AON *FIM Rider Personal Accident Insurance*
Incident / Claim Form

Personal Accident Claim Form

Please return completed forms to:

Proclaim

Locked Bag 32012, Collins Street East, VIC 8003
Email: ahclaims@proclaim.com.au
Phone: 02 9287 1302
Fax: 1300 858 329

Please ensure all sections are fully completed. Failure to do so may delay settlement of your claim.

MA License / International License / Other Number: ……..

Name: (Mr/Mrs/Miss/Ms): ……

Address: ……

……Post code……

Telephone: (Home) …… (Work hrs) ……

Date of Birth: ……/……/…… (Email): ……..

Event at which Injury was sustained:- ……

Track at which Injury was sustained: ……Country:……..

Date of Departure from Australia: …… Date of return to Australia: ……..

DETAILS OF LOSS:
(Please attach Medical Reports/Certificates, Invoices for medical treatment:

Date of Injury: ……/……/……

Describe the Injuries suffered: ……

Did you seek medical treatment: ☐ Yes ☐ No

Name & Address of attending Physician: ……

……

Details/Description of the Incident:

……

……

……

BANK DETAILS

Account Holder's Name: ……

BSB: ……Account Number:……

Medical Expenses:

Describe procedures, medical services and supplies furnished:-

Date	Medical Service	Amount
……	……	……
……	……	……
……	……	……
……	……	……

Amount: ($A or other currency) $ …… Total: ……

Are any of the expenses covered by other Insurance? (e.g. Event Organiser / Promoter / Team / Private Health Insurance / Travel Insurance) ☐ Yes ☐ No

If yes provide details:……

Important Notes

Please attach all itemised receipts (be sure to copy them before you claim with your health fund as they will retain the original). Hospital claims must be accompanied by an itemised Invoice (not just an estimate). If treatment is covered by your Private Health Fund please send their rebate advice with a copy of the relevant account.

No cover is provided for Surgeons, Anaesthetists, Doctors, X-rays or other accounts which are partly covered by Medicare. The Australian Health Insurance Act does not permit the insurer to contribute to any charges covered by Medicare (including the Medicare Gap).
The insurer will pay for chiropractic, physiotherapy, osteopath, naturopath, massage, ambulance (if not otherwise covered), emergency dental and emergency optical.
Subject to the Insurance Contracts Act 1984 any treatment rendered necessary by injury must be completed within 24 calendar months from the date of such injury occurring.

*An **excess** applies to all Medical Expenses claims including:*
$ 500 each and every loss in respect of track/road events
$1,000 each and every loss in respect of off road events

DECLARATION AGREEMENT AND AUTHORISATION BY CLAIMANT

I_____(insert name) solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

I hereby authorise Motorcycling Australia Insurance Ltd and their claims managers, Proclaim, to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, any hospital, physician, medical practice, any medical services provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employer, copies of accounts and accountants statements including my taxation returns and assessments.

I consent to the collection, use and disclosure of personal information by Motorcycling Australia Insurance Ltd and their service providers in order to assess the claim. Motorcycling Australia Insurance Ltd complies with the obligations of the Privacy Act 2001 and the principals laid out in our privacy policy which is readily available upon request.

Signature of Claimant _____ Date _____

(or Legal Guardian if under 18 years of age)

Name of Guardian: _____

ATTENDING PHYSICIAN'S REPORT

IMPORTANT

1. **The patient is responsible for any fee for this statement.**
2. **This form can <u>only</u> be completed by the treating Medical Practitioner, Surgeon** (Physiotherapist may complete for minor injuries only).
3. **If "Yes" answered to any of the following, please give details.**
4. **Dashes or blank spaces are not acceptable.**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Full Name:	How long have you known the patient?

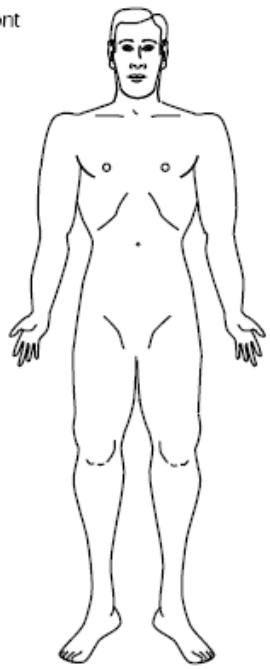
What date were you first consulted by the patient in connection with the present injury? / /

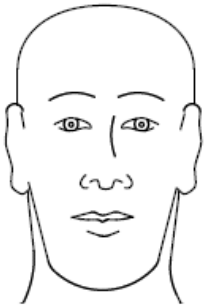
Are you the patient's regular general practitioner? ☐ Yes ☐ No

If not, please advise who is .....

What is the exact nature of the present injury? (Please detail symptoms and diagnosis)

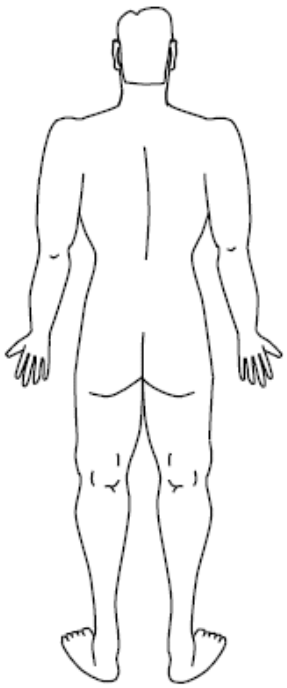
Front





Head

Back



Do you consider the patients injury to be a new injury? ☐ Yes ☐ No

A recurrence of an old injury? ☐ Yes ☐ No

If yes, please state condition and advise when previous treatment was given .....

.....

Have you referred the patient to any other services or treatment? ☐ Yes ☐ No

Please specify the type and approximate number of treatments required:

☐ Physiotherapy .....

☐ Chiropractic .....

☐ Other .....

Have any surgical procedures been performed? If yes, please specify.....

.....

What surgical procedures are contemplated? .....

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

.....

Is there any permanent disability at present? ☐ Yes ☐ No

If yes, please explain giving estimated percentage loss of function .....

.....

Was the patient obliged to cease work? ☐ Yes From ...../...../..... ☐ No

If so, when do you expect the claimant to resume: Some Duties .....

Full Duties .....

What date do you advise the patient may return to motocross? .....

Does the patient have any congenital defects or chronic diseases? ☐ Yes ☐ No

If yes, please give dates, name of treating doctor and describe.....

.....

.....

If the patient has been hospitalised, please give name of hospital and dates hospitalised:

Name of Hospital: Date Admitted / / Date Released / /

CERTIFICATION BY ATTENDING PHYSICIAN

I hereby certify I have personally examined the above named patient and in my opinion the statements made in the Accident details section of this claim form are consistent with the patient's injury.

Name:..... Telephone Number: ( ) .....

Fax: ( ) ..... Email: .....

Address: .....

Signature:..... Qualifications: .....

Date:.....