Personal Accident Claim Form

www.velosure.com.au
1300 83 5678

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 on the back of the form.

Please fax the claim form to (02) 9346 6799.

1. Your details

Policy Number	Expiry date
	/ /

Name of Insured

Name of Rider at the time of accident

Postal Address

Postcode

Phone Number	Work / Mobile Number
( )	( )

Bicycle details

Make:

Model:

Serial No:

Colour:

2. Incident details

Date of Occurrences	Time
/ /	: am / pm

Where did the event occur?

Postcode

Please describe what happened

Where is the bike now?

3. Injuries sustained in the accident

Please provide details of the injuries sustained in the accident

4. Additional accident information

At the time of the accident were you:

☐ Competing in an event ☐ Training
☐ On a recreational ride ☐ In transit (aeroplane, bus etc)

At the time of the accident were you cycling on a:

☐ Sealed public road ☐ Dedicated cycle way
☐ Dirt road ☐ Bush track

Describe the weather condition at the time of the accident

☐ Dry ☐ Wet ☐ Sunny ☐ Overcast ☐ Dark

5. Insurance and Medical History

Do you have Private Health Insurance? ☐ Yes ☐ No

If Yes, please provide details

Name of Fund:

☐ Hospital only ☐ Extras only ☐ Hospital and Extras

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

☐ Yes ☐ No If Yes, please provide details

Please provide details of your usual family doctor

Name:

Address:

Postcode

Phone number: ( )

Numbers of years as a patient:

6. Witnesses

Please provide details of anyone who witnessed the accident

Name:

Address:

Postcode

Phone number: ( )

7. Previous claims

Have you ever lodged a personal accident claim before?

☐ Yes ☐ No If Yes, please provide details

8. Goods and Services Tax (GST)

Are you registered for GST? ☐ Yes ☐ No

If Yes, please provide your ABN number:

Do you have an entitlement to claim Input Tax Credit in respect of your bicycle insurance premium? ☐ Yes ☐ No

If Yes, what is your entitlement? %

9. 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 the insurance first.

10. Declaration

1. 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.

2. I authorise Velosure 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.

3. I authorise any hospital, physician or other person who attended me to provide Velosure or it's 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.

Insured signature:

Date: / /