

Accident/injury report

1. Please complete this form using **black ink** and write within the boxes in CAPITAL LETTERS.
Mark appropriate answer boxes with a cross. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE.**
2. Please complete all details that are relevant to you on both sides of this form.
3. Read the declaration and sign all the signature panels you need to.

Section A: Your details

MBF Policy number (This can be found on your MBF Card)

Surname

First name

Unit number

Street number

PO Box number

Street name

Suburb

State

Postcode

Home phone number

Daytime phone number

Mobile phone number

Fax number

Email address

If you would like to receive your bills (if applicable), payment reminders, tax statements, benefit statements (when available) and/or LivingWell magazine via email, and be kept up-to-date with MBF news and services via email please cross this box.

Full name of person(s) injured

Date of birth

Section B: Accident and injury details

1. Particulars of accident or injury

Was the injury the result of an accident?

Yes (please complete questions 2 to 7)

No (please complete questions 2a and 2b)

2. Details of accident/injury/condition

a. Date and time of the onset of condition/injury/accident

b. Describe how the condition/injury/accident occurred

c. Place of accident/injury

d. Describe the nature of injury sustained and when the symptoms first appeared

e. Names and addresses of any witnesses

f. Please attach a copy of the doctor/hospital/police report or claim form which was completed at the time of your accident/injury (if available).

3. Are you entitled to claim

a. Workers' Compensation[^] Yes (go to question 4) No*

b. Third Party damages from persons liable? Yes (go to question 5) No*

c. Damages for persons liable at law, eg Public Risk? Yes (go to question 6) No*

* If you answered 'No' to all of the questions above, go to the declaration.

[^] If you have claimed under Workers' Compensation or Third Party and have been refused, please attach a certified copy of the official letter of refusal with written confirmation that no appeal will be lodged.

4. Workers' Compensation (to be completed if work-related)

a. Did the accident/injury happen at work, or going to and from work?

Yes No - provide name and address of employer

b. Do you intend to claim Workers' Compensation?

Yes No - give reasons



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5. Third Party insurance *(to be completed if a motor accident)*

a. Name of driver of your vehicle *(if applicable)*

b. Name of owner of your vehicle *(if applicable)*

c. Was another vehicle involved? Yes No

d. Name and address of the negligent party

e. Do you intend to claim against the Third Party?

Yes No - give reasons

6. Damages/compensation *(eg public liability, criminal compensation)*

Do you intend to claim damages from any other party?

Yes No - give reasons

7. Claim details

If you have made a claim for compensation or intend to make a claim for compensation or damages, please provide details (if available) of either your employer's Workers' Compensation insurer, Third Party or Public Liability insurer and your claim number from that insurance company.

Section C: Declaration

I understand that MBF might require more information before processing my claim. I authorise MBF to contact any necessary persons if additional information is required (including providing medical reports) to establish my eligibility for Benefits.

I understand that MBF may pay a Benefit if: the customer/dependant is entitled to claim damages/compensation, the customer/dependant agrees to pursue the claim, and the customer/dependant signs an Acknowledgement and Undertaking agreeing to pursue legal action and to repay Treatment expenses paid by MBF in the event of the claim for compensation/damages, however described, being successful.

I understand that a Benefit is not payable if: the customer/dependant refuses to pursue a claim without adequate cause or the customer/dependant has been successful in a claim for compensation or damages and has received a settlement including payments by way of ex-gratia and/or non-disclosed settlement. Any Benefits paid in these circumstances must be refunded to MBF.

I declare that the above statement is true and correct.

Signature

X

/ /

Witnessed by

Date

/ /