CBHS CORPORATE

CBHS Corporate Health Pty Ltd ACN 85 609 980 896

Please send this claim form and any additional information:

By email: claims@cbhscorp.com.au
By post: CBHS Corporate, Locked Bag 5098, Parramatta NSW 2124

Accident/Injury/Condition form

SECTION A – PARTICULARS OF ACCIDENT/INJURY/CONDITION

1. Customer details

Member No.

Surname

Given name(s)

Street address

Suburb/Town

State/Territory Postcode

Telephone

2. Patient details

(if different to customer's details)

Title Mr Mrs Miss Ms Dr

Surname

Given name(s)

Telephone ( )

3. The nature of your condition

4. Is your treatment related to an accident/injury/condition?

(Including domestic, sporting, vehicle or employment)

No *Go to Section B – Signature* **Yes**

5. Details of accident/injury/condition

Date of accident / injury / condition / /

Place of accident / injury / condition

Describe how the accident / injury / condition occurred

When did you first seek treatment from a Health Care Provider for matters related to this accident?

Date / /

Name of Provider

Type of Provider

6. Please answer the following questions:

Does your accident / injury / condition relate to the nature of your employment? **No** **Yes**

Did the accident/injury/condition occur whilst at work? **No** **Yes**

Did your accident/injury/condition occur whilst involved in sporting activities or training? **No** **Yes**

You may be entitled to lodge a claim with Work Cover and all relevant treatment and claims should be forwarded to your employer's Insurance Company or, in the event of a motor vehicle accident, sent to Third Party Insurance company.

Note: *If the Insurance Company has rejected your claim please provide CBHS Corporate with a copy of the document which will enable CBHS Corporate to correctly assess your claim.*

SECTION B – SIGNATURE

7. I acknowledge that I must give all relevant information as requested by CBHS Corporate. I declare the above statement to be true and correct.

Signature

Date / /