

School Student Accident Report

# Claim Form

**To be completed by the Student or Guardian**

Name of school	Policy Prefix and Number		
Students Full Name	Street Address		
City	State	Postcode	
Date of Birth	Height and Weight	Sex	Telephone

1. Give full description of injury from which you are now suffering. State when, where and how it happened.

	Injury	
	How Sustained	Where
	Full Description	
2. (a) Have you ever had this, or a similar condition, in the past?		
(b) If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Condition(s)  Dates:  Treated By:

3. (a) Give exact date when injury occurred (a) Date / / Time AM / PM

(b) When did you first consult a physician for this condition? (b) Date / / Time AM / PM

(c) When did you become totally disabled (unable to attend school)? (c) Date / / Time AM / PM

(d) When were you able to return school? (d) Date / / Time AM / PM

(e) If still totally disabled, when do you expect your disability to terminate? (e) Date / / Time AM / PM

4. (a) Give names, addresses and telephone numbers of all attending physicians

Names	Addresses	Telephone

(b) Give name, address and telephone number of usual family physician.

Names	Addresses	Telephone

5. Are you covered by Private Health Insurance? YES / NO Have you claimed yet? YES / NO

Give Membership No. and Branch

**To be completed by the Insured School**

I certify that \_\_\_\_\_ is/was enrolled at this school at the time of the injury.

Was the student injured during a school organised activity? YES / NO

Name of school			
Name	Position		
Address	Phone number		

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

Signature	Name			
	Date			
	Witness			

## Information Authority And Warranty

I

hereby authorise any hospital, physician or other person who has attended me/the Insured Person, to furnish Chartis Australia Insurance Limited or its representatives with any hospital and medical reports/notes and/or any information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment). I agree that a Photocopy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that the Chartis relies upon the truthfulness of the particulars supplied by me in respect of the claim.

## Privacy Consent

### I consent to Chartis:

- Collecting and using my personal information for the purposes of administering my claim including investigating, assessing and paying any claim made by me or on my behalf. (If we do not collect this information we may not be able to process your claim.)
- Disclosing my personal information to related entities of Chartis, their staff members located outside Australia, the insured (if not myself), other insurers and reinsurers, insurance reference bureaus, law enforcement agencies, investigators, lawyers, assessors, repairers, advisors and the agent of any of these, insurance broker, insurance agent or other intermediary, my employer or Financial Ombudsman Service Limited (FOS) for the purposes of administering my claim or providing a report.
- I understand that a copy of the Chartis privacy policy statement, including information about access, may be obtained by writing to: The Privacy Manager, Chartis, GPO Box 4363, Melbourne VIC 3001, or by downloading from Chartis website [www.chartisinsurance.com.au](http://www.chartisinsurance.com.au)

Name	<input type="text" value="Please Print"/>	Signature
Date	<input type="text" value=" / /"/>	

## Electronic Funds Transfer (EFT) details

- Do you want the benefit to be deposited directly into a financial institution account via EFT?
  - Name the account is held in:
  - BSB number (6 digits in total)       Financial institution account number (up to 9 digits only)
- (If you are unsure of the BSB number, please contact the financial institution where the account is held.)
- Financial Institution:  Branch:

### Please submit your claim form and supporting documents to:

Chartis Claims Dept.  
GPO Box 4363, Melbourne, VIC 3001

Email: [austclaims@chartisinsurance.com](mailto:austclaims@chartisinsurance.com)  
Facsimile: 61 (3) 9522 4974 Telephone: 1800 339 663

### Alternatively you may choose to lodge your claim on-line at:

[www.chartisinsurance.com.au](http://www.chartisinsurance.com.au)  
(click on the Claims Tab)

**PLEASE KEEP A PHOTOCOPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORD**

## Attending physician's statement of disability

To be completed by your attending physician

The insured is responsible for completion of this form without expense to the company

Patient's Name And Address	<input type="text" value="Name"/>
	<input type="text" value="Address"/>
1. When did patient suffer the injury?	<input type="text"/>
2. What were the circumstances surrounding the injury?	<input type="text"/>
3. When did patient first receive medical treatment?	<input type="text"/>
4. Please give a complete diagnosis of this condition	<input type="text"/>
5. Please give results of any objective findings	
(a) X-Rays	<input type="text"/>
(b) Other Tests — Please advise tests done and findings	1. <input type="text"/>
	2. <input type="text"/>
6. Was patient confined to hospital?	<input type="text" value="YES / NO"/>
If YES please advise: (a) Name and address of hospital	<input type="text"/>
(b) Period of Confinement	From <input type="text" value="/ /"/> To <input type="text" value="/ /"/>
7. What other treatment has patient undergone?	<input type="text"/>
8. What other treatment is required?	<input type="text"/>
<b>History</b>	
1. (a) Was there a previous history of this or a similar condition?	<input type="text" value="YES / NO"/>
(b) If yes, please state condition and advise when previous treatment was given	<input type="text"/>
	<input type="text"/>
2. (a) How long have you known the patient?	<input type="text"/>
(b) Are you the regular general practitioner?	<input type="text" value="YES / NO"/> If not, please advise who is <input type="text"/>
	<input type="text"/>
<b>Degree Of Disability</b>	
1. When was patient obliged to cease school?	<input type="text"/>
2. If Patient is still unfit for school, when approximately will the patient be able to resume?	<input type="text"/>
3. If Patient has recovered, when was patient able to resume school?	<input type="text"/>
Are there any underlying conditions affecting recovery from the current condition?	<input type="text" value="YES / NO"/>
If Yes, please advise nature of underlying conditions and how they affect disability and recovery	<input type="text"/>
	<input type="text"/>
Please advise names and addresses of other treating physicians	<input type="text"/>
	<input type="text"/>
If you have terminated treatment, please advise date	<input type="text" value="/ /"/>
What is the current prognosis?	<input type="text"/>
	<input type="text"/>
Are there any further remarks which may assist in assessing this condition?	<input type="text"/>
	<input type="text"/>
Is there any permanent disability at presents?	<input type="text" value="YES / NO"/>
If YES, please explain giving estimated percentage loss of function	<input type="text"/>
	<input type="text"/>

Date	<input type="text" value="/ /"/>	Signature	<input type="text"/>	Degree	<input type="text"/>
Name (please print)	<input type="text"/>				
Street Address	<input type="text"/>	City/Town	<input type="text"/>	State	<input type="text"/>
Phone No.	<input type="text" value="[ ]"/>				