CLAIM REPORT FORM

# Accident or Sickness

## Important Information

The provision of this form by AIG is not an admission of liability or acceptance by AIG of your claim.

1. This form must be accompanied by an Attending Physicians Statement, which can be obtained by telephoning any of our offices listed.
2. The Privacy Consent must be completed for all claims.
3. To avoid delay in processing your claim please ensure all sections are completed and necessary documentation specified in the section relevant to your claim is sent with this claim form.

## Section I. Policyholder Details

| Full name of Policyholder: | | Policy No.: |
|---|---|---|

### To be completed by Policyholder

| | | |
|---|---|---|
| Are you registered for GST purposes? | ☐ Yes | ☐ No |
| If 'Yes', what is your Australia Business Number (ABN)? | | |
| Have you claimed or are you entitled to claim an Input Tax Credit (ITC) on your monthly or quarterly Business Activity Statement to the Australian Taxation Office in respect to the GST paid on the insurance premium for this policy? | ☐ Yes | ☐ No |
| If 'Yes', what percentage of GST did you claim or are you entitled to claim? (If the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%) | | % |
| Name: | | |
| Position/Title: | | |
| Company: | | |
| Date: | D D M M Y Y Y Y | Signature: |

## Section II. Claim Details

| | | | |
|---|---|---|---|
| Insured Person's Full Name: | | | |
| Street Address and Postcode: | | | |
| Telephone (including area code): | Home: | Business: | |
| Email Address: | | Date of Birth: D D M M Y Y Y Y | |
| Height: | | Weight: | Gender: |
| Occupation prior to disablement: | | | |

Describe usual duties:

Describe the injury or sickness for which you are claiming:

| On what date did your sickness commence or injury occur? | D D M M Y Y Y Y |
|---|---|

If injury, what were you doing at the time?

Have you ever suffered a similar sickness or injury in the past? ☐ Yes ☐ No

If 'Yes', give details:

| | | | | |
|---|---|---|---|---|
| When did you first consult a doctor for the condition for which you are claiming? (Date and Time) | D D M M Y Y Y Y | at: | ☐ am | ☐ pm |
| When did you become totally disabled (unable to work)? (Date and Time) | D D M M Y Y Y Y | at: | ☐ am | ☐ pm |
| If still totally disabled, when do you expect to return to work? (Date and Time) | D D M M Y Y Y Y | at: | ☐ am | ☐ pm |

If you have returned to work, when were you able to again perform:

| | | | | |
|---|---|---|---|---|
| Part of your occupational duties? (Date and Time) | D D M M Y Y Y Y | at: | ☐ am | ☐ pm |
| All of your occupational duties? (Date and Time) | D D M M Y Y Y Y | at: | ☐ am | ☐ pm |

Give details of all attending physicians and hospitals attended.

| Name | Address | Telephone |
|---|---|---|
| | | |
| | | |
| | | |

Who is your usual doctor?

| Name | Address | Telephone |
|---|---|---|
| | | |

Have you ever lodged a Personal Accident or Sickness claim before? ☐ Yes ☐ No

If 'Yes' give details. Insurer/Address/Claim No/Policy No/Details:

| Insurer | Address | Claim No. | Policy No. | Details |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Are you making any other insurance or compensation claim in respect of this disability?

☐ Worker's Compensation ☐ Government Benefits ☐ Motor Accident Law ☐ Superannuation or Life Insurance

Other:

Do you have private health insurance? ☐ Yes ☐ No

If 'Yes', please provide name of health fund and level of cover.

## Section lll. Information Authority and Warranty

I,

hereby authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish AIG or its representatives with:

(i) All copy hospital and medical reports/notes;

(ii) All copy employment records and income tax returns; and

(iii) All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment), employment history and income tax returns.

I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that AIG relies upon the truthfulness of the particulars supplied by me in respect of the claim.

## Section IV. Privacy Notice

AIG collects personal information from you, your agents and people involved in this claim to assist in investigating or processing the claim, improve customer service and products and carry out research and analysis, including data analytics. This may include third parties claiming under the policy, witnesses and medical practitioners. Please note that we will only request for and rely on information that is relevant in assisting us to process your claim. However, failure to disclose information required may result in AIG not being able to administer or declining the claim.

AIG may disclose your information to:

- your or our agents, AIG related entities, reinsurers, contractors or third party providers providing services related to the administration of the claim;
- assessors, third party administrators, emergency providers, retailers, medical providers or travel carriers, or any third parties or insurer from whom AIG seeks recovery related to the claim;
- entities to which AIG is related and third party providers for data analytics functions; and
- government, law enforcement, dispute resolution, statutory or regulatory bodies, or as required by law.

Some of these entities may be located overseas, including in a country in which you have a claim and such other countries as may be notified in our Privacy Policy from time to time.

Where we transfer information to another country, we will take steps to ensure that your Personal Information is adequately protected and transferred in accordance with the requirements of data protection law.

Our Privacy Policy www.aig.com.au/privacy-policy is available at www.aig.com.au or by contacting us on 1300 030 886 and contains information about how you may access and correct your personal information, how to complain about a breach of the applicable privacy principles and how AIG will deal with such a complaint.

## Section V. Consent

I consent to AIG collecting, using and disclosing personal information as set out in this notice. If I have provided or will provide information to AIG about any other individuals, I c onfirm that I am authorised to disclose his or her personal information to AIG and also to give this consent on both my and their behalf.

| | |
|---|---|
| Name: | |
| Date: | D D M M Y Y Y Y |
| Signature: | |

## Section VI. Electronic Funds Transfer (EFT) Details

Do you want the benefit to be deposited directly into a financial institution account via EFT? ☐ Yes ☐ No

Name the account is held in:

| BSB number (6 digits in total) Bank | Financial institution account number (up to 9 digits only) |
|---|---|
| ☐☐☐–☐☐☐ | ☐☐☐☐☐☐☐☐☐ |

(If you are unsure of the BSB number, please contact the financial institution where the account is held.)

| | |
|---|---|
| Financial Institution: | Branch: |

## Section VII. If Self Employed

| | |
|---|---|
| What are your average weekly earnings, net of expenses, but before tax? | $ |

Do you operate as a Propriety Limited Company? ☐ Yes ☐ No

Do you or your Company pay a Workers Compensation Levy? ☐ Yes ☐ No

| | | |
|---|---|---|
| What is your business trading name? | | |
| Address: | | |
| Telephone No.: | | Commenced Trading: D D M M Y Y Y Y |

**Please submit documentation to validate earnings.**

## Section VIII. If employed as a wage earner, the following is to be completed by your Employer.

| | |
|---|---|
| I hereby certify that: | |

became incapacitated on: D D M M Y Y Y Y and is *expected to/did resume duties on: D D M M Y Y Y Y

| | |
|---|---|
| * His/her average weekly salary (excluding bonuses, commissions, overtime payments and other allowances) for the 12 months prior to the injury or sickness was: | $ per week |

During the period of incapacity he/she received:

| | | |
|---|---|---|
| $ | Normal Pay – from / to: | |
| $ | Sick Pay – from / to: | |
| $ | Workers Compensation – from / to: | |
| $ | Other (Please specify) – from / to: | |
| * He/she has been employed since: | | |
| Name of Company: | | |
| Address: | | |
| Signature of Supervisor or Paymaster: | | |
| Name of Supervisor or Paymaster: | | |
| Telephone No.: | | Date: D D M M Y Y Y Y |

* Delete whichever is not applicable

## Section IX. If claiming under a Sports Injury Insurance Policy, the following is to be completed by the Club Secretary/Treasurer.

| | | | |
|---|---|---|---|
| I certify that: | | was injured on: | D D M M Y Y Y Y |
| whilst playing: | | Grade with the club. | |
| Name of Club: | | | |
| Secretary/Treasurer's Name: | | | |
| Address: | | | |
| Telephone No.: | | | |
| Signature: | | | |
| Date: | D D M M Y Y Y Y | Witness: | |

## Section X. If claiming under a Student Accident Policy, the following is to be completed by the Registrar/Principal or Student Union.

| | | | |
|---|---|---|---|
| I certify that: | | was injured on: | D D M M Y Y Y Y |
| during the following school/university organised activity: | | | |
| Name of School/University: | | | |
| Telephone No.: | | | |
| Address: | | | |
| Signature: | | | |
| Print Name: | | Position/Title: | |
| Date: | D D M M Y Y Y Y | Witness: | |

**Please submit your claim form and supporting documents to:**
Email: austclaims@aig.com
Telephone: 1800 339 663
AIG Claims Dept.
GPO Box 4363, Melbourne, VIC 3001

AIG recognises that some customers require additional support when dealing with us. AIG has a range of inclusive support initiatives to assist customers with specific needs. If you have a physical or mental illness, financial challenges, difficulty understanding or reading English we can help. Please visit https://www.aig.com.au/customer-care for more information on how we can assist you. Alternatively, you can speak to our Customer Care team by calling 1300 295 016 or email us at aucustomercare@aig.com

**PLEASE KEEP A PHOTOCOPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORD**

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