

School student accident claim form

Personal details

Name of school _____

 Student's full name _____

 Street address _____
 _____ City _____ State _____ Postcode _____
 Date of birth ____ / ____ / ____ Telephone (____) _____

Electronic Funds Transfer

Following ACE's approval of your claim, should you wish to have your claim settlement transferred directly into your bank account, please provide the following details

Bank name _____
 Account name _____
 BSB no. _____
 Swift code (if applicable) _____

1. Injury description

Give full description of injury from which you are suffering. State when, where and how it happened

Injury _____
 How it was sustained _____

 Where _____
 Full description _____

(a) Give exact date when injury occurred

Date ____ / ____ / ____

(b) When did you first consult a physician for this condition?

Date ____ / ____ / ____

(c) When did you become totally disabled (unable to attend school)?

Date ____ / ____ / ____

(d) When were you able to return to school?

Date ____ / ____ / ____

(e) If still disabled, when do you expect your disability to terminate?

Date ____ / ____ / ____

(f) Have you ever had this, or a similar condition in the past?

No Yes

If yes, state the nature of the condition, dates of the treatment, names and addresses of treating doctors, hospitals and clinics

Condition(s) _____
 Date ____ / ____ / ____ Treated by _____
 Name of hospital/clinic _____

2. Attending physician(s)

Give names, addresses and telephone numbers of **all attending** physicians

Name _____
 Address _____
 _____ Telephone (____) _____
 Name _____
 Address _____
 _____ Telephone (____) _____

Give names, addresses and telephone numbers of usual family physician

Name _____
Address _____
_____ Telephone (____) _____

3. Are you covered by private health insurance?

No Yes If 'yes', name of insurer _____

Give membership no. and branch _____

Have you claimed yet?

No Yes

If 'yes' please submit a Statement of Benefits from your private health insurer.

Please note, this policy does not cover the Medicare gap.

Authorisation

I hereby authorise any hospital, physician or other person who has attended to me to furnish ACE Insurance or its representatives, any and all information with respect to any injury, medical history, consultation, prescriptions, or treatment, copies of all hospital and medical records. I agree that a photocopy of this authorisation shall be considered as effective and valid as original.

I do solemnly and sincerely 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 shall make any false or fraudulent statements, or suppress, conceal or falsely state any material fact whatsoever then my claim may be voided and my rights of financial recovery forfeited.

I consent to the collection, use and disclosure of information by ACE Insurance and their service providers in order to assess the claim. ACE Insurance complies with the obligations of the Privacy Act 2001 and the principles laid out in our Privacy Policy, which is readily available on request.

Dated ____ / ____ / ____

Name (please print) _____

Relationship to student _____

Signed _____

To be completed by school registrar/principal

Please ensure that all questions have been fully answered

I certify that (insert student name) _____

_____ was injured as stated.

Name of school _____

Name _____

Position _____

Address _____

_____ Telephone (____) _____

Please complete claim form and return to:



ACE Insurance Limited
GPO Box 4065 Sydney 2001
Phone (02) 9335 3282
Fax (02) 9231 3697

I hereby certify that the particulars shown on this form are to the best of my belief and knowledge, true and correct.

Signature _____

Date ____ / ____ / ____

Witness _____

Medical Practitioner's Statement

The claimant is responsible for any fee for this statement. This form should be completed and returned to ACE Insurance promptly.

Patient's details

Patient's full name _____

Date of birth ____ / ____ / ____

Diagnosis

(If fracture or dislocation, describe nature and location ie: simple, compound)

Does the patient have any other injury that is contributing to the condition?

No Yes, give details _____

Was the disability accident related?

No, give details Yes _____

Date of accident/first symptoms

____ / ____ / ____

When did the patient first consult you for this condition?

____ / ____ / ____

How long have you been the patient's usual doctor/medical practice?

____ years

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated?

No Yes, give details _____

Date performed or anticipated ____ / ____ / ____

Give name of hospital _____

Did you provide other medical services (including pathology) to the patient?

No Yes, give details

Date ____ / ____ / ____ _____

Date ____ / ____ / ____ _____

Please turn over >

Was the patient referred by you or to you?

No Yes, give details

Please provide name and address of referring doctor

Name: _____

Street address _____

_____ City _____ State _____ Postcode _____

Date of referral ____ / ____ / ____

Is the patient still disabled?

No Yes, if yes, how long will the patient be:

• totally disabled (unable to return to their pre-injury education)

from ____ / ____ / ____ to ____ / ____ / ____

• partially disabled (unable to return to a substantial part of their pre-injury education)

from ____ / ____ / ____ to ____ / ____ / ____

If partially disabled, what educational activities could the patient perform and how many hours a week?

_____ hours per week _____

Has the patient ever had the same or similar condition?

No Yes, give details _____

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, sports body or any other insurance body?

No Yes, give details _____

Name of company and claim number _____

Contact name and telephone number _____

Remarks

Please complete claim form and return to:

Signature

Signature of medical practitioner _____

Name (in print) _____

_____ Date ____ / ____ / ____

Qualifications _____

Street address _____

City _____ State _____ Postcode _____

Telephone (____) _____



ACE Insurance Limited
GPO Box 4907 Sydney 2001
Phone (02) 9335 3355
Fax (02) 9231 3697