Student Accident Claims are managed by the insurer AIG Australia Limited (formerly Chartis).

Completed claim forms and supporting documentation should be submitted, preferably by email, to the following address – Please keep a copy of documents submitted:

Email: WillisPA@aig.com

Please Note (in relation to Non Medicare Medical and Dental Expenses):

- Before returning the completed claim form with attachments all invoices must be presented to Medicare and/or Private Health Fund, or other applicable insurance (Registered Club or Association) before you present the invoices to the Student Accident insurer Chartis.

- Health Insurance Act (Cth) 1973 prevents insurers from paying medical expenses which are subject to full or partial rebate from Medicare, including the Medicare Gap.

- Legislation (Private Health Insurance Act 2007) means that insurers can only pay Non-Medicare Medical Expenses (including Dental Expenses) resulting from injuries to Students who are:
  - Taking part in organised sporting and youth activities
  - Participating in activities organised and supervised by the school

- The Policy provides cover for expenses incurred for a period of 24 months from the date of the accident / injury.
# School Student Accident Report

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

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

### 1. Injury Details

**Injury**

<table>
<thead>
<tr>
<th>How Sustained</th>
<th>Full Description</th>
<th>Where</th>
</tr>
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</table>

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

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

3. (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 school?
   - (e) If still totally disabled, when do you expect your disability to terminate?

4. (a) Give names, addresses and telephone numbers of all attending physicians.
   - (b) Give name, address and telephone number of usual family physician.

5. Are you covered by Private Health Insurance?  Yes  No  Have you claimed yet?  Yes  No

**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**

**Date**

**Witness**
Information Authority and Warranty

I hereby authorise any hospital, physician or other person who has attended me/the Insured Person, to furnish AIG Australia 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 AIG relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Privacy Consent:

I consent to AIG:

(a) 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.)

(b) Disclosing my personal information to related entities of AIG, 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.

(c) I understand that a copy of the AIG privacy policy statement, including information about access, may be obtained by writing to: The Privacy Manager, AIG, GPO Box 4363, Melbourne VIC 3001, or by downloading from AIG website www.aig.com.au

Name [Please Print]
Date / / 
Signature

Electronic Funds Transfer (EFT) details

1. Do you want the benefit to be deposited directly into a financial institution account via EFT? ☐ Yes ☐ No

2. Name the account is held in: ____________________________

3. 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.)

4. Financial Institution: ____________________________ Branch: ____________________________

Please submit your claim form and supporting documents to:

AIG Claims Dept.
GPO Box 4363, Melbourne, VIC 3001
Email: austclaims@aig.com
Facsimile: 61 (3) 9522 4974   Telephone: 1800 339 663

Alternatively you may choose to lodge your claim on-line at: www.aig.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

Name

Address

1. When did patient suffer the injury?

2. What were the circumstances surrounding the injury?

3. When did patient first receive medical treatment?

4. Please give a complete diagnosis of this condition

5. Please give results of any objective findings
   (a) X-Rays
   (b) Other Tests - Please advise tests done and findings

6. Was patient confined to hospital?  
   Yes  No
   If YES please advise:
   (a) Name and address of hospital
   (b) Period of Confinement
       From / / To / /

7. What other treatment has patient undergone?

8. What other treatment is required?

History

1. (a) Was there a previous history of this or a similar condition?  Yes  No
   (b) If yes, please state condition and advise when previous treatment was given

2. (a) How long have you known the patient?
   (b) Are you the regular general practitioner?  Yes  No
   If not, please advise who is
Attending physician’s statement of disability (continued)

Degree Of Disability

1. When was patient obliged to cease school?

2. If Patient is still unfit for school, when approximately will the patient be able to resume?

3. If Patient has recovered, when was patient able to resume school?

Are there any underlying conditions affecting recovery from the current condition? ☐ Yes ☐ No

If Yes, please advise nature of underlying conditions and how they affect disability and recovery

Please advise names and addresses of other treating physicians

If you have terminated treatment, please advise date / /

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Is there any permanent disability at present? ☐ Yes ☐ No

If YES, please explain giving estimated percentage loss of function

Date / / Signature __________________________ Degree __________________________

Name (Please print) __________________________

Street Address __________________________

City or Town __________________________ State __________________________

Phone No [ ] __________________________

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