



Accident or Sickness Report Form

Claim Form

This form must be accompanied by an Attending Physicians Statement, which can be obtained by telephoning any of our offices listed.

Full name of Policyholder Policy Number

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

Signature

Insured Person's Full Name

Street Address and Postcode

Telephone (including area code) Home [] Business []

Email Address Date of Birth

Height Weight Sex

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?

Accident or Sickness Report Form | Claim Form

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 & Time)

at am pm

When did you become totally disabled (unable to work)? (Date & Time)

at am pm

If still totally disabled, when do you expect to return to work? (Date & Time)

at am pm

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

Part of your occupational duties? (Date & Time)

at am pm

All of your occupational duties? (Date & Time)

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 so, 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?

Workers 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.

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.

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 United States of America, Canada, Bermuda, United Kingdom, Ireland, Belgium, The Netherlands, Germany, France, Singapore, Malaysia, the Philippines, India, Hong Kong, New Zealand as well as a country in which you have a claim and such other countries as may be notified in our Privacy Policy from time to time.

Our 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.

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 confirm 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

Signature

Date

Electronic Funds Transfer (EFT) details

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

2. Name the account is held in:

3. BSB number (6 digits in total) 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.)

4. Financial Institution:

Branch:

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

Please submit documentation to validate earnings.

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

I hereby certify that

became incapacitated on

and is *expected to/did resume duties on

*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

* Delete whichever is not applicable

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

I certify that	<input type="text"/>	was injured on	<input type="text"/>
whilst playing	<input type="text"/>	Grade with the club.	
Name of Club	<input type="text"/>		
Secretary/Treasurer's Name	<input type="text"/>		
Address	<input type="text"/>		
Telephone No.	<input type="text"/>		
Signature	<input type="text"/>		
Date	<input type="text"/>	Witness	<input type="text"/>

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

I certify that	<input type="text"/>	was injured on	<input type="text"/>
during the following school/university organised activity:	<input type="text"/>		
Name of School/University	<input type="text"/>		
Telephone No.	<input type="text"/>		
Address	<input type="text"/>		
Signature	<input type="text"/>		
Print Name	<input type="text"/>	Position/Title	<input type="text"/>
Date	<input type="text"/>	Witness	<input type="text"/>

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

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



Head Office
Sydney Level 19, 2 Park Street, Sydney NSW 2000
Melbourne Level 13, 717 Bourke Street, Docklands VIC 3008
Brisbane 10 Eagle Street, Brisbane QLD 4000
Perth 77 St. George's Terrace, Perth WA 6848

Australia wide T 1300 030 886
F 1300 634 940
International T +61 3 9522 4000
F +61 3 9522 4645

www.aig.com.au