

EMERGENCY TRANSPORT CLAIM FORM



Complete this form and forward to:

CFMEU
Level 1, 32 South Terrace
ADELAIDE SA 5000
Ph: (08) 8231 5532 Fax: (08) 8231 3822

1. Member Details

Full Name:

Residential Address:

State:

Postcode:

Phone No:

Mobile:

Occupation:

Employer Name:

Employer Ph No:

Union Member ☐ CFMEU ☐ CEPU

If **not** a union member BIRST member number

2. Incident Details

Date the ambulance was used:

Name of person who used the ambulance:

Relationship to Member (wife, daughter, member, etc):

Date of birth:

What was the reason for the ambulance usage?

If the use of the ambulance was not as a result of an accident, provide the name and telephone number of the Doctor who requested the transport.

Name:

Contact No:

ORIGINAL ACCOUNT MUST BE ATTACHED TO THIS FORM

I acknowledge that the Administrator has the right to seek additional information in support of this claim.

DECLARATION

I do solemnly declare that the foregoing particulars are true and correct in every detail, and I agree that if I have made, or in any further declaration in respect of the said injury or sickness shall make, any false or fraudulent statements, or suppress, conceal or falsely state any material fact whatsoever, the Policy shall be void and all rights to recover thereunder in respect of the past or future injuries or sickness shall be forfeited.

"I the undersigned hereby acknowledge and agree to the information contained herein (including our personal information) being shared with the other members of our CAAW Trust as part of the Trust's Risk Management process and reporting criteria"

Signature of Member:

Date: