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 (___) _____

Please turn over >

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 supress, 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 (___) _____

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 _____

Please complete claim form and return to:

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