Compensation/Accident **Questionnaire**

Current Primary Member details

Member number: | Title:

First name: | Surname:

Address: | Telephone:

Questionnaire

Claimant Name: | Date of incident:

Type of claim:
(Worker's Compensation - accepted, ongoing, etc)

Nature of injury:

Place of incident:

How did the injury or illness happen?

Name of law firm representing your case & contact details (if any):

Compensation

Are you entitled to lodge a claim for Workers Compensation, Motor Vehicle Personal Injury Compensation, Criminal Injury Compensation, or other types of compensation? Yes ☐ No ☐

Fund benefits will not be paid for a claim made under any cover for expenses incurred in relation to a condition, ailment or injury where the member has received, or established a right to receive or foregone a right to receive, a payment by way of compensation in respect of that condition, ailment or injury.

Declaration

I authorise HIF to contact any relevant persons (including legal representatives) if additional information or supporting documentation is required to establish my eligibility for benefits. I declare that all the information giving is true and correct.

Signature: | Date: