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My Family Daycare Educator

Combined Liability Insurance Cover

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Family Day Care Educator Personal Accident Claim Form

The issue of this form is not an admission of liability

PLEASE ENSURE

- ***You fully complete every question before your doctor (or dentist) completes the Doctor's Statement.***
- ***You have enclosed all requested information/documentation including supporting medical evidence detailing the Injury sustained and a copy of the Incident Report along with evidence of the Out of Pocket expenses you are claiming.***
- ***Your attending doctor has fully completed the Medical Statement or you attach a Hospital or Emergency Department Discharge Summary.***

Failure to do any of the above will result in delays in handling your claim

Section 1 – To be completed by Claimant / Parent

Certificate/Policy No (if known):	
Name of Family Day Care Educator:	
Full Name of Child:	
Date of Birth:	
Name of Parent:	
Postal Address:	
Suburb:	**Postcode:**
Telephone Business hrs:	**Mobile:**
Telephone Home:	
EMAIL:	

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Section 2 – To be completed by Claimant / Parent

What is the injury?
How exactly did the Injury occur?
When did the *Injury* occur? **Date: / / Time:**
Who is your child's usual GP or family doctor or dentist?
Name:
Clinic/Medical Centre:
Address:
Telephone Number:
When did you first see your usual doctor/dentist for this condition? / /
When did you first get treatment from any medical practitioner for this Injury?
Date of first Consultation or Emergency Department visit? / /
Name of this Doctor/Dentist or Hospital:
Address:
Telephone Number:
Was your child hospitalised? **If yes, when: / / to / /**
At which Hospital:
Detail all surgery performed:
What other treatment have you had or has been recommended?
OTHER INSURANCE / BENEFITS
Do you have Private Health Insurance? **Yes ☐** **No ☐**
Name of Health Fund:
Type of cover: **Hospital Only ☐** **Extras ☐**
Don't forget to include a copy of your Fund Benefit or HICAPS Statement with the invoice

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DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS
I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.
I authorise any hospital, physician or other person who has attended my child to furnish Imalia or its representatives with any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports.
I authorise any Insurer, Superannuation Fund or other organisation or body through which I am or may claim similar benefits to furnish Imalia with all information with respect to coverage and claims for this Sickness or Injury to enable assessment of my claim.
I agree that a Photocopy of this authorisation shall be considered as effective as the original.
Your Signature:
Your Name – print
Your Child's name:
Date:

PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.
Please complete the following:

Bank: _____

Account Holders Name(s): _____

BSB Number: ___ ____ ___ --- ___ ____ ___

Account Number: _____

Swift Code (for International Account only) _____

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Section 3. – DOCTOR'S/DENTISTS STATEMENT - ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON

Patient's Name: Date of Birth:
Date of Injury: / /
When did you first examine the patient? / /
How did the Injury occur?
What was your clinical diagnosis?
If not with you, when did the patient first receive medical attention for this condition? / /
From whom:
Are you the patient's usual doctor? YES/NO
If NO, please give name and address of claimant's usual doctor:
Please detail any investigations and provide results:-
Any other comments/clinical findings?
Was the patient hospitalised as a result of this condition? YES/NO
If yes, which Hospital?
How many days was the patient hospitalised? ___ Days From: ____/_____/____To: ____/_____/____
Detail any Surgical Procedures performed or planned:
Procedure:
Date performed/to be performed:
Have you referred the patient to any other Medical Practitioner?
(Name & Speciality)
Detail any Treatment recommended? i.e. physiotherapy
Do you believe the patient will recover or is any Permanent Impairment likely?
Signed:
On Date:
Please use validation stamp or complete in block capitals:-
Doctor's Name: Qualifications:
Practice/Clinic:
Address:
Telephone No: