



## Accident & Health

### Student Accident Claim Form – National Independent Schools

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

#### YOUR INFORMATION

Policy Number: **47-ZAH-4202-04**

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.*

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## 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.*

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**Email:** [ahclaimsaustralia@bhspecialty.com](mailto:ahclaimsaustralia@bhspecialty.com)

**Phone:** 1300 380 377

**Mail:** Berkshire Hathaway Specialty Insurance  
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### 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](mailto: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](mailto: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.