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:
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