see-u by HBF
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Accident Report

An Accident is an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or injury to the body, which requires **Treatment by a Medical Practitioner or a Hospital Emergency department within 48 hours** (supporting documentation may be required). This definition excludes unforeseen conditions attributable to medical causes.

Please note that failure to complete this form in full may result in delays to the assessment of your claim.

1 CLAIMANT DETAILS

Policy number: Contact number:

Full name:

2 ACCIDENT DETAILS

When did the accident occur? Date: Time:

Place/Address of accident/injury:

Describe how the accident occurred:

Describe the nature of your injury:

Did you seek medical attention within 48 hours? ◯ Yes ◯ No *(a copy of the applicable doctor/hospital report may be requested)*

Doctor/Hospital where treatment received:

3 ARE YOU ENTITLED TO CLAIM

Workers compensation: ◯ Yes ◯ No *(if yes, please complete Workers Compensation section)*

Third party damages from persons liable: ◯ Yes ◯ No *(if yes, please complete Motor Vehicle Accident section)*
(e.g. Motor Accident)

Damages for persons liable at law: ◯ Yes ◯ No *(if yes, please complete Other Compensation section)*
(e.g. Public risk)

If yes, please complete the appropriate sections below detailing further information.

4 WORKERS COMPENSATION

Did the accident/injury happen at work, or while going to or from work? ◯ Yes ◯ No

Name of employer:

Address of employer:

Contact number of employer:

Workcover claim number:

Insurer Details (Name & Contact Email/Number):

5 MOTOR VEHICLE ACCIDENT

Name of driver of your vehicle:

Name of owner of your vehicle:

Was another vehicle involved? ◯ Yes ◯ No

Name of driver:

Name of owner:

If a person other than you is deemed to have caused the accident, please provide their name and address:

CTP claim number:

Insurer Details (Name & Contact Email/Number):

6 OTHER COMPENSATION DETAILS

Do you intend to claim damages from any other party? ◯ Yes ◯ No

Please provide specifics including type of claim, contact, address:

Are you being represented by a lawyer or any other party in relation to this claim? ◯ Yes ◯ No

Name:

Address:

Contact number/email:

7 DECLARATION

- I declare the information I have provided on this form is true and correct and that no material information has been withheld.
- I authorise see-u to disclose and collect my personal information relevant to the processing of this claim to or from any entity or person as allowed by law.
- I will provide to see-u every assistance or requested documentation and understand that failure on my behalf to do so may result in this claim being delayed, refused or a benefit reduced.
- I understand that under see-u's Fund Rules, benefits are not payable for expenses incurred in relation to an injury where I have received, or may be entitled to receive, compensation in respect of that injury.
- I understand that submitting this signed accident report does not constitute an obligation on the part of see-u to accept the claim or pay a benefit under the policy.
- I acknowledge and agree that if the answer to the above questions are later proven to be untrue, or otherwise cease to be true, then see-u reserves the right to a full and immediate reimbursement from me of any benefits paid on my behalf.

Signature:

Date: