Chubb Insurance Australia Limited
ABN: 23 001 642 020
AFSL: 239687

Grosvenor Place
Level 38,
225 George Street
Sydney NSW 2000
Australia

GPO Box 4065
Sydney NSW 2001
Australia

O 1800 688 640 (main)
O 1800 815 675 (customer service)
F +61 2 9321 3697 (claims fax)
E a&hclaims.au@chubb.com
www.chubb.com/au

Medical Practitioner's Statement to Chubb Insurance Australia Limted

The Claimant is responsible for any fee for this statement.
This form should be completed and returned to Chubb promptly.

Patient's Details

Patient's Full Name:

Date of Birth:	dd / mm / yyyy

Medical Details

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?
dd / mm / yyyy	dd / mm / yyyy

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

yrs

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated?

☐ Yes ☐ No If Yes, give details:

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Chubb14-180-0117

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Date performed or anticipated	Give name of hospital?
dd / mm / yyyy	

Did you provide other medical services (including pathology) to the patient?

☐ Yes ☐ No If Yes, give details:

Date:	Services provided:
dd / mm / yyyy	
dd / mm / yyyy	
dd / mm / yyyy	
dd / mm / yyyy	

Was the patient referred by you or to you?

☐ Yes ☐ No If YES, please provide name and address of referring doctor:

Name:

Address:

Date of referral:
dd / mm / yyyy

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?

Hours per week:

Has the patient ever had the same or similar condition?

☐ Yes ☐ No If Yes, give details:

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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 No.:

Contact Name and Telephone No.:

Remarks:

Medical Practitioner's Declaration

Signature of Medical Practitioner:

Name (Please print):	Date:

Qualifications:

Address:

Telephone Number:

Date of referral:

dd / mm / yyyy

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