Aon's Student Accident Protection Plan
School student accident claim form

This form should be completed and returned to Chubb promptly.
Chubb Insurance Australia Limited Level 38, 225 George Street, Sydney NSW 2000
Email: a&hclaims.au@chubb.com Phone: 1300 722 032 Fax: (02) 9231 3697

CLAIMS PROCEDURE

To ensure that your claim is dealt with as quickly as possible, it is important to follow a few simple steps:

1. Report the accident as soon as possible to school administration.
2. Pay all medical and other accounts as the insurer will not pay those on your behalf.
3. Make your Medicare claim.

   Student Accident Insurance includes coverage for non-Medicare medical expenses (when the accident happened during school or organised sporting activities). Any portion of any expense for which a Medicare benefit is paid or payable, including the balance of monies you have to bear after deduction of any Medicare benefit or rebate from the actual expense incurred (commonly known as the 'Medicare gap'), is unable to be reimbursed under this or any other general insurance. It is in fact a breach of the Health Insurance Act to reimburse such costs.

   All claimable non-Medicare medical expenses need to be for treatment, certified necessary by a legally qualified medical practitioner, to a registered private hospital, physiotherapist, chiropractor, osteopath, nurse or similar provider of medical services excluding the cost of dental treatment unless such treatment is necessarily incurred to sound and natural teeth, excluding dentures, and is caused by the accident.
4. Make Private Health insurance claims, as the insurer's obligation is only for any portion not covered by Private Health.
5. Complete this School student accident claim form (note that there is a section to be completed by the school).
6. Ask the attending doctor to complete the Medical practitioner's statement.
7. Send all completed documents and any accounts and receipts in support of out of pocket expenses claimed direct to Chubb.

POLICYHOLDER DETAILS

Name of Policyholder: Georges River Grammar

Certificate Id: AONSAPP00079

Name of school (if different to Name of Policyholder):

PERSONAL DETAILS

Student's full name:

Street address:

City: State: Postcode:

Date of birth: / /

Parent name:

Parent telephone number: ( )

Parent email address:

ELECTRONIC FUNDS TRANSFER

Following Chubb's approval of your claim, should you wish to have your claim settlement transferred directly into your bank account, please provide the following details.

Name of Bank: Account name:

BSB: Account Number.: Swift code (if applicable):

1. INJURY DESCRIPTION

Please give a full description of the injury you suffered, stating when, where and how it happened.

Injury

How it was sustained

Where it was sustained

Were you involved in school or organised sporting activities when you were injured: Yes ☐ No ☐

(a) Exact date when injury occurred / /

(b) When did you first consult a physician for this condition? / /

(c) When did you become unable to attend school? / /

(d) When were you able to return to school? / /

(e) If still disabled, when do you expect your disability to terminate? / /

(f) Have you ever had this, or a similar condition in the past? Yes ☐ No ☐

*If you answered **Yes** to question **1(f)**, please state the nature of the condition, dates of previous treatment, names and addresses of treating doctors, hospitals and clinics.*

Condition(s)

Date / /

Treated by

Name of hospital/clinic

2. ATTENDING PHYSICIAN(S)

Please give names, addresses and telephone numbers of all attending physicians for the Injury that is the subject of this claim.

Name

Phone ( )

Address

2. ATTENDING PHYSICIAN(S) *continued...*

Name

Phone ( )

Address

*Please give the name, address and telephone number of your **usual family physician**.*

Name

Phone ( )

Address

3. PRIVATE HEALTH INSURANCE

Are you covered by private health insurance? Yes ☐ No ☐

If "yes", what it the name of your health insurer

Health Insurance Membership Number

Have you claimed yet? No ☐ Yes ☐ *If "yes" please submit a Statement of Benefits from your private health insurer.*

Authorisation

I hereby authorise any hospital, physician or other person who has attended to me to furnish Chubb 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 Chubb and their service providers in order to assess the claim. Chubb complies with the obligations of the Privacy Act 2001 and the principles laid out in our Privacy Policy, which is readily available on request.

Name (please print)

Date / /

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

Phone ( )

Address

Do you want to be copied in on the acknowledgement letter for this claim? Yes ☐ No ☐

If YES, Please provide:

Contact Name

Contact email address

I hereby certify that the particulars shown on this form are to the best of my belief and knowledge, true and correct.

Date / /

Witness Name

Signed

Witness Signature

CHUBB

Please complete claim form and return to:
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AON Empower Results®

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Medical practitioner's statement

The claimant is responsible for any fee for this statement. This form should be completed and returned to Chubb Insurance Australia Limited promptly.

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PATIENT'SDETAILS

Full name

Date of birth / /

Diagnosis (If fracture or disclocation, describe nature and location i.e. simple, compound)

Does the patient have any other injury that is contributing to the condition? Yes ☐ No ☐

If yes, give details

Was the disability accident related? Yes ☐ No ☐

If yes, give details

Date of accident/first symptoms

/ /

When did the patient first consult you for this condition?

Date of accident/first symptoms

/ /

How long have you been the patient's usual doctor/medical practice?

years

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated? Yes ☐ No ☐

If yes, give details

Date performed or anticipated

/ /

Give name of hospital

Did you provide other medical services (including pathology) to the patient? Yes ☐ No ☐

If yes, give details

Date Services provided

/ /

Date Services provided

/ /

Was the patient referred by you or to you? Yes ☐ No ☐

If yes, please provide name and address of referring doctor

Name

Street address

City | State | Postcode | Date of referral

Is the patient still disabled? Yes ☐ No ☐

If yes, how long will the patient be:

- Totally disabled (unable to return to their pre-injury education)

from / / to / /

- Partially disabled (unable to return to a substantial part of their pre-injury education)

from / / to / /

If partially disabled, what educational activities could the patient perform and how many hours a week?

Has the patient ever had the same or similar condition? Yes ☐ No ☐

If yes, give details

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, sports body or any other insurance body? Yes ☐ No ☐

If yes, give details

Name of company and claim number

Contact name and telephone number

Remarks

Signature of medical practitioner | Name (in print)

Date

/ /

Qualifications

Street address

City | State | Postcode

Telephone ( ) | Date of referral / /

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