The Essington School Darwin Student Accident Insurance

Notice of Claim

Student Personal Accident & Injury

Policy Number: 04P0007724SA

Student Accident Claim Form – The Essington School Darwin

NOTIFICATION OF A CLAIM OR CIRCUMSTANCE THAT MAY GIVE RISE TO A CLAIM

YOUR INFORMATION

School Name: THE ESSINGTON SCHOOL DARWIN LTD

Student Name: _____

Full Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Parent/Guardian Name: _____

Telephone Mobile: _____ Telephone Work: _____

Email Address: _____

School Contact: _____

School Address: 19 CHRISP STREET RAPID CREEK NT 0810 Telephone Number: 8985.0100

ACCIDENT

Location where accident occurred: _____

Date & time of accident: _____

Please describe how the injury/accident occurred:

Please advise the extent of the student's injuries:

Has the student previously been treated for serious injury? ☐ Yes ☐ No

If yes, please provide full details including how long the student was away from school:

TREATMENT

Was Emergency Transportation required? eg. Ambulance ☐ Yes ☐ No

When did the student first obtain treatment from a doctor? Date: _____ Time: _____

Name of Treating Doctor: _____

Address of
Treating Doctor: _____

Is this doctor still treating the student for the injury? ☐ Yes ☐ No

Is this doctor the student's regular doctor? ☐ Yes ☐ No

If no, please provide name and address of the student's regular doctor.

Name: _____

Address: _____

Is the student covered by Private Health Insurance? Hospital ☐ Yes ☐ No Extras ☐ Yes ☐ No

If yes, please provide name and membership number:

Name: _____ Membership Number: _____

Have you claimed medical expenses under Private Health Insurance? ☐ Yes ☐ No

(If you are a member of a Private Health Insurance Fund please lodge your claim prior to submitting this accident claim.)

Is there any condition past or present affecting the student's current disability? ☐ Yes ☐ No

If yes, please provide details:

AUTHORITY TO GIVE INFORMATION

I/we hereby authorise any doctor or medical attendant who has treated _____ *(insert student name)* to give the insurer such information as it may require regarding any injury or illness or physical or mental condition or prognosis, to assist in the proof and settlement of my claim. A photocopy of this authority can be acted upon as if it were original.

_____ _____

Signature of Parent or Guardian Date

CERTIFICATE OF ATTENDING PHYSICIAN

To be completed by attending physician.

The claimant must obtain, at his/her own expense, the completion of this certificate from a duly qualified and registered medical practitioner. In the event of the medical practitioner being unable to answer from their own personal knowledge any of the following questions, they are requested to state so.

Furnished in connection with the disability of:

Name of Patient: _____

Full Address: _____

Are you the patient's regular physician? ☐ Yes ☐ No

If yes, how long have you known the patient? (years & months)

_____

Has the patient previously suffered from the same or similar injuries/sicknesses? ☐ Yes ☐ No

If yes, provide the date and diagnosis:

Date of first consultation of this condition: _____

In your opinion, how long has this condition been in existence whether treated for same or not?

Present Condition:

Prognosis:

Nature of operation (if any):

Name of physician(s) who previously treated patient for the above condition:

Are the patient's symptoms:

Due exclusively to the accident? ☐ Yes ☐ No

Traceable to disease? ☐ Yes ☐ No

Infirmity or any other cause? ☐ Yes ☐ No

Is there anything in the patient's medical history which may have contributed, directly or indirect, to the injury/illness or which may be likely to impede the patient's recovery? ☐ Yes ☐ No

If yes, please provide details:

Is the patient still under your care for this condition? ☐ Yes ☐ No

If no, on what date did you release the patient to return to school?

_____

Dates unfit for school, or unable to perform specific parts of the patient's occupation? *(if uncertain please estimate)*

_____

Have you any reason to suppose that the patient was under the influence of intoxicants or drugs at the time of the accident? ☐ Yes ☐ No

If hospitalised, please provide dates: _____

Name of hospital: _____

Dates patient was totally disabled: _____

In your opinion, probable further disability should not exceed past the following date:

_____

Name of Physician: _____

Full Address: _____

Office Phone Number: _____ Mobile Phone Number: _____

Qualifications:

_____

_____ _____

Signature of Physician Date

ELECTRONIC FUNDS TRANSFER (EFT) DETAILS:

Following approval of your claim, should you wish to have your claim transferred directly into your bank account, please provide the following details:

Name of Financial Institution: _____

Account Name: _____

BSB: _____ Account Number: _____

Please note that we are not liable for any bank processing fees incurred by you.

PARENT OR GUARDIAN DECLARATION

I hereby declare, for and on behalf of the Insured that the foregoing statements are true and correct:

Name: _____ Relationship to student: _____

Signature: _____ Date: _____