DIVE INJURY CLAIM FORM

for non-Australian Members

DAN Group Insurance Number:
Insurer: Accident & General Insurance

Member's Statement	**1. Primary DAN AP Member's Name:**		**2. DAN AP Member Number:** _ _ _____
	3. Patient's Relationship to Primary DAN AP Member *(tick one):* ☐ Self ☐ Spouse ☐ Child	**4. Patient's DAN AP Insurance Plan:** ☐ Standard ☐ Master ☐ Preferred ☐ Preferred Plus	**5. Insured's Patient's date of birth:** (dd/mm/yy) ____ / ____ / _____
	6. Insured Patient's name: Surname: _____ First name: _____ Middle Initial: _____		
	7. Insured Patient's home address: Street: _____ City: _____ State: _____ P/Code: _____ Country: _____ Tel (daytime): _____ Email: _____		
	ALL CLAIMS MUST BE: 'COVERED' IN-WATER DIVING OR SNORKELLING ACCIDENTS (Except for non-diving incidents covered under the Preferred Plus policy)		
	8. Where did the accident occur?		**9. Date of accident:** (dd/mm/yy): ___ / ___ / ____

10. Describe the situation which caused the injury: (NOTE: For diving incidents you must also 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) *Use extra pages if needed and attach these.*

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

12. Is this claim the result of a work or research-related illness or injury? *(tick one)*

☐ Yes

☐ No

13. Insured's Employer details *(if accident work-related)*

Employer: _____

Street: _____

City: _____ State: _____

P/Code: _____ Country: _____

13. What was the max. depth during dive (series): _____ **metres.**

14. Breathing gas used: ☐ Air ☐ Other, please specify _____

_____

15. Diving qualification(s) _____

16. When was a doctor first seen for this injury?

Date: (dd/mm/yy): ___ / ___ / ____ Doctor: _____

Other Insurer(s) Information

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)*

Health, medical or dental insurance?	☐ Yes	☐ No	Travel Insurance?	☐Yes	☐ No
Medicare?	☐ Yes	☐ No	Accident Insurance?	☐Yes	☐ No
Any Statutory Insurance?	☐ Yes	☐ No			

18. If 'Yes' circled, please provide the full name and address of the insurance companies.

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?

☐ Yes ☐ No If Yes, please provide details:

Authorisat-ion 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 as valid as the original.

Insured Patients signature	**Date** dd/mm/yy
	/ /

21. IF PAYMENT IS TO BE MADE TO PROVIDER, 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.

Insured Patient's signature	**Date** dd/mm/yy
	/ /

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.

Insured Patient's signature	**Date** dd/mm/yy
	/ /

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 bills to: **DIVERS ALERT NETWORK Asia-Pacific Ltd** **ABN 67 066 827 129** **PO BOX 384** **ASHBURTON VIC 3147** **AUSTRALIA**