



DefenceHealth

Defence Health Limited
ABN 80 008 629 481 AFSL 313890
PO Box 7518 Melbourne VIC 8004
Freecall 1800 335 425
Facsimile 1300 665 096
www.defencehealth.com.au
info@defencehealth.com.au

Member No

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Applicant Surname		
Applicant First name		Title/Rank
Address		
Suburb	State	Postcode
Daytime phone	Email	

A Accident questionnaire

Names of persons injured _____
Date of accident/injury / / Time _____
Nature of injuries _____
Place of accident/injury State _____
Describe how the accident/injury happened

B Workers compensation

Did the accident/injury happen at work or going to or from work? Yes No
Have you lodged a claim with your employer/Workers compensation? Yes No
If you are not entitled, please state reasons.

What is your occupation? _____
Are you self employed? Yes No
Name and address of employer/business

C Transport accident

Did the accident/injury occur when travelling in a motor vehicle or on public transport Yes No
Was another vehicle involved? Yes No
Were you the: Driver Passenger Other
Have you lodged a claim with the Transport Accident Commission (Vic) or Third Party? Yes No
If you are not entitled, please state reasons.

D Crimes compensation

Was the accident/injury the result of negligence or violence by another person? Yes No
Have you lodged a claim for Criminal Injuries Compensation? Yes No
Do you intend to pursue a Common Law Personal injuries claim? Yes No
If you are not entitled to either of the above, please state reasons.

E Settlement details

Have you received a Common Law, Third Party or Workers compensation settlement? Yes No
If yes, please attach a copy of the Award/Settlement
Name and address of solicitor or other party acting in connection with such a claim

Name and address of insurance company involved

F Declaration

I authorise Defence Health Limited ABN 80 008 629 481 to contact any necessary persons if additional information or supporting documentation is required to establish my eligibility for benefits. I declare that the information given is true and correct.

Signature
Date



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