

### 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 ( \_\_\_\_ ) \_\_\_\_\_

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