Student Accident Claim Form

Important: Please read before you complete this form

1. Please ensure Section 6 – Privacy Statement, Declaration and Medical Authority is signed and dated.
2. Please ensure Section 7 – Declaration (to be completed by School/College/University) is completed and signed 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 a&hclaims@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

Arch Underwriting at Lloyd's (Australia) Pty Ltd

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Section 1: Personal Information

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

Section 2: Policy Details

Policy Holder Policy Number

School/College/University Name

School/College/University Contact Name (Title)

Contact Email Address Contact Number

Section 3: Electronic Funds Transfer (EFT) authorisation and GST information

Please provide bank and account details for payment. For security purposes, Arch will contact you to verify the EFT details provided.

BSB Number (6-Digits)	Account Number	Account Holders Name	Bank

Section 4: Incident Details

Date of Incident

Time of Incident

Location of incident

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

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 5: Medical information

Was Emergency Transportation required? Eg. Ambulance Y N

Date of First Medical Consultation Date of First Treatment

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	Medical and/or Hospital Expenses	Amount Claimed (Please state currency)
		Total Amount Claimed:

Please attach separate sheet if insufficient space above*

Section 6: Privacy Statement, Declaration and Medical Authority

Privacy Statement

I/We agree that, by signing this form, the personal information I/we provide to Arch may be collected, held, used and disclosed in the manner set out in the Arch Privacy Statement found at www.archinsurance.com.au, including for the processing of this claim.

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.

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: 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?

When did the patient first consult you/your clinic for this claimed condition?

Has the patient ever had the same or similar condition? Y N

If yes, please advise when and the diagnosis:

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

