# Lockton Student Accident Protection Plan

### School student accident claim form



This form should be completed and returned promptly.

Please complete claim form and return to: a&hclaims.au@chubb.com and copy in cewainsurance.au@lockton.com

Chubb Insurance Australia Limited Level 38, 225 George Street, Sydney NSW 2000, 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 the school administration.
- 2. Pay all medical and other accounts as the insurer will not pay those on your behalf.
- 3. Make your Medicare claim.

POLICYHOLDER DETAILS

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.

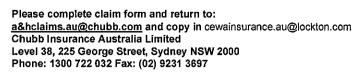
Name of Policyholder	•		Policy Number
Name of school (if different to N	lame of Policyholder)		•
PERSONAL DETAILS			
Student's full name			
Street address			
City	**	State	Postcode
Date of birth Par	ent name		
L = L			
Parent telephone number	Parent email address		
()			
ELECTRONIC FUNDS TRANSF	ED		
		lement transferred directly into your bank account, p	lease provide the following details.
Name of Bank		Account name	,
BSB Acc	count 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 No Were you involved in school or organised sporting activities when you were injured: Yes (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 Νo 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/dinic 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  N	_
Are you covered by private health insurance? Yes N  If "yes", what it the name of your health insurer	D.
yes, while it are name or your realar made.	
Health Insurance Membership	ne.
Have you claimed use? Mrs. Voc7f "you" steems out the	it a Chatamant of Danafta from well with the health Incurre
	it a Statement of Benefits from your private health insurer.
any injury, medical history, consultation, prescriptions, or t be considered as effective and valid as original. I do solem that if I have made or in any further declaration in respect	who has attended to me to furnish Chubb or its representatives, any and all information with respect reatment, copies of all hospital and medical records. I agree that a photocopy of this authorisation so any and sincerely declare that the foregoing particulars are true and correct in every detail and I agree of the said injury shall make any false or fraudulent statements, or suppress, conceal or falsely stated and my rights of financial recovery forfeited. I consent to the collection, use and disclosure of to assess the claim. Chubb complies with the obligations of the Privacy Act 2001 and the principles leest.
Name (please print)	Date
	1 1
Relationship to student	Signed
Please ensure that all questions have been fully answered certify that (insert student name)	was injured as stated.
Name of school	Name
Position	Phone
# 1 vol 1	{ )
Address	
Do you want to be copied in on the acknowledgement lette	er for this claim? Yes No
f YES, Please provide:	
Contact Name	Contact email address
hereby certify that the particulars shown on this form are	to the best of my belief and knowledge, true and correct.
Pate	Witness Name
/ /	
Signed	Witness Signature







# **Lockton Student Accident Protection Plan**





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

Chubb Insurance Australia Limited, Level 38, 225 George Street, Sydney NSW 2000

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PATIENT'S DETAILS Date of birth Full name 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 If yes, give details Was the disability accident related? Yes If yes, give details Date of accident/first symptoms 1 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? Name of patient's usual doctor/medical practice Has the patient had surgery or is it anticipated? Yes If yes, give details Date performed or anticipated Give name of hospital Did you provide other medical services (including pathology) to the patient? Yes If yes, give details Date Services provided Date Services provided 1

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s the patient still disabled?	res No								
fyes, how long will the	patient be:								
Totally disabled (	ınable to return	to their pre-inj	ury education)						
from	1	to	1	1					
Partially disabled	(unable to retu		tial part of their r	ore-intury edu	cation)				
Torday disdoice	/ ,			/					
from	<u>'                                    </u>	to							
partially disabled, what	educational acti	vities could the	patient perform	and how mar	y hours a week?				
			∏ No [	$\neg$					
yes, give deta <b>i</b> s			ا ۱۰۰۰ لسا	i					
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as the patient requested	medical evider	nce for the cur	rent disability to	be issued to	any other	— г	_		
surance company, accid-	ent commission,	, sports body o	r any other insura	ance body?		Yes No			
f yes, give details									
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