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 ______________________________

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

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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: _____/_____/_____

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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