



CHUBB INSURANCE COMPANY OF AUSTRALIA LIMITED

A.C.N. 003 710 647

ASFL239778

Level 51, Rialto South Tower, 525 Collins Street, Melbourne Victoria 3000 Australia

Telephone : 61-3-9242 5111 λ Facsimile: 61-3-9629 7417 λ DX: 30973 - Stock Exchange Melbourne

Student Accident Claim Form

Please return this form together with attachments:

STUDENT NAME:

DATE OF BIRTH:

ADDRESS:

SEX:

TELEPHONE:

NAME OF SCHOOL:

GIVE A FULL DESCRIPTION OF THE INJURY SUSTAINED. ALSO DESCRIBE WHERE AND HOW IT OCCURRED:

*NOTE: If student injured during an organised school activity please attach confirmation note from the activity co-ordinator

HAVE YOU EVER PREVIOUSLY SUFFERED FROM THIS TYPE OR SIMILAR TYPE OF INJURY? IF YES, PLEASE PROVIDE FULL DETAILS.

ARE YOU OR YOUR DEPENDANT COVERED BY ANY OTHER GROUP INSURANCE OR GOVERNMENT PLAN:

STATE EXACT DATE WHEN INJURY OCCURRED:

DATE:

TIME:

am/pm

WHEN DID YOU FIRST SEEK MEDICAL TREATMENT?

DATE:

TIME:

am/pm

WHEN DID YOU BECOME TOTALLY UNABLE TO ATTEND SCHOOL?

DATE:

TIME:

am/pm

WHEN WERE YOU ABLE TO RETURN TO SCHOOL?

DATE:

TIME:

am/pm

IF STILL DISABLED, WHEN DO YOU EXPECT TO RETURN TO SCHOOL?

DATE:

TIME:

am/pm

PHYSICIANS OR PROVIDERS NAME, ADDRESS & TELEPHONE NUMBER:

PLEASE ADVISE NAME, ADDRESS & TELEPHONE NUMBER OF USUAL FAMILY PHYSICIAN

ARE YOU COVERED BY PRIVATE HEALTH INSURANCE? No Yes

HAVE YOU CLAIMED YET? No Yes

I hereby authorise any hospital, physician or other person who has treated or assisted me in the treatment of my injury to release any information required by the insurer to assist in the proof and settlement of my claim. A copy of this Authority can be acted upon as if it were original. I hereby declare that I am suffering or have suffered the injury detailed above and warrant the truth of the foregoing particulars in every respect and that if I have made or shall make any false or untrue statement, suppression or concealment, my right to compensation could be forfeited.

DATE: NAME (Please print) SIGNATURE

TO BE COMPLETED BY THE SCHOOL REGISTRAR, BURSAR OR PRINCIPAL

To the best of your knowledge was the student injured as stated? Was the student injured during a school organised activity?

NAME OF SCHOOL Your Position

ADDRESS Phone number

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

SIGNATURE DATE



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Attending Physicians Claim Form

THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION AND COST OF THIS REPORT

PATIENTS NAME & ADDRESS

ARE YOU THE PATIENTS REGULAR PHYSICIAN?

IF SO. HOW LONG HAVE YOU KNOWN THE PATIENT?

WHEN DID THE PATIENT FIRST RECEIVE MEDICAL TREATMENT?

PLEASE GIVE A COMPLETE DIAGNOSIS OF THE CONDITION

WHAT TREATMENT HAS THE PATIENT UNDERGONE?

WAS THE PATIENT CONFINED TO HOSPITAL? IF SO, PLEASE ADVISE NAME & ADDRESS OF HOSPITAL AND ADVISE LENGTH OF CONFINEMENT

WHAT OTHER TREATMENT IS REQUIRED?

WAS THERE A PREVIOUS HISTORY OF THIS OR A SIMILAR CONDITION?

IF YES, PLEASE PROVIDE DETAILS INCLUDING TREATMENT UNDERTAKEN

WHEN WAS THE PATIENT OBLIGED TO CEASE ATTENDANCE AT SCHOOL?

IF THE PATIENT IS STILL UNFIT TO ATTEND SCHOOL, PLEASE ADVISE AN APPROXIMATE RETURN DATE

IF THE PATIENT HAS RECOVERED, PLEASE ADVISE WHEN PATIENT WAS ABLE TO RESUME ATTENDANCE AT SCHOOL

ARE THERE ANY UNDERLYING CONDITIONS AFFECTING RECOVERY FROM THE CURRENT CONDITION? IF YES, PLEASE ADVISE

WHAT IS THE CURRENT PROGNOSIS?

IS THERE ANY ADDITIONAL INFORMATION THAT WILL ASSIST IN THE ASSESSMENT OF THIS CLAIM?

Date Signature Qualifications

Please print your NAME
ADDRESS
PHONE NUMBER