

# Student Accident Claim Form



## Details

Queensland University of Technology

Policy Number AGPA 002874QLD

Student's full name \_\_\_\_\_

Student ID Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone (\_\_\_\_)

## 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 was it sustained \_\_\_\_\_

Where \_\_\_\_\_

Full description \_\_\_\_\_

(a) Give exact date when injury occurred

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(c) When did you become totally disabled (unable to attend school)?

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(d) When were you able to return to school?

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(e) If still disabled, when do you expect your disability to terminate?

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(f) Have you ever had this, or a similar condition in the past?

No  Yes

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 \_\_\_\_\_

Address \_\_\_\_\_

# Student Accident Claim Form



\_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

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

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**3. Are you covered by private health insurance?**

No  Yes If 'yes', name of insurer \_\_\_\_\_

Give membership no. and branch \_\_\_\_\_

Have you claimed yet?

No  Yes

If 'yes' please submit a Statement of Benefits from your private health insurer.

**Please note, this policy does not cover the Medicare Gap**

## Authorisation

I hereby authorise any hospital, physician or other person who has attended to me to furnish ACE Insurance 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.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (please print) \_\_\_\_\_

Relationship to student \_\_\_\_\_

Signed \_\_\_\_\_

## To be completed by the University

Please ensure that all questions have been fully answered.

I certify that (insert student name) \_\_\_\_\_

\_\_\_\_\_ was injured as stated.

Name of University \_\_\_\_\_

Name \_\_\_\_\_

Position \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

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

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness \_\_\_\_\_

# Medical Practitioner's Statement



The claimant is responsible for any fee for this statement.

Patient's full name \_\_\_\_\_

## Patient's details

\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

## Diagnosis

(If fracture or dislocation, describe nature and location i.e. simple, compound)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the patient have any other injury that is contributing to the condition?

No  Yes, give details

\_\_\_\_\_  
\_\_\_\_\_

Was the disability accident related?

No  Yes, give details

\_\_\_\_\_  
\_\_\_\_\_

Date of accident/first symptoms

\_\_\_\_/\_\_\_\_/\_\_\_\_

When did the patient first consult you for this condition?

No  Yes, give details

How long have you been the patient's usual doctor/medical practice?

\_\_\_\_\_ years

Name of patient's usual doctor/medical practice

\_\_\_\_\_  
\_\_\_\_\_

Has the patient had surgery or is it anticipated?

No  Yes, give details

\_\_\_\_\_

Date performed or anticipated \_\_\_\_/\_\_\_\_/\_\_\_\_

Give name of hospital \_\_\_\_\_

\_\_\_\_\_

Did you provide other medical services (including pathology) to the patient?

No  Yes, give details

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the patient referred by you or to you?

No  Yes, give details

Please provide name and address of referring doctor

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Date of referral \_\_\_\_/\_\_\_\_/\_\_\_\_



# Medical Practitioner's Statement

**Is the patient still disabled?**

No  Yes, if yes, how long will the patient be:

- Totally disabled (unable to return to their pre-injury education)

From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

- Partially disabled (unable to return to a substantial part of their pre-injury education)

From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

If partially disabled, what education activities could the patient perform and how many hours a week?

No  Yes, if yes, how long will the patient be:

- Totally disabled (unable to return to their pre-injury education) from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

- Partially disabled, what educational activities could the patient perform and how many hours a week?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Hours per week \_\_\_\_\_

**Has the patient ever had the same or similar condition?**

No  Yes, give details: \_\_\_\_\_

\_\_\_\_\_

Name of company and claim number \_\_\_\_\_

\_\_\_\_\_

Contact name and telephone number \_\_\_\_\_

\_\_\_\_\_

**Remarks**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature**

Signature of medical practitioner \_\_\_\_\_

Name (*in print*) \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Qualifications \_\_\_\_\_

Street Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_