

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'S DETAILS

Full name

Date of birth

Diagnosis (If fracture or dislocation, 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

CHUBB

Please complete claim form and return to:
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