



Accident & Health

Student Accident Claim Form – Independent Schools of Victoria

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

YOUR INFORMATION

Policy Number: **47-ZAH-4204-01**

School Name: _____

Student Name: _____

Full Address: _____

Date of Birth: _____ Sex: Male Female

Parent/Guardian Name: _____

Telephone Mobile: _____ Telephone Work: _____

Email Address: _____

School Contact: _____

School Address: _____ School Telephone Number: _____

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: _____

SCHOOL DECLARATION

I certify that _____ is/was enrolled at _____ school at the time of the injury. I hereby certify that the particulars shown on this form are, to the best of my belief and knowledge, true and correct.

Name: _____ Position: _____

Signature: _____ Date: _____

Please include a copy of the student's incident report form.

Email: ahclaimsaustralia@bhspecialty.com

Phone: 1300 380 377

Mail: Berkshire Hathaway Specialty Insurance
GPO Box 650
Sydney NSW 2001

About Us

We are Berkshire Hathaway Specialty Insurance Company (ABN 84 600 643 034, AFS Licence No. 466713), authorised by the Australian Prudential Regulation Authority to carry on general insurance business in Australia.

Privacy

We are committed to safeguarding your privacy and the confidentiality of your personal information. We, and entities acting on our behalf, only collect personal information from or about you for the purpose of assessing your application for insurance and administering your insurance policy, including managing and administering any claim made by you. Without your personal information, we may not be able to issue insurance cover, administer your insurance or process your claim.

We will only use your personal information in accordance with the *Privacy Act 1988* (Cth) and for the purposes outlined above.

We may disclose your personal information to third party service providers for the purposes outlined above or where disclosure is permitted by law. These entities may be located in Australia or overseas, including in India, Singapore, Hong Kong, the United Kingdom, New Zealand and the United States of America. Where such disclosure is made, we make all reasonable efforts to ensure that the arrangements we have in place with overseas parties impose appropriate privacy and confidentiality obligations on those parties to ensure that imparted personal information is kept secure and that such information is only used for the purposes noted above.

If you wish to obtain details of the personal information we hold about you (including contacting us to correct or update the personal information we hold about you), or if you have a complaint about a breach of your privacy, please refer to our privacy policy available at <http://www.bhspecialty.com/privacy-policy.html>, or contact our Chief Risk Officer by email to australasia.privacy.compliance@bhspecialty.com.

We reserve the right to refuse access under the grounds permitted by the *Privacy Act 1988* (Cth) and if you are seeking information on another person's behalf, we will require written authorisation from that individual.

Complaints

If you have a complaint or concern about our insurance products or services we provide, please contact your intermediary or your usual BHSI contact.

If you are not satisfied with our response, you may escalate your complaint by contacting complaints.australia@bhspecialty.com. Our internal dispute resolution process is free of charge and we will aim to respond to your escalated complaint within fifteen (15) business days.