**School Student Accident Report**

### Claim Form

**Complete and return as soon as possible**

<table>
<thead>
<tr>
<th>Name of school</th>
<th>Policy Prefix and Number</th>
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<table>
<thead>
<tr>
<th>Students Full Name</th>
<th>Street Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Postcode</th>
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<tr>
<th>Date of Birth</th>
<th>Height and Weight</th>
<th>Sex</th>
<th>Telephone</th>
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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.

<table>
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<tr>
<th>Names</th>
<th>Addresses</th>
<th>Telephone</th>
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5. Are you covered by Private Health Insurance? YES / NO
   Have you claimed yet? YES / NO

Give Membership No. and Branch

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Information Authority And Warranty

I hereby authorise any hospital, physician or other person who has attended me / the Insured Person, to furnish Chartis 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:

(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 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.

(c) 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, 549 St Kilda Road, Melbourne VIC 3004, or by downloading from Chartis website www.chartisinsurance.com.au

Please ensure that all questions have been fully answered

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

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

Please Print

/ /
# 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

<table>
<thead>
<tr>
<th>Patient's Name And Address</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
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<tr>
<td>Address</td>
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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?  
   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?  
   (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?  
       If not, please advise who is |  |

## 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?  
   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 presents?  
If YES, please explain giving estimated percentage loss of function |  |
<table>
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<tr>
<th>Date</th>
<th>/   /</th>
<th>Signature</th>
<th>Degree</th>
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| Name (please print) |  |  |  |

| Street Address |  | City/Town |  | State |
|-----------------|  |-----------|  |------|

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<th>Phone No.</th>
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