MARSH & MCLENNAN AGENCY

Marsh & Mclennan Agency Pty Ltd
ABN 33 000 668 584
108 North Tce Adelaide SA 5000
Telephone: (+61-8) 8385 3600
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Dive Injury Claim Form

For Australian members

MEMBER'S STATEMENT

1. **Primary DAN AP Member's Name:** ……………………………………………………………………………………

2. **DAN AP Member Number: AA**…………………..

3. **Patient's Relationship to Primary DAN AP Member** *(tick one)* ☐ **Self** ☐ **Spouse** ☐ **Child**

4. **Patient's DAN AP Insurance Plan:** *(tick one)* ☐ **STANDARD** ☐ **MASTER** ☐ **PREFERRED**

5. **Insured's Patient's Date of Birth:** *(dd/mm/yyyy)* …… **/** …… **/** ……

6. **Insured Patient's Full Name:**……………………………………………………………………………………………

7. **Insured Patient's Home Address: Street:**…………………………………………………………………………..

   City:…………………………………… **State:**………………………………….. **Post Code:**……………………

   Country:……………………………………………………………………………..

EFT Authorisation: (if applicable) I hereby authorise and request that Marsh & McLennan Agency P/L credit our bank account as indicated below:

Name of Bank:…………………………Branch Address:……………………………………………………

BSB No:……. -……. .Account No:………………………Account Name:………………………………..…

Please note that if you elect to receive any payments by EFT then Marsh & McLennan Agency P/L accept no responsibility for the incorrect allocation of these payments by the Bank/Building Society or Credit Union.

ALL CLAIMS MUST BE: 'COVERED' IN-WATER DIVING OR SNORKELLING ACCIDENTS

8. **Where did the accident occur:**……………………………………………………………………………………… **.**

   ……… ..

9. **Date of Accident:** *(dd/mm/yyyy)* …… **/** …… **/** ……

10. **Describe the dive or snorkelling situation which caused the injury:** ……………………………………………….

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11. **Describe the signs and symptoms of your injury and the first aid that was provided, if any.**

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12. **Is this claim the result of a work-related illness or injury?** *(tick one)* ☐ **Yes** ☐ **No**

13. **If accident is work-related, please provide Insured's Employer details:**

    Employer:…………………………………………………………………

    Street:……………………………………………………………………

    City:……………………………… **Postcode:**..…………………………

    Country: ……………………………………………………………....

14. **What was the maximum depth during dive (series):** ………………………………………….. **metres**

15. **Breathing gas used:** ☐ Air ☐ Other, please specify …………………………………………………

    ………

16. **Diving Qualification(s):** ………………………………………………………………………………………………

17. **When was a Doctor first seen for this injury?** **Date:** *(dd/mm/yyyy)* …… **/** …… **/** ……

    Doctor's Details: ……………………………………………………………………………………………..…..

OTHER INSURER(S) INFORMATION

18. **In addition to the DAN Group Insurance are you entitled to health or medical insurance benefits from another source?** *(tick 'Yes' or 'No" for all questions)*

    Health, medical or dental insurance? ☐ Yes ☐ No

    Medicare? ☐ Yes ☐ No

    Travel Insurance? ☐ Yes ☐ No

    Accident Insurance? ☐ Yes ☐ No

    Any Statutory Insurance? ☐ Yes ☐ No

    If 'Yes", please provide the full details of the claim/benefits and the Insurance Companies.

    ………

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19. Have you, or will you submit a claim against any other party for damages as a result of the accident or injury described in this form? *(tick one)* ☐ Yes ☐ No

If 'Yes' please provide details: ……………………………………………………………………………………………

………

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AUTHORISATION TO OBTAIN INFORMATION AND ASSIGN BENEFITS

20. Insured Patient or parent (in the case of a Minor) must sign below:
I hereby authorise any insurance company or prepayment organisation, employer, hospital or physician to release all information with respect to me or any of my dependants which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. I also agree that a photostatic copy of this authorisation shall be valid as the original.

Dated ....20 Insured Patients Signature:..

21. If payment is to be made to a provider, please sign below:

I hereby authorise payment of benefits otherwise payable to me for services to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorisation.

Dated ....20 Insured Patients Signature:..

22. I hereby state that any person who knowingly and with intent to defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information about the accident, injury or about other insurance coverage may prejudice the claim and the right to compensation forfeited.

Dated ....20 Insured Patients Signature:..

THIS CLAIM CANNOT BE ASSESSED OR COMPENSATION
PAID WITHOUT COPIES OF ALL OTHER INSURERS' EXPLANATION OF BENEFIT (EOB) FORMS.
PLEASE ATTACH OR SEND AS SOON AS POSSIBLE.
YOUR CLAIM WILL BE PENDED UNTIL
THESE EOB'S ARE RECEIVED.

PLEASE SEND THE COMPLETED FORM AND MEDICAL INVOICES TO:

Marsh & McLennan Agency Pty Ltd
Personal Accident Claims
GPO Box 2637
ADELAIDE SA 5001
AUSTRALIA

Or email:

binder.claims.sa@marshmc.com