Medibank Private Limited
ABN 47 080 890 259

Compensation Questionnaire

This form provides *Medibank* or *ahm* (the *Fund*) with information relating to your *Compensable Condition* and provides us with an authority to support a recovery of *Benefits*.

Please complete this form by providing the requested information and circling the applicable answer. Italicised terms have the same meaning as in the *Fund Rules*.

Personal Details			
Medibank or ahm Membership Number:			
Surname:		Given Name/s:	
Date of Birth:	Email Address:		
Address:			
State:		Postcode:	
Phone (Business):		(Home/Mobile):	

Section A – Details of Injury or Illness			
Date of injury or diagnosis of illness:		Location (insert State/ Territory):	
Describe your injury/illness:			
Is your treatment for your injury or illness:			
i.	Complete	Yes/No	If yes, when was it completed?
ii.	Currently underway	Yes/No	If yes, what is the expected timeframe?
iii.	Not yet started	Yes/No	If yes, when do you expect it to start?

Section B – Type of claim		
Is your injury/illness a result of an incident or circumstances:		
i.	At work?	Yes / No
	If yes- Are you self-employed?	Yes / No
ii.	Involving a motor vehicle?	Yes / No
iii.	Involving a sporting accident?	Yes / No
iv.	Involving dust diseases (e.g. asbestos related)?	Yes / No
v.	Involving a health professional or hospital?	Yes / No
vi.	At some other place?	Yes / No
vii.	Involving a criminal act by another?	Yes / No

Section C – Details of your *Compensation* claim		
Have you or do you intend to make a claim for *Compensation*? (circle appropriate answer)		Yes/No/Not sure/Not yet
If you answered yes to the last question, state:		
i.	The name of the insurer or insurance scheme handling your claim (if known)	
ii.	The insurer's claim reference number	
iii.	Have you been awarded compensation already?	Yes / No

Section D – Details of your claim (continued)
If you are not entitled or do not intend to claim *Compensation*, please explain why:
If your claim has already been declined by an insurer, please provide details and attach a copy of the letter from the insurer.

Section E – Your solicitor/lawyer/Insurer details (if applicable)			
Firm/Company name:			
Contact Person:			
Email address:			
Street Address:			
State:		Postcode:	
Telephone:		Reference *(If applicable)*:	

Acknowledgement of obligations

I acknowledge that:

1. under the *Fund Rules*, the *Fund* is not obliged to pay health insurance *Benefits* in respect of a *Compensable Condition*:
2. I will:
    a. promptly inform the *Fund* if I decide to claim, or not to claim, *Compensation*; and
    b. ensure that all *Benefits* paid in relation to my *Compensable Condition* are included in any claim that I make for Compensation, and I will inform my solicitor accordingly if I appoint one, and
    c. obtain from the Fund a statement of the full amount of *Benefits* that are repayable to the *Fund* (a Notice of Charge); and
    d. if I recover *Compensation*, repay the full amount of *Benefits* paid in respect of my *Compensable Condition*, unless the *Fund* has agreed in advance to accept a reduced amount; and
    e. use the amount of compensation received in respect of future treatment expenses to pay for future treatment in relation to my *Compensable Condition*, until the amount is exhausted.
3. if I do not comply with the *Fund Rules* then the *Fund* may cease payment of *Benefits* in respect of a *Compensable Condition*; and
4. email may not be a secure communications channel and, if I communicate with the *Fund* by email, I accept the risk to the security of such communications; and
5. more information about *Members'* obligations in relation to *Compensation* may be found in section F7 of the *Fund Rules*.

Irrevocable Authority

I irrevocably authorise and direct -

1. the *Fund* to disclose to my legal representative or a third party insurer details of *Benefits* paid to me in relation to my *Compensable Condition* for the purposes of reimbursing those *Benefits* to the Fund;
2. my legal representative, as appointed by me from time to time, or third-party insurer, to disclose to the *Fund* information in connection with my *Compensation* claim;
3. my legal representative to ensure that the terms of any settlement of my *Compensation* claim be permitted to be disclosed to the *Fund*; and
4. my legal representative to withhold in trust, from any *Compensation* that I receive in relation to a *Compensable Condition*, an amount not less than the full amount of the *Benefits* paid in respect of my *Compensable Condition*, until authorised by the *Fund* to release that money; and
5. my legal representative, or third-party insurer, to pay the amount due and repayable to the *Fund*, directly to the *Fund*, without further instruction from me.

Declaration

I declare that:

- the information provided in this form is true and correct to the best of my knowledge and belief;
- I have read and understand the Acknowledgement of obligations; and
- I have read, understand and hereby grant the Irrevocable Authority described above.

Sign here

SIGNATURE OF MEMBER/CLAIMANT: _____ DATE:_____/ /