# Aon's Student Accident Protection Plan

## Medical practitioner's statement

**The claimant is responsible for any fee for this statement. This form should be completed and returned to Chubb Insurance Australia Limited promptly.**

Chubb Insurance Australia Limited, Level 38, 225 George Street, Sydney NSW 2000
Email: a&hclaims.au@chubb.com Phone: 1300 722 032 Fax: (02) 9231 3697

### PATIENT'SDETAILS

Full name

Date of birth / /

Diagnosis (If fracture or disclocation, describe nature and location i.e. simple, compound)

Does the patient have any other injury that is contributing to the condition? Yes ☐ No ☐

*If yes, give details*

Was the disability accident related? Yes ☐ No ☐

*If yes, give details*

Date of accident/first symptoms

/ /

When did the patient first consult you for this condition?

Date of accident/first symptoms

/ /

How long have you been the patient's usual doctor/medical practice?

years

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated? Yes ☐ No ☐

*If yes, give details*

Date performed or anticipated

/ /

Give name of hospital

Did you provide other medical services (including pathology) to the patient? Yes ☐ No ☐

*If yes, give details*

Date Services provided

/ /

Date Services provided

/ /

Was the patient referred by you or to you? Yes ☐ No ☐

*If yes, please provide name and address of referring doctor*

Name

Street address

City | State | Postcode | Date of referral

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 / / to / /

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

from / / to / /

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

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

*If yes, give details*

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, sports body or any other insurance body? Yes ☐ No ☐

*If yes, give details*

Name of company and claim number

Contact name and telephone number

Remarks

Signature of medical practitioner | Name (in print)

Date

/ /

Qualifications

Street address

City | State | Postcode

Telephone ( ) | Date of referral / /

**Please complete claim form and return to:**
**a&hclaims.au@chubb.com**
**Chubb Insurance Australia Limited**
**Level 38, 225 George Street, Sydney NSW 2000**
**Phone: 1300 722 032 Fax: (02) 9231 3697**

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