

# Aon's Student Accident Protection Plan

## School student accident claim form



### PERSONAL DETAILS

Name of school

Student's full name

Street address

City

State

Postcode

Date of birth

Phone

### 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?

Were you involved in school activities at the time of injury?

Yes  No

Full description

(a) Give exact date when injury occurred

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

(c) When did you become totally disabled (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 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

Phone

Address

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

Name  Phone   
( )

Address

*Give names, addresses and telephone numbers of usual family physician.*

Name  Phone   
( )

Address

**3. PRIVATE HEALTH INSURANCE**

Are you covered by private health insurance? Yes  No

*If "yes", name of insurer*

Give membership number and branch

Have you claimed yet? Yes  No  *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 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.

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

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

Date  /  /

Witness

Signed

Signed



Please complete claim form and return to:  
ACE Insurance Limited GPO Box 4065 Sydney 2001  
Phone (02) 9335 3355 Fax (02) 9231 6940  
Email GroupPA.claims@ace-ina.com

