

# Personal Accident Claim Form



The issue or acceptance of this form is not to be construed as an admission of liability on the part of the company.

Please provide complete details to the questions asked on this form. If there is insufficient space for your answers, please attach a separate page to the back of the form.

Please return the completed form to us by either:

**Email** bike@realinsurance.com.au

**Post** PO Box 199 Chatswood NSW 2057

**Fax** (02) 8889 9554

## YOUR DETAILS

Policy Number: \_\_\_\_\_

Name of insured: \_\_\_\_\_

Name of rider at time of accident: \_\_\_\_\_

Address (Insured): \_\_\_\_\_  
\_\_\_\_\_

Best phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Preferred method of contact:  Email  Phone

Serial number of bicycle/s under claim:  
\_\_\_\_\_

## INCIDENT DETAILS

Date of occurrence: \_\_\_\_\_ Time: \_\_\_\_\_

Where did the incident occur?  
\_\_\_\_\_

Please describe what happened:

Where is your bike now?  
\_\_\_\_\_

## INJURIES SUSTAINED IN THE ACCIDENT

Please provide details of the injuries sustained in the accident:

## INSURANCE AND MEDICAL HISTORY

Do you have private health insurance?

Yes  No If yes, please provide details

Name of fund: \_\_\_\_\_

Hospital only  Extras only  Both

Have you ever had this injury or a similar injury in the past?

Yes  No If yes, please provide details

\_\_\_\_\_  
\_\_\_\_\_

Please provide details of your usual family doctor:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Number of years as patient: \_\_\_\_\_

## ACCIDENT WITNESSES

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## PREVIOUS CLAIMS

Have you ever lodged a personal accident claim before?  Yes  No If yes, please provide details

## DETAILS OF NON-MEDICARE EXPENSES CLAIMED

### IMPORTANT NOTE REGARDING CLAIMS FOR MEDICAL EXPENSES

We do not provide cover for any account that is fully or partially covered by Medicare. This means that we do not cover expenses claimable from Medicare nor do we pay the Medicare gap. The reason for this is that the Australian Health Insurance Act does not permit us to do so. Please do not send us any account or receipt for a service that is covered by Medicare. We do cover non-Medicare medical expenses for charges involving private hospital, dental, ambulance, chiropractic treatment, physiotherapy or any similar provider of medical services provided always that such treatment is certified necessary by a legally qualified medical practitioner.

Date of treatment	Name of provider	Type of service	Cost of service	Health fund rebate	Amount claimed

To avoid delays in processing your claim, please attach all original invoices and receipts to this form. Please note if you have private health insurance you must make a claim on your private health insurance first.

## DECLARATION

- I hereby certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I understand that this claim may be refused if information is untrue, inaccurate or concealed.
- I authorise Real Bike Insurance to give to, or obtain from, other insurers or any insurance reference bureau, any information to this claim or any other claim made by me or any insurance held by me.
- I authorise any hospital, physician or other person who attended me to provide Real Bike Insurance or its representative with copies of all hospital and medical records together with any or all information with respect to any injury, medical history, consultation, prescription or treatment. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_