibility of the insured person

COMPULSORY

TITLE: GIVEN NAME(S): FAMILY NAME:

DATE OF BIRTH: ☐☐ ☐☐ ☐☐☐☐ ☐ M ☐ F ☐ Other

HEIGHT: WEIGHT:

Date of Injury: ☐☐ ☐☐ ☐☐☐☐

When did you first examine the patient? ☐☐ ☐☐ ☐☐☐☐

Please give full details of circumstances of injury

What was your clinical diagnosis?

If not with you, when did the patient first receive medical attention for this condition? ☐☐ ☐☐ ☐☐☐☐

With whom/where?

Has the patient ever suffered with this or any similar condition before the present episode? Yes ☐ No ☐

If YES, please give details including dates treatment and consultation:

Are you the patient's usual doctor? Yes ☐ No ☐

If NO, please give name and address of claimant's usual doctor:

Disability

On what date did incapacity commence? ☐☐ ☐☐ ☐☐☐☐

Is patient still incapacitated? Yes ☐ No ☐

If YES please estimate when you estimate the patient to be able to return to work? ☐☐ ☐☐ ☐☐☐☐

OR Please complete:

I estimate the patient should have functional capacity to return to work in ☐☐ DAYS ☐☐ MONTHS ☐☐ YEARS

I intend to review the patient on: ☐☐ ☐☐ ☐☐☐☐

If the patient is no longer disabled, when did he/she return to work? ☐☐ ☐☐ ☐☐☐☐

Please detail any investigations and provide results:

Any other comments/clinical findings?

Was the patient hospitalised as a result of this condition? Yes ☐ No ☐

If YES, which Hospital?

How many days was the patient hospitalised? ☐☐ DAYS FROM ☐☐ ☐☐ ☐☐☐☐ TO ☐☐ ☐☐ ☐☐☐☐

Detail any Surgical Procedures performed or planned:

Procedure: Date performed/to be performed: ☐☐ ☐☐ ☐☐☐☐

Procedure: Date performed/to be performed: ☐☐ ☐☐ ☐☐☐☐

Have you referred the patient to any other Medical Practitioner? Yes ☐ No ☐

If YES, give Name & Speciality

Detail any Treatment recommended? i.e. physiotherapy

Is there any other injury, or condition impacting the patient's recovery from the claimed condition?

Is the condition due to Injury arising out of the patient's employment? Yes ☐ No ☐

If YES, have you discussed Workers' Compensation with the patient?

Do you believe the patient will recover or is any Permanent Impairment likely?

SIGNATURE DATE ☐☐ ☐☐ ☐☐☐☐

Please use validation stamp or complete in block capital:

PRINT NAME: QUALIFICATIONS:

PRACTICE/CLINIC: ADDRESS:

PHONE: FAX: EMAIL:

OR VALIDATION STAMP

Non-Medicare Medical Expenses Notice to Claimants

If you are claiming reimbursement for medical expenses incurred as a direct result of injury, please complete the following claim schedule. If you are claiming the difference in shortfall of a payment from Batch Underwriting you must first seek reimbursement from your Private Health fund (if applicable) and submit the accounts with your claim. For reimbursement relating to Medical Expenses, please read the following information carefully.

We advise that Your Policy will cover non-Medicare Medical Expenses to the amount stated in the Policy (after the deduction of any excess) for injuries which occur during insured activities. The policy will cover fees incurred as a result of injury including, but not limited to fees paid to nurses, hospitals, chiropractors, osteopaths and physiotherapists. Please note that you are expected to settle accounts first and then seek reimbursement.

We advise that this company must comply with Federal legislation that limits the benefits that General Insurers, Health Funds (and others) are legally allowed to insure. As a General Insurer we are prohibited from reimbursing medical expenses that are covered by the Medicare Scheme.

What we pay:

- 100% of Theatre Fees & Accommodation Fees in a hospital where the Insured Person is a private patient in a public or private hospital, subject to policy limits.
- Any other Medical expenses which are not covered by Medicare.

What we DONT pay:

- Any out of hospital or outpatient expenses which have a Medicare component.
- Any amounts above the Scheduled Fee, or “gap” fees related to Medicare services
- When you are a public patient in a private or public hospital. Everything is covered by Medicare in this circumstance.
- For out of hospital Doctor or Specialist visits, Medicare refunds a specific percentage of the Scheduled Fee depending on the service. No-one can reimburse any other amount for these expenses.

Examples:

Medical Services	Amount Charged	Scheduled Fee	Medicare Pays	We Pay	Insured Pays
Private Hospital Accommodation	$400.00	$0.00	$0.00	$400.00	$0.00
Private Hospital Doctor Consultation	$92.00	$68.85	$47.14	$0.00	$44.86
GP Consultation out of hospital (no bulk billing)	$36.00	$24.50	$20.85	$0.00	$15.15

*Please note no reimbursement is available on the ‘Gap’ or ‘Out of Pocket’ portion of a fee charged by a surgeon, anaesthetist, or any other doctor where Medicare and/or your Private Health Fund have or will contribute a rebate on that service.

*The Policy can respond to gaps when only your Private Health Fund has paid a Benefit under your Extras or Ancillaries cover.

*Please submit all itemised invoices when submitting your claim

Further information on these limitations should be available from the Department of Human Services.

Accident / Injury Expenses

Reimbursement is calculated as follows:
A – D in the case of no Medicare component.
Please note: Federal Legislation prohibits General Insurers from contributing to out of pocket expenses against Medicare eligible services.
Please note: In the case of a "Medicare gap" being paid by your Health Fund, no further benefit is claimable from Batch Underwriting.

		A	B	C	D	Official Use Only	
Date Expense Incurred	Item Description	Fee Charged	Scheduled Fee	Medicare Benefits	Health Fund Benefit	Amount Payable by Batch	Details
	Totals						