



Lutheran Church of Australia

School Student Personal Accident Protection Plan

2013 - 2014 Claims Procedure and Summary of Cover

(For complete details, please refer to the Product Disclosure Statement and Policy Document)

Claims Procedure

Please complete a Student Accident Claim Form **and** a Medical Practitioners Statement, attach copies of supporting documentations such as medical accounts/receipts, medical diagnosis, etc. and send to –

ACE Insurance Limited
GPO Box 4065
Sydney 2001
Phone (02) 9335 3355 or 1800 688 640
Fax (02) 9231 6940
Email: A&HClaims.AU@acegroup.com

CLAIMS

Written **notice of claim** must be given to the above **Insurance Company within thirty (30) days after the occurrence of any Event** covered by the Policy, or as soon thereafter as is reasonably possible. (This flier is a summary only of the cover arranged. Claims will be settled in accordance with the Policy conditions, definitions and exclusions). A copy of the full Policy document can be viewed at the School or copy provided by the Lutheran Church insurance broker & advisor, Aon.

Brief Summary of Cover

THE PLAN

The School as a condition of enrolment, has arranged an Accident insurance Plan to cover all Full time Students.

COVERAGE

In respect to injuries happening:-

- While student is engaged in school activities and school-related extra curricular activities (including work experience)
- While student is engaged in organised school sporting activities
- While student is engaged in organised non-school sporting activities
- Travel to and from school activities, organised school sporting activities, organised non-school sporting activities

which are not otherwise insured elsewhere.

GEOGRAPHICAL SCOPE

Worldwide

COVER

Please note that there are various benefits payable by the policy, including Lump Sum payment for MAJOR injuries (as detailed in the Table of Events in the policy) and Non Medicare Medical Expenses (as defined below). **Please note however, this policy cannot cover any Medicare related expense (including any Medicare "gap") due to Australian Health legislation.** It is also a policy condition that any other available insurance (eg Private Health) must be exhausted first, and any shortfall claimed hereunder.

Non-Medicare Medical Expenses means expenses that are not subject to any full or partial Medicare rebate nor recoverable by You from any other source and incurred within twelve (12) calendar months of sustaining Injury and paid by You for treatment, certified necessary by a Doctor, to a registered private hospital, physiotherapist, chiropractor, osteopath, nurse or similar provider of medical services excluding the cost of dental treatment unless such treatment is necessarily incurred to sound and natural teeth, excluding dentures, and is caused by Injury.

Non-Medicare Medical Expenses does not include:

(a) any or part of any expense for which a Medicare benefit is paid or payable including the balance of monies due or payable by You after deduction of any Medicare benefit or rebate from the actual expense incurred. (Commonly known as the "Medicare Gap"); and

Provided that

- (a) We shall not be liable to make any refund in respect of:
- I. any expenses recoverable by You from any other insurance scheme or any plan providing medical/physiotherapy or similar coverage or from any other source except for the excess of the amount recoverable from such other insurance/plan or source; and
 - II. any expense to which Section 67 of the National Health Act 1953 (Cth.) (as amended) or any of the regulations made thereunder apply;
- (b) the maximum total liability shall not exceed, in respect of any one Injury, \$8,000.

Claim forms and blank Medical Practitioners Statements are available from your school or the LCA website, or you can contact -

Christine Noble at Aon Risk Services
Ph (08) 8301 1114
or by email christine.noble@aon.com.au

A copy of the Policy Wording is also available from your School or from Aon.

Aon's Student Accident Protection Plan

School student accident claim form



This form should be completed and returned to ACE Insurance promptly.

ACE Insurance Limited GPO Box 4065 Sydney 2001 Phone 1800 688 640 Fax (02) 9231 3697 Email a&hclaims.au@acegroup.com

CLAIMS PROCEDURE

To ensure that your claim is dealt with as quickly as possible, it is important to follow a few simple steps:

1. Report the accident as soon as possible to school administration.
2. Pay all medical and other accounts as the insurer will not pay those on your behalf.
3. Make Private Health insurance claims, as the insurer's obligation is only for any portion not covered by Private Health.
4. Make your Medicare claim.

Student Accident Insurance includes coverage for non-Medicare medical expenses (when the accident happened during school or organised sporting activities). Any portion of any expense for which a Medicare benefit is paid or payable, including the balance of monies you have to bear after deduction of any Medicare benefit or rebate from the actual expense incurred (commonly known as the 'Medicare gap'), is unable to be reimbursed under this or any other insurance. It is in fact a breach of the Health Insurance Act to reimburse such costs.

All claimable non-Medicare medical expenses need to be for treatment, certified necessary by a legally qualified medical practitioner, to a registered private hospital, physiotherapist, chiropractor, osteopath, nurse or similar provider of medical services excluding the cost of dental treatment unless such treatment is necessarily incurred to sound and natural teeth, excluding dentures, and is caused by the accident.

5. Fill in the School student accident claim form (note that there is a section to be completed by the school).
6. Ask the attending doctor to fill in the Medical practitioner's statement.
7. Send all completed documents and any accounts and receipts in support of out of pocket expenses claimed direct to ACE Insurance Limited at GPO Box 4065 Sydney 2001.

PERSONAL DETAILS

Name of school

Student's full name

Street address

City

State

Postcode

Date of birth

Parent name

Parent telephone number

Parent email address

ELECTRONIC FUNDS TRANSFER

Following ACE's approval of your claim, should you wish to have your claim settlement transferred directly into your bank account, please provide the following details.

Bank name

Account name

BSB no.

Swift code (if applicable)

1. INJURY DESCRIPTION

Give full description of the injury from which you are suffering. State when, where and how it happened.

Injury

How it was sustained

Where

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

(a) Give exact date when injury occurred

(b) When did you first consult a physician for this condition?

(c) When did you become totally disabled (unable to attend school)?

(d) When were you able to return to school?

(e) If still disabled, when do you expect your disability to terminate?

(f) Have you ever had this, or a similar condition in the past?

Yes No

If yes, state the nature of the condition, dates of the treatment, names and addresses of treating doctors, hospitals and clinics.

Condition(s)

Date

Treated by

Name of hospital/clinic

2. ATTENDING PHYSICIAN(S)

Give names, addresses and telephone numbers of all attending physicians.

Name

Phone

Address

2. ATTENDING PHYSICIAN(S) continued...

Name

Phone

Address

Give names, addresses and telephone numbers of usual family physician.

Name

Phone

Address

3. PRIVATE HEALTH INSURANCE

Are you covered by private health insurance? Yes No

If "yes", name of insurer

Give membership number and branch

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

Authorisation

I hereby authorise any hospital, physician or other person who has attended to me to furnish ACE Insurance 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 ACE Insurance and their service providers in order to assess the claim. ACE Insurance complies with the obligations of the Privacy Act 2001 and the principles laid out in our Privacy Policy, which is readily available on request.

Name (please print)

Date

Relationship to student

Signed

TO BE COMPLETED BY SCHOOL REGISTRAR/PRINCIPAL

Please ensure that all questions have been fully answered.

I certify that (insert student name)

was injured as stated.

Name of school

Name

Position

Phone

Address

Do you want to be copied in on the acknowledgement letter for this claim?

Yes No

If YES, Please provide:

Contact Name

Contact email address

I hereby certify that the particulars shown on this form are to the best of my belief and knowledge, true and correct.

Date

Witness

Signed

Signed



Please complete claim form and return to:
ACE Insurance Limited GPO Box 4065 Sydney 2001
Phone 1800 688 640 Fax (02) 9231 3697
Email a&hclaims.au@acegroup.com



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 ACE Insurance promptly.
ACE Insurance Limited GPO Box 4065 Sydney 2001 Phone 1800 688 640 Fax (02) 9231 3697 Email a&hclaims.au@acegroup.com

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



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