

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

Accident & Health International

Underwriting Pty Limited



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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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

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.

<p>Section 4 - <u>MEDICAL CERTIFICATE</u></p> <p><i>If you are unable to answer any of the questions below, please indicate.</i></p> <p>Describe Injury _____</p> <p>_____</p> <p>When did you first treat the student for this condition? _____</p> <p>Since when has this condition (in your opinion) been in existence? ____/____/____</p> <p>Has the student previously suffered from the same or a similar injury?</p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> Date: ____/____/____</p> <p>Diagnosis _____</p> <p>_____</p> <p>Are there or do you envisage any complications?</p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> Give details</p> <p>_____</p> <p>_____</p> <p>Are the student's symptoms due or traceable exclusively to this injury?</p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>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?</p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> Give Details</p> <p>_____</p>	<p>Present Condition: _____</p> <p>Prognosis _____</p> <p>Name of operation (if any) If hospitalised, give dates</p> <p>From ____/____/____ to ____/____/____</p> <p>Name of Hospital _____</p> <p>Have you any reason to suppose that the student was under the influence of intoxicants at the time of the accident?</p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>When did you release student to return to school (if applicable)? _____</p> <p>In your opinion, probable further disability should not exceed ____Weeks ____Months</p> <p>Name of Attending Physician (Please Print) _____</p> <p>Signature _____ Date ____/____/____</p> <p>Qualifications _____</p> <p>Address _____</p>
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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