Accident & Health
International Underwriting
Pty Ltd (AHI)
GPO Box 4616
Sydney NSW 2001

ABN: 26 053 335 952
AFS Licence No: 238261

T. +61 2 9251 8700
E. claims@ahiinsurance.com.au
www.ahiinsurance.com.au

Claim Form
Sport / Voluntary Workers
Equestrian Australia Limited

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, 3, 4, 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 AHI.

01. Your Details

Compulsory

Policy Number
5547877

Membership No.

Membership Type
☐ Member ☐ Coach ☐ Official

Type of sports/activity
☐ Dressage ☐ Show jumping ☐ Cross Country ☐ Eventing ☐ Endurance
☐ Para ☐ Driving ☐ Show Horse ☐ Other

Given Name(s)

Family Name

Date of Birth: dd/mm/yyyy

Gender
☐ M ☐ F ☐ Other

Parent or Legal Guardian Name

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

BSB Number (6-Digits)

Account Number

Bank

03. Details of Injury

Compulsory

Date of Injury: dd/mm/yyyy

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 see a doctor for this condition? Date: dd/mm/yyyy

Have you previously suffered from the same or a similar injury? Yes No Date: dd/mm/yyyy

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) to

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

05. Loss of Income

To be completed only if claiming loss of income

Occupation

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 slip).

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

Name of Company

Has been employed since

Address

Signature of Supervisor or Paymaster

Date: dd/mm/yyyy

Name (Please Print)

Telephone Number

06. Declaration

Compulsory

General Insurance Code of Practice
AHI proudly supports the General Insurance Code of Practice (the 'Code'). The purpose of the Code is to raise the standards of practice and service in the general insurance industry. For further information on the Code, please visit www.codeofpractice.com.au.

Complaints
If there are any concerns or complaints about AHI's products or service, AHI's staff are always available to listen and help where they can. We will attempt to resolve your complaint immediately, but if we cannot, we will acknowledge your complaint and advise you of the procedures we will follow in handling and investigating your complaint.

We will keep you up to date regarding our progress and will endeavour to respond to your complaint within 30 calendar days. Our response will be in writing and will advise you of the outcome of our investigations and our proposed resolution of your complaint. If we cannot resolve your complaint within 30 calendar days, we will write to you and provide you with details of the Australian Financial Complaints Authority so that you may consider taking your complaint to them.

By signing this Claims Form below, you agree to the following:

Declaration
The person completing this form declares that their answers are accurate and complete, and acknowledges that the insurance claim may be declined if that is not the case.

Authority to release medical and/or dental records
The Claimant completing this Claim Form authorises any hospital, physician or dentist, who has treated them to provide Accident & Health International Underwriting Pty Ltd (AHI) with copies of their medical and/or dental records, or of their past medical and/or dental history, as specifically requested by AHI.

This Authority extends to the circumstance in which the Claimant is the legal parent, or legally appointment guardian, of a child (who is to be referred to as the Patient in Section 13 of this Form) who is deemed by the holder of the records as not having the capacity to personally consent to this request by AHI for access, in circumstances when this request relates to the medical and/or dental records of that child.

Privacy Statement
The person submitting this Claim Form agrees that the personal information it contains will be collected by Accident & Health International Underwriting Pty Ltd (AHI) and managed in accordance with its privacy policy which can be read online at ahiinsurance.com.au/privacy or by calling AHI on (02) 9251 8700 to ask for a copy.

AHI handles all personal information in accordance with the Privacy Act 1988. It collects personal information directly, through its agents and other companies within the Tokio Marine global corporate group. AHI uses the personal information it collects to conduct its business, including assessing insurance claims, which it cannot do if it is not able to receive this information.

AHI may send personal information it collects overseas, including Japan, USA, Canada, Bermuda, New Zealand, Thailand, Hong Kong, Europe (including the United Kingdom), Singapore and India. Contact AHI for more information about how it handles personal information or if you have a privacy complaint.

Signature of Claimant

Date: dd/mm/yyyy

Signature of the Insured Person (if not the Claimant)

Date: dd/mm/yyyy

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Medical Certificate

The claimant must obtain at own expense from the patient's usual doctor in all cases
Important: the medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries

07. Patient Details

Compulsory

Patients Full Name

Date of Birth: dd/mm/yyyy

Please give complete diagnosis of this condition

History

When did the patient first receive medical treatment?

Is there a previous history of this or a similar condition? Yes No

If Yes, please provide details

How long have you known the patient? Days Months Years

Are you the regular general practitioner? Yes No If not, please advise who is

Sickness

When was sickness first contracted?

OR

When did symptoms become evident?

Injury

When did the patient first suffer the injury?

What was the cause of the injury?

Degree of Disability

When was patient obliged to cease work?
Date: dd/mm/yyyy

When was / will the patient be able to return to:
Some Duties?
Full Duties?

Treatment of Present Condition

When were you consulted?
Initially
Most recently

Was patient confined to hospital? Yes No
From
To

If Yes, please advise name and address of hospital

What other surgical or medical procedures are possibly contemplated?

Are there any underlying conditions affecting recovery from the current conditions? Yes No

If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Print Name

Qualification

Signature

Address

Phone

Fax

Date: dd/mm/yyyy

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Non-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 AHI 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.

We can 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.

We cannot 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 Acommodation	$400.00	$0.00	$0.00	$400.00	$0.00
Private Hospital Doctor Consultation	$92.00	$62.85	$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 that where a Private Health Fund has reimbursed the “gap”, no further reimbursement is available.

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

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Claim Form
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 AHI.

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