

Personal Accident Claim Form

The issue of this form is not an admission of liability

THANK YOU FOR NOTIFYING US OF YOUR CLAIM

PLEASE ENSURE

- ***You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim.***
- ***You have enclosed all requested information/documentation.***
- ***You have signed this claim form.***
- ***Your attending doctor fully completes the statement at Section 3.***
- ***You have claimed any benefits you are entitled to from your Private Health Fund and attached a copy of the Benefit Statement with the account***

Section 1 – To be completed by Claimant

Policy No:	DENT1008LLOYDS01 / Savannah Dentisure, Student Dental Accident Insurance		
Full Name of Insured Person:			
Date of Birth:			
Full Address:			
Suburb:		Postcode:	
Employers Name:			
Telephone Business:			
Telephone Home:			
Mobile:		EMAIL:	

OTHER INSURANCE / BENEFITS	
Are you entitled to claim insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, or sports body/organisation insurance?	
No:	Yes: - give details below:
Name of organisation:	
Name of Insurer & Telephone Number:	
Type of cover/Benefit claimable:	
Amount Claimed/Claimable:	
Do you have Private Health Insurance?	
If yes, please indicate level of Cover: (I.e. Hospital Only, Hospital & Extras)	
Do you have Ambulance Cover?	
DECLARATION & AUTHORISATION - COMPLETE FOR ALL CLAIMS	
I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.	
I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim Pty. Ltd or its representatives any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports.	
I authorise any Insurer, organisation or body through which I am claiming similar benefits to furnish Proclaim with all information with respect to this Sickness or Injury to enable assessment of my claim.	
I agree that a Photocopy of this authorisation shall be considered as effective as the original.	
Your Signature:	
Name – print	Date:

PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.

Please complete the following:

Bank: _____

Account Name(s): _____

BSB Number: ___ ___ ___ --- ___ ___ ___

Account Number: _____

