Student Accident Protection Plan
Claim Form

This form should be completed and returned to us via email (claims@acsfinancial.com.au) , facsimile (1300 881 552) or post.

Please note: Federal Legislation prohibits us from contributing to out of pocket expenses against Medicare eligible services.

In the case of no Medicare component Please note: In the case of a "Medicare gap" being paid by your Health Fund, no further benefit is claimable through the insurer.

Section A. School Details (Please use BLOCK letters)

School Name:

School Postal Address: | Suburb: | State: | Postcode

Phone (BH): ( ) | Fax: ( )

Declaration

I certify that (insert student's full name) _____ was injured on date: DD / MM / YYYY whilst in the care of our school.

Signature | **Date:** DD / MM / YYYY

Name: | Position Held:

Email: | Mobile:

Section B. Student Details (Please use BLOCK letters)

1. Student Details

Name: | Date of Birth: DD / MM / YYYY

Address: | Suburb: | State: | Postcode

2. Parent/Guardian Details

Title: | Name: | Relationship:

Postal Address (if different from above): | Suburb: | State: | Postcode

Phone (BH): ( ) | Mobile:

Email:

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3. Bank Details

Bank: | Branch: | Swift Code:

BSB | Account No.: | Account Name:

4. Private Health Insurance

Are you covered by private health insurance: ◯ Yes ◯ No

If 'yes', name of insurer: | Account No.:

Have you claimed yet? ◯ Yes ◯ No If 'yes' please submit a Statement of Benefits from your private health insurer.

If 'no' please submit a claim to your Private Health Insurer and provide us with their Statement of Benefit.

Section C. Injury Details

1. Injury date and nature

Date of injury: DD / MM / YYYY | Nature of injury:

2. Cause and location of injury

Cause of injury:

Address where injury occured: | Suburb: | State: | Postcode

3. Activity which caused this injury

Were you involved in school or organised sporting activities when you were injured? ◯ Yes ◯ No

4. Attending Physician information

Postal Address: | Suburb: | State: | Postcode

Date of of first appointment: DD / MM / YYYY

5. Medical History

Have you ever had this or a similar condition in the past? ◯ Yes ◯ No

If yes, please advise us of the nature of the condition, date(s) of the treatment, name(s) and address(es) of treating doctor(s), hospital(s) and clinic(s). Use separate page if required.

Condition(s): | Date: DD / MM / YYYY

Treated by: | Name of Hospital/Clinic:

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Section D. Privacy Statement

ACS Financial Pty Ltd (ACN 062 448 122) (AFSL 247388) (ABN 91 460 778 961) ("ACS Financial") ("we"/"us") is committed to ensuring the confidentiality and security of your personal information.

We are bound by the Australian Privacy Principles ("APPs") under the Privacy Act 1988 (Cth) regarding the way we handle your personal information.

We have implemented a Privacy Policy, under the APPs, which explains how we collect, hold, use and disclose your personal information, and how you can access and/or correct that information. Nothing in this policy limits any of our obligations at law.

You can obtain a copy of the 'ACS Group Privacy Policy' by calling 1800 646 777 or by downloading a copy at www.acsfinancial.com.au/customer-support - Privacy Policy.

Your personal information is collected for the purposes set out in the ACS Group Privacy Policy and is relevant to any recommendation that you acquire or offer to arrange for the issue of an insurance policy or a mutual protection to you as well as the amount of your premiums or contributions or the assessment of any claims made by you or your personal representative. If you do not provide the full information that we request and disclose every matter that you know or could reasonably be expected to know, we may be unable to assist you with your application or if you accept insurance cover and/or mutual protections you may be in breach of your Duty of Disclosure.

Ensure that you seek permission from individuals before you provide us with their personal information, and let them know about this Privacy Statement and how they can contact us if they want to access or correct information we hold about them.

We do not trade, rent or sell your personal information. We may use your personal information to provide you with information about other products, services and special offers. If you do not want your personal information used in this way, please write or email ACS Insurance Services with your opt-out request and we will arrange accordingly.

Section E. Declaration

Declaration

I/We declare that:

- the information I/we have provided is true, complete and correct to the best of my/our knowledge, and I/we will inform ACS Financial should any of this information change in the future;
- the information I/we have provided includes every matter known to me/us that is relevant to the claim;
- I/We are duly authorised to act for and on behalf of the above-named organisation and have completed this form on behalf of it and all those who may be entitled to indemnity/Protection, after due enquiry of all directors or office bearers and senior staff;
- I/We authorise ACS Financial to obtain from or give to any insurer or ACS Mutual Limited (ACN 162 909 346) or insurance reference bureau or credit reporting agency any personal information relating to this or other insurance cover/Protection relating to me or the above-named organisation including claims or credit history; and
- I/We understand that I/we can obtain the ACS Group Privacy Policy, access personal information held about me/us, or raise privacy concerns by calling the ACS Group Privacy Officer on 1800 646 777, and consent to ACS Financial and its service providers using and disclosing my/our information in the way described in the Privacy Statement. Where information about a third party individual is supplied, I/we declare that the person has been made aware of that fact and of the Privacy Policy.

Section F. Authorisation

I hereby authorise any hospital, physician or other person who has attended to me to furnish ACS Financial or its representatives, any and all information with respect to any injury, medical history, consultation, prescriptions, or treatment, copies of all hospital and medical records. I agree that a photocopy of this authorisation shall be considered as effective and valid as original. I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury shall make any false or fraudulent statements, or suppress, conceal or falsely state any material fact whatsoever then my claim may be voided and my rights of financial recovery forfeited. I consent to the collection, use and disclosure of information by ACS Financial and their service providers in order to access the claim.

In acknowledgement of Sections D, E and F, signature of the Claimant or person with authority to sign on behalf of the Claimant.

Signature | **Date** DD / MM / YYYY

Name: | Relationship to student:

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Section G. Medical Practitioner's Statement

School Name:

Patient Name:

Date of Birth: DD / MM / YYYY

Are you the patient's usual doctor/medical practitioner? ◯ Yes ◯ No

Diagnosis (if fracture or dislocation, describe the nature and location):

Does this patient have any other injury that is contributing to this condition? ◯ Yes ◯ No

If 'yes', give details:

Is this injury accident related? ◯ Yes ◯ No

Give details:

Date of accident/first symptoms: DD / MM / YYYY

When did the patient first consult you for this condition: DD / MM / YYYY

Has the patient ever had the same or similar condition? ◯ Yes ◯ No

If 'yes' please provide details:

Has the patient had, or is anticipated to have surgery? ◯ Yes ◯ No

If 'yes' please provide details of surgery:

Date surgery performed or anticipated: DD / MM / YYYY

Name of hospital:

Is the patient still disabled? ◯ Yes ◯ No

If 'yes', how long will the patient be:

• Totally disabled (unable to return to their pre-injury education)

From: DD / MM / YYYY To: DD / MM / YYYY

• Partially disabled (unable to return to a substantial part of their pre-injury education)

From: DD / MM / YYYY To: DD / MM / YYYY

If partially disabled, what educational activities could the patient perform and how many hours a week?

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Has the patient ever had, the same or similar condition? ◯ Yes ◯ No

If 'yes' please provide details:

Has the patient requested medical evidence for this disability to be issued to any other insurance company or other body? ◯ Yes ◯ No

If 'yes' please provide details:

Signature of Medical Practitioner

Date DD / MM / YYYY

Print Full Name of Medical Practitioner:

Qualifications:

Postal Address:

Suburb:

State:

Postcode

Phone (BH): ( )

Fax: ( )

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