Frank Accident Declaration Form

What is an accident?

An accident is an unforeseen event, occurring by chance and caused by an external force or object which results in involuntary injury to the body requiring immediate treatment and a hospital admission. For an accident to be covered, the accident must have occurred after purchasing hospital cover and treatment must be sought from a doctor or Emergency Department within 48 hours of sustaining the injury. For the purposes of accident protection coverage, any related hospital admission must occur with 90 days. The completion of this form will help us ensure the eligibility criteria has been met. More information is available in the Frank Fund Rules, Important Information Guide and Fact Sheet.

Frank definition of an Accident excludes the following:

Medical Conditions (disease or illness that is not immediately due to an external injury), Podiatric Surgery by an accredited podiatrist, Pre-Existing Conditions, Sudden Illness, Pregnancy, birth and IVF procedures, Injuries due to alcohol or drug use, or drugs not prescribed by a registered practitioner, Accidents arising from surgical procedures, Aggravation of an existing condition, Elective Cosmetic Surgery, Damage to teeth caused by eating or drinking, or Claims covered by third parties (such as Workcover and TAC).

How to use this form

- You can complete section 1 – 3 of this form digitally and print form for your doctor to complete section 4
- Once all sections of the form are complete and signed, return all pages to Frank
  Email: accidents@frankhealthinsurance.com.au **Post:** Reply Paid 69 Geelong, Victoria 3320

Section 1 - Tell us about yourself

Member number

Date of birth

First name

Last name

Home Address

Suburb

State

Postcode

Postal address

Suburb

State

Postcode

Email address

Phone number

Section 2 - Tell us about the accident/injury

Patient date of birth

Patient name (if different from above)

Date accident occurred

Did the patient seek medical attention within 48 hours?

☐ yes ☐ no

Injured area (e.g. arm/wrist)

Section 2 continued

Describe how the accident/injury occurred

Section 3 - Other claims and compensation

Do you have an accepted claim for compensation with another insurance scheme (such as Worker Compensation or TAC) in relation to this accident? ☐ yes ☐ no

Provide details

If no to the above, have you submitted a claim for compensation with another insurance scheme (such as Worker Compensation or TAC) in relation to this accident? ☐ yes ☐ no

Declaration and acknowledgment

By submitting this declaration I agree to and acknowledge the following:

1. I consent to the collection, use and disclosure of my personal information including sensitive and health information, in relation to this Accident Admission, in accordance with Frank Health Insurance Privacy Statement and our privacy policy which is available at frankhealthinsurance.com.au or on request by contacting us. GMHBA Limited (Frank) complies with the Privacy Act 1988 (Cth) to ensure your personal information, sensitive information including health information, is protected.
2. I authorise Frank to contact the provider of any professional service for clarification of any details provided in this declaration
3. Any future expenses incurred from related services as a result of an Accident will not be subject to compensation from any other source including Work Cover, TAC, Third Party Repatriation or claim for damages.
4. I acknowledge that, where practical, information has been provided with the consent of the individual to whom it relates.
5. All information I have supplied in relation to this declaration is true and correct.

Signature

Date

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This section must be completed by the Medical Practitioner who completed the initial assessment or who referred you to a specialist for hospital treatment.

Our member (nominated in Section 2) has advised hospital treatment was/is required because of an accident and has authorised Frank to collect the following information. Frank uses this information to assess whether benefits can be paid towards this treatment.

Thank you for completing this section promptly.

TO BE COMPLETED BY THE RECOMMENDING HEALTH CARE PROVIDER

Section 4 - Provider details

Provider number

Provider first name

Provider Last name

Practice address

Suburb

State

Postcode

Postal Address

Suburb

State

Postcode

Email address

Phone number

Accident / Injury details

Do you consider the injury to be consistent with the description provided by the patient in section 2? ☐ yes ☐ no

Treatment

Will the patient be, or have they been admitted to hospital as a result of this injury? ☐ yes ☐ no

Admission date*
*If admission has been scheduled; please provide the date the admission is to take place.

What is the likely/expected course of treatment?

Additional comments

Declaration and acknowledgment

I declare that the information provided is true and correct. Any opinion expressed above is my true opinion. I consent to be contacted by Frank to verify any information provided on this form or in connection to this patient's accident or care.

Signature

Date