Accident & Health International
Underwriting Pty Limited

Accident and Health

STUDENT ACCIDENT INSURANCE CLAIM FORM

FEDERATION OF PARENTS' & CITIZENS' ASSOCIATIONS OF NEW SOUTH WALES

The issue or acceptance of this form is not construed as an admission of liability on the part of the Company. Please print clearly. To avoid delays please ensure all relevant sections are completed.

Section 1

School Name: _____

Student's Name: _____ Date of Birth: ____/____/____

Parent/Legal Guardian's Name: _____

Postal Address: _____ Postcode: _____

Daytime Telephone Number: _____

Are you claiming for:

- ☐ Capital/Broken Bone Benefit only
  (Complete Sections 1, 2 and 4 only – please include a copy of the x-ray report for fractures, or if applicable, coroner's report or medical report)
- ☐ Any Medical Expenses
  (Complete All Sections)
- ☐ Non-Medical Expenses only
  (Complete Sections 1,2 and 5 only)
- ☐ Capital/Broken Bone Benefit and Medical and/or Non-Medical Expenses
  (Complete All Sections)

Please tick preferred from of ☐ Cheque ☐ Direct Payment

If you have selected Cheque please nominate payee _____

Bank _____ Account Name _____

Branch Number _____ Account Number _____

Section 2

Date and Time of injury: _____

What is the injury? _____

Location where injury occurred: _____

What was the student doing at the time of the injury? _____

How did the injury occur? _____

_____

Was this a school activity? _____

Section 3

Does the student have other private health cover? _____ Type of Cover: _____

Name & Phone number of initial Medical Attendant _____

Name & Phone number of your regular Medical Attendant _____

Declaration

Please send completed Claim form to:

Sydney
Level 4, 33 York Street
SYDNEY NSW 2000
GPO Box 4213, SYDNEY NSW 2001
T: +61 2 9251 8700
F: +61 2 9251 8755

ABN 26 053 335 952
AFS Licence No:238261
Email: enquiries@acchealth.com.au
Website: www.acchealth.com.au
Freecall 1800 618 700
Freefax 1800618 755

I/We agree that, by submitting this form, the personal information I/We provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in our Privacy Policy including for the processing of this claim.

I authorise any doctor or medical attendant who has treated or examined the student to give the underwriter any information it requires in relation to this claim, to assist in the proof and settlement of any claim. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Payment Authority: I hereby authorise payment of any benefits be made payable to: _____

_____

Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Please send completed Claim form to:

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At your own expense, you must have this certificate completed by a duly qualified Medical Practitioner. To avoid delays, please ensure this certificate is fully completed and returned with the claim form.

Section 4 - MEDICAL CERTIFICATE

If you are unable to answer any of the questions below, please indicate.

Describe Injury_____

_____

When did you first treat the student for this condition?

_____

Since when has this condition (in your opinion) been in existence? ____/____/____

Has the student previously suffered from the same or a similar injury?

No ☐

Yes ☐ Date: ____/____/____

Diagnosis_____

_____

Are there or do you envisage any complications?

No ☐

Yes ☐ Give details

_____

_____

Are the student's symptoms due or traceable exclusively to this injury?

No ☐

Yes ☐

Is there anything in the student's medical history which may have contributed directly or indirectly, to the injury or which may be likely to retard the student's recovery?

No ☐

Yes ☐ Give Details

_____

Present Condition:

_____

Prognosis

_____

Name of operation (if any)
If hospitalised, give dates

From ____/____/____ to ____/____/____

Name of Hospital_____

Have you any reason to suppose that the student was under the influence of intoxicants at the time of the accident?

No ☐

Yes ☐

When did you release student to return to school (if applicable)?

_____

In your opinion, probable further disability should not exceed

_____Weeks _____Months

Name of Attending Physician (Please Print)

_____

Signature_____Date___/____/____

Qualifications

_____

Address

_____

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STUDENT ACCIDENT MEDICAL EXPENSE CLAIM FORM

Section 5		A	B	C	D	Office Use Only	
Date Expense Incurred	Item Description	Fee Charged	Scheduled Fee	Medicare Benefit	Health Fund Benefit	Amount Payable By A&HI	Details
	Totals:						

Reimbursement is calculated as follows:
A – D in the case of no Medicare component
B – C in the case of an “in-hospital” expense, this is known as the “gap”.

STUDENT ACCIDENT MEDICAL EXPENSE CLAIM FORM

Please note that in the case of a “gap” being paid by your Health Fund, no further benefit is claimable from Accident & Health International