

## DIVE INJURY CLAIM FORM

for Australian Resident Members

DAN Group Insurance Number: ISO3 AAPT  
Insurer: Certain Underwriters at Lloyds

<b>Member's Statement</b>	<b>1. Primary DAN AP Member's Name:</b>		<b>2. DAN AP Member Number:</b> AA _____		
	<b>3. Patient's Relationship to Primary DAN AP Member</b> (tick one):  <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		<b>4. Patient's DAN AP Insurance Plan:</b> <input type="checkbox"/> Standard <input type="checkbox"/> Master <input type="checkbox"/> Preferred		<b>5. Insured's Patient's date of birth:</b> (dd/mm/yy) ____ / ____ / ____
	<b>6. Insured Patient's name:</b>  Surname: _____ First name: _____ Middle Initial: _____				
	<b>7. Insured Patient's home address:</b>  Street: _____ City: _____ State: _____ P/Code: _____ Country: _____				
	<b>ALL CLAIMS MUST BE: 'COVERED' IN-WATER DIVING OR SNORKELLING ACCIDENTS</b>				
	<b>8. Where did the accident occur?</b>			<b>9. Date of accident:</b> (dd/mm/yy): ____ / ____ / ____	
	<b>10. Describe the dive or snorkelling situation which caused the injury:</b> (NOTE: You must include details of all dives in previous 72 hours with max. depths, times, stops & surface intervals. Also include what decompression guide was being used, eg. what tables or dive computer) <i>Use extra pages if needed and attach these.</i>				

	<b>11. Describe the signs and symptoms of your injury and the first aid that was provided, if any.</b>	
	<b>12. Is this claim the result of a work or research-related illness or injury? (tick one)</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No	<b>13. Insured's Employer details (if accident work-related)</b> Employer: _____ Street: _____ City: _____ State: _____ P/Code: _____ Country: _____
	<b>13. What was the max. depth during dive (series): _____ metres.</b>	
	<b>14. Breathing gas used:</b> <input type="checkbox"/> Air <input type="checkbox"/> Other, please specify _____ _____	
	<b>15. Diving qualification(s)</b> _____	
	<b>16. When was a doctor first seen for this injury?</b> Date: (dd/mm/yy): ___ / ___ / ___      Doctor: _____	

<b>Other Insurer(s) Information</b>	<b>17. In addition to the DAN Group Insurance are you entitled to health or medical insurance benefits available from? (tick 'Yes' or 'No' for all questions)</b> Health, medical or dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No      Travel Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No  Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No      Accident Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No  Any Statutory Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>18. If 'Yes' circled, please provide the full name and address of the insurance companies.</b> _____ _____	
	<b>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?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, please provide details:	

<b>Authorisation to obtain information and assign benefits</b>	<b>20. Insured Patient or parent (in the case of a Minor) <u>must</u> sign below:</b> 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 as valid as the original.	
	<b>Insured Patients signature</b>	<b>Date</b> dd/mm/yy
		/ /
	<b>21. IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW:</b> 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.	
	<b>Insured Patient's signature</b>	<b>Date</b> dd/mm/yy
		/ /
<b>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.</b>		
<b>Insured Patient's signature</b>	<b>Date</b> dd/mm/yy	
	/ /	
<b>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.</b>	Please send the completed form and medical bills to:  <b>DIVERS ALERT NETWORK</b> <b>Asia-Pacific Ltd</b> <b>ABN 67 066 827 129</b> <b>PO BOX 384</b> <b>ASHBURTON VIC 3147</b> <b>AUSTRALIA</b>	