

Student Claim Form

Important: Please read before you complete this form

1. Please ensure Section 6 is signed and dated.
2. Please ensure Section 7 is completed, signed and dated by an authorised representative
3. Please ensure Section 8 – Doctor's Statement is completed by a qualified medical practitioner
4. Please scan and email the claim documentation to Arch Insurance at ahclaims@archinsurance.com.au
5. The issue of this form is not an admission of liability.

Please note you may be required to provide additional supporting information to assist with the assessment of your claim. For your specific claim, this information is including, but not limited to:

Medical and Additional Expenses

- Medical Certificate and Reports
- Original Medical Receipts
- If applicable, information from your private health insurer

Please note we are strictly prohibited to cover any expenses that have incurred a Medicare rebate. The Health Insurance Act 1973 (Cth) strictly prohibits any general insurer from covering any item that is listed on the Medicare Benefits Schedule. This also means that regardless of your out of pocket expenses, it is against the law for the Insurer to cover you for the Medicare Gap.

Arch Underwriting at Lloyd's (Australia) Pty Ltd

Sydney: Level 10, 155 Clarence Street, Sydney NSW 2000 | **P:** +61 2 8284 8400 **F:** +61 2 8088 1024

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archinsurance.com.au

Section 1: Policy and Personal Information

Policy Holder		Policy Number
Student Given Name(s)		Gender
Student Family Name		Date of Birth
Student Grade/Year		
Parent/Guardian Given Name(s)		
Parent/Guardian Family Name		
Residential Address		
Suburb	State	Postcode
Parent/Guardian Email Address		
Daytime Contact Number		Alternative Number
School/College/University Name		
School/College/University Contact Name (Title)		
Contact Email Address		Contact Number

Section 2: Electronic Funds Transfer (EFT) authorisation

I/We direct that the settlement money be paid to the nominated bank account as follows:

AUSTRALIAN BANK DETAILS

BSB Number:	Account Number:
Account Name:	Name of Bank:

INTERNATIONAL BANK DETAILS

Bank Name:	
Bank Address:	
Account Number:	IBAN:
Sort/Branch Code:	Swift Code:
Account Name:	Account Currency (International Payments):

Important: Arch shall not be liable for any losses incurred by you, as a result of you providing Arch with an incorrect bank account number under this section for the payment of this claim.

Section 3: Details of Incident

Date of Incident (DD/MM/YYYY)

Time of Incident (HH/MM) (AM/PM)

Location of incident

- ☐ Home ☐ School ☐ Excursion ☐ Road
- ☐ Sports Venue (School) ☐ Sports Venue (other) ☐ Other (please give details below)

Address

Suburb

State

Postcode

Incident occurred during

- ☐ School Hours ☐ Before School ☐ After School ☐ Holiday/Public Holiday
- ☐ Weekend

Please describe the event/incident that occurred

Please provide any additional comment in relation to this claim

Section 4: Medical Details

Was Emergency Transportation required? Eg. Ambulance

☐ Y ☐ N

Date of First Medical Consultation. (DD/MM/YYYY)

Date of First Treatment (DD/MM/YYYY)

Name of current Usual Doctor + Clinic

Telephone number

Email Address

Clinic Name/ Address:

Is the student covered by Private Health Insurance?

☐ Y ☐ N

If Yes, please provide details including:

Name:

Membership Number:

Type of cover (eg Hospital/Extras)

Please state the diagnosis(es) of your claimed condition:

Please state the symptoms of your claimed condition:

Have you previously been treated from a similar or same injury

☐ Y ☐ N

If yes, please give details

Has the student previously been treated for serious injury:

☐ Y ☐ N

If yes, please provide full details:

Section 5: Medical and Additional Expenses

- Medical Receipts will be required to accompany this section.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the curtailment of the journey.
- All medical and hospital accounts Incurred within Australia must first be submitted to your private health fund if applicable, If the limit has been reached on your private health fund for the specified service, we will require documentation from the health fund confirming the same.
- Please note we are strictly prohibited to cover any expenses that have incurred a Medicare rebate. The Health Insurance Act 1973 (Cth) strictly prohibits any general insurer from covering any item that is listed on the Medicare Benefits Schedule. This also means that regardless of your out of pocket expenses, it is against the law for the Insurer to cover you for the Medicare Gap.

Date of expense	Treatment	Cost of treatment	Medicare Rebate	Private Health contribution	Amount being claimed (please state currency)

Please attach separate sheet if insufficient space above*

Section 6: Privacy Notice, Medical Authority and General Authority

Privacy Notice

We collect, use and handle your personal information in accordance with our Privacy Policy found at <https://insurance.archgroup.com/divisions/international/australia/privacy-and-data-protection-australia/>, or you can request a copy by our contact details:

*Arch Underwriting at Lloyd's (Australia) Pty Ltd,
Level 10, 155 Clarence Street
Sydney, NSW, 2000*

or by telephone at (02) 8284 8400

or by email: info@archinsurance.com.au

Medical Authority

I understand that by investigating my claim or by accepting proof of my claim, Arch has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Arch using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to Arch's Privacy Policy and this document.

I/We hereby authorise any hospital, medical practitioner, and any other person or entity who has attended to or examined me, to provide Arch with copies of medical records (including but not limited to consultations, prescriptions, treatment, hospital records, reports, medical correspondence) as requested.

General Authority

I understand that, by investigating my claim or by accepting proof of my claim, Arch has made no acceptance of liability nor waived any of its rights.

I authorise Arch to collect, use and disclose my personal and financial information to any insurer, insurance broker, employer, financial institution, government body or other person or entity, for the purpose of assessing and administering my/our claim.

I authorise any such party to provide Arch with information and documents relevant to my claim, including but not limited to:

- details of insurance policies held (current or past);
- claims made, benefits paid or payable, and policy terms;
- financial information including earnings, employment and business activities; and
- any other information required to verify my/our entitlement to benefits or determine concurrent insurance.

I understand this authority is provided in accordance with Arch's Privacy Policy and the Privacy Act 1988 (Cth). I acknowledge that if I do not consent to this authority, Arch may be unable to process or assess my claim.

This authority remains valid for the duration of the claim unless revoked by me in writing. A copy of this authority shall be as effective as the original.

Declaration

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I will use my best endeavours and render all reasonable assistance and cooperation to Arch in the assessment of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, Arch may not be able to process or assess my claim.

Parent or Guardian Declaration

Name or Parent/Guardian:

Signature or Parent/Guardian:

Date: (DD/MM/YYYY)

Section 7: Education Provider Declaration

To be completed by the School/College/University

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

Policy Number

Policy Holder Name

School/College/University Name

School/College/University Phone

Email Address

Contact Name

Contact Title

Period of Cover

Do you consider that the information provided by the parent/guardian to be accurate?

☐ Y ☐ N

If no, please comment on the discrepancies below:

If yes, please provide any additional comment in relation to this claim

Name of Authorised Representative

Signature of Authorised Representative

Date: (DD/MM/YYYY)

Section 8: Doctor's Statement

To be completed by your treating doctor

The claimant is responsible for any fee for this statement. This form should be FULLY completed and returned promptly.

Patients Name:

DOB:

Please state the patient's diagnosis(es) and symptoms

Cause:

Date of onset/first symptoms? (DD/MM/YYYY)

When did the patient first consult you/your clinic for this claimed condition? (DD/MM/YYYY)

Has the patient ever had the same or similar condition?

Y N

If yes, please advise when and the diagnosis: (DD/MM/YYYY)

Is there anything in the patient's medical history which may have contributed, directly or indirect, to the injury/illness or which may likely impact the recovery?

Y N

If yes, please provide details

If the patient has been hospitalised, please provide the name of the hospital and dates/periods they have been admitted

Has the patient been referred to a specialist?

Y N

If yes, please provide the name, specialty, address, phone number and date of referral of the specialist:

Please comment on your patient's overall prognosis:

Please comment on their expected recovery in the next 3, 6 and 12 months

Signature of Medical Practitioner

Qualifications (please print)

Telephone number

Clinic Name/ Address

Email Address

Date
