STUDENT ACCIDENT INSURANCE CLAIM FORM
FEDERATION OF PARENTS’ & CITIZENS’ ASSOCIATIONS OF NEW SOUTH WALES

The issue or acceptance of this form is not construed as an admission of liability on the part of the Company. Please print clearly. To avoid delays please ensure all relevant sections are completed.

Section 1
School Name: _____________________________________________ Date of Birth: ____/____/____
Student’s Name: ___________________________________________ Parent/Legal Guardian’s Name: ___________________________________________________________________
Postal Address: ___________________________________________ Postcode: __________
Daytime Telephone Number: ________________________________

Are you claiming for:
☐ Capital/Broken Bone Benefit only
(Complete Sections 1, 2 and 4 only – please include a copy of the x-ray report for fractures, or if applicable, coroner’s report or medical report)
☐ Any Medical Expenses
(Complete All Sections)
☐ Non-Medical Expenses only
(Complete Sections 1.2 and 5 only)
☐ Capital/Broken Bone Benefit and Medical and/or Non-Medical Expenses
(Complete All Sections)

Section 2
Date and Time of injury: ______________________________________
What is the injury? _______________________________________________________________________________________
Location where injury occurred: ___________________________________________________________________________
What was the student doing at the time of the injury? _______________________________________________________________________________________
How did the injury occur? ___________________________________________________________________________________
Was this a school activity? ________________________________________________________________________________

Section 3
Does the student have other private health cover? ________________ Type of Cover: _________________________________
Name & Phone number of initial Medical Attendant _______________________________________________________________________________________
Name & Phone number of your regular Medical Attendant ___________________________________________________________

I authorise any doctor or medical attendant who has treated or examined the student to give the underwriter any information it requires in relation to this claim, to assist in the proof and settlement of any claim. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

Parent/Legal Guardian Signature: ___________________________________________ Date: ____/____/____

Payment Authority: I hereby authorise payment of any benefits be made payable to: _____________________________________________
__________________________________________ Date: ____/____/____

Parent/Legal Guardian Signature: ___________________________________________ Date: ____/____/____

Please send completed Claim form to:

Sydney
Level 4, 33 York Street
SYDNEY NSW 2000
GPO Box 4213, SYDNEY NSW 2001
T: +61 2 9251 8700
F: +61 2 9251 8755

ABN 26 053 335 952
AFS Licence No:238261
Email: enquiries@acchealth.com.au
Website: www.acchealth.com.au
Freecall 1800 618 700
Freex 1800618 755
Section 4 - MEDICAL CERTIFICATE

If you are unable to answer any of the questions below, please indicate.

Describe Injury______________________________________________________
______________________________________________________________________

When did you first treat the student for this condition?
______________________________________________________________________

Since when has this condition (in your opinion) been in existence? ___/___/____

Has the student previously suffered from the same or a similar injury?

No ☐  
Yes ☐  Date: ___/___/____

Diagnosis______________________________________________________________
______________________________________________________________________

Are there or do you envisage any complications?

No ☐  
Yes ☐ Give details
______________________________________________________________________

Are the student’s symptoms due or traceable exclusively to this injury?

No ☐  
Yes ☐

Is there anything in the student’s medical history which may have contributed directly or indirectly, to the injury or which may be likely to retard the student’s recovery?

No ☐  
Yes ☐ Give Details
______________________________________________________________________

Name of operation (if any)

______________________________________________________________________

If hospitalised, give dates

From ___/___/____ to ___/___/____

Name of Hospital_______________________________________________________
______________________________________________________________________

Have you any reason to suppose that the student was under the influence of intoxicants at the time of the accident?

No ☐  
Yes ☐

When did you release student to return to school (if applicable)?
______________________________________________________________________

In your opinion, probable further disability should not exceed ______Weeks ______Months

Name of Attending Physician (Please Print)
______________________________________________________________________

Signature_____________________Date___/____/____

Qualifications
______________________________________________________________________

Address
______________________________________________________________________
NON-MEDICARE MEDICAL EXPENSES
NOTICE TO CLAIMANTS

PLEASE READ PRIOR TO SUBMITTING YOUR CLAIM FOR ANY MEDICAL EXPENSES

If you are claiming reimbursement for Medical, Tuition, Clothing or Emergency Transport Expenses, please complete the schedule over page. If you are claiming the “gap” from Accident & Health, you must first seek reimbursement from Medicare and submit the Medicare Benefit Statement and accounts with your claim. For reimbursements for Medical Expenses, please read the following information carefully:

We advise that the Student Accident Policy will cover 85% of non-Medicare Medical Expenses to a maximum of $5,000.00 (after the deduction of $50.00 excess) for injuries which occur during school time or school organised activities. The policy will cover fees incurred as a result of injury including, but not limited to fees paid to registered medical practitioners, nurses, chemists, hospitals, chiropractors, osteopaths and physiotherapists. Please note that you are expected to settle accounts first, then seek reimbursement, however if hospitalisation is involved and the fees large, prior arrangement must be made if you wish accounts to be settled directly.

We advise that this company must comply with legislation that limits the benefits Health Funds (and others) are legally allowed to insure. Like health insurers, we are not entitled to provide 100% reimbursements on medical expenses that are covered by the Medicare Scheme.

We can pay:

✔ 100% of Theatre Fees & Accommodation Fees in a hospital where the Insured Person is a private patient in a public or private hospital.
✔ Any other medical expenses which are in no way covered by Medicare.

We cannot pay:

✗ Any out of hospital or outpatient expenses which have a Medicare component.
✗ Any amount above the Scheduled Fee.
✗ When you are a public patient in a private or public hospital. Everything is covered by Medicare in this circumstance.
✗ The Emergency ward charges of a Private Hospital are not considered to be an “in-hospital” expense. Therefore it is deemed out of hospital and we cannot pay any benefit. (When you are admitted as a full patient, the normal restrictions apply as outlined above.)
✗ Pharmaceuticals in the Pharmaceutical Benefits Scheme (PBS).
✗ Specifically, for out of hospital GP or specialist Doctor visits, Medicare refunds 85% of the Scheduled Fee. No-one can reimburse any other amount for these expenses.

Examples

<table>
<thead>
<tr>
<th>Medical Service</th>
<th>Amount Charged</th>
<th>Scheduled Fee</th>
<th>Medicare Pays</th>
<th>We Pay 85%</th>
<th>Insured Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Hospital Accommodation</td>
<td>$400.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$340.00</td>
<td>$60.00</td>
</tr>
<tr>
<td>Hospital Doctor Consultation</td>
<td>$92.00</td>
<td>$62.85</td>
<td>$53.45</td>
<td>$0.00</td>
<td>$38.55</td>
</tr>
<tr>
<td>GP Consultation out of hospital (no bulk billing)</td>
<td>$36.00</td>
<td>$24.50</td>
<td>$20.85</td>
<td>$0.00</td>
<td>$15.15</td>
</tr>
</tbody>
</table>

Please note that where a Private Health Fund has reimbursed the “gap, no further reimbursement is available.

Further information on these limitations should be available at government offices on Health and Family Services.
Reimbursement is calculated as follows:

**A – D** in the case of no Medicare component

**B – C** in the case of an “in-hospital” expense, this is known as the “gap”.

Please note that in the case of a “gap” being paid by your Health Fund, no further benefit is claimable from Accident & Health International.