Claim Report

Accidental Injury

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. 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 Please Print

Date / /

Signature

If you will follow these simple instructions, we will be able to give your advice immediate attention when we receive this form

- If you have suffered a condition covered by the policy, complete this form as soon as possible after diagnosis and/or Bed Care. Answer every question completely and accurately, then give this form to your doctor.
- Ask your doctor to answer all questions on the opposite page.
- Arrange completion of the Certificate of Bed Care.
- After both you and your doctor have answered all questions and you have had the Certificate of Bed Care completed, send the completed forms to the address below. The furnishing of this form does not constitute an admission of liability.

Please submit your claim form and supporting documents to:
AIG Claims Dept.
GPO Box 4363, Melbourne, VIC 3001
Email: austclaims@aig.com
Facsmile: 61 (3) 9522 4974 Telephone: 1800 339 663

Alternatively you may choose to lodge your claim on-line at:
www.aig.com.au
(click on the Claims Tab)

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Claim Report

Employer or Group

Full Policy Number with Prefix | Certificate Number

Full Name of Member | Phone [ ]

Full Name of Patient

Phone [ ] | Date of Birth / /

Residential Address | Postcode

Patient's Relationship to Member | Patient's Occupation

1. When did accident occur / /
2. Describe the accident
3. Describe injury
4. When did you first see a doctor for this condition / /
   Doctor's name and address
5. Dates hospitalised: Admitted / / Discharged / /
   Name and address of Hospital
6. If confinement in convalescent home after hospitalisation was necessary, give:
   a. Date of confinement 20 to 20
   b. Where (Name & Address)
7. Have you ever seen a doctor for this or similar condition in the past? ☐ Yes ☐ No
   (If "yes" give dates, names and addresses of doctors)
8. Name and address of regular family physician
   Phone [ ]

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:

This form must be completed without expense to the Insurer

Attending Physician's Statement

Patient's Name | Age

1. If injury, when did accident occur? / /
2. Diagnosis, chief complaint, history, complications and list any fractures
3. When did patient first receive medical attention for the above? / /

   By whom? Name & Address
4. Dates hospitalised: Admitted / / Discharged / /

   Name and location of hospital
5. What operation, if any, was performed?
6. Name, addresses and specialities of other doctors in attendance or consultation:
7. Was confinement in a convalescent home necessary after hospitalisation? ☐ Yes ☐ No

   If "yes", please give dates: From 20 to / / 20

   Date discharged from your care 20
8. Has patient ever had same or similar conditions? ☐ Yes ☐ No (if "yes" give dates and describe)
9. Have you previously treated this patient? ☐ Yes ☐ No When?

   For What?
10. Has patient been diagnosed with osteoporosis? ☐ Yes ☐ No If so, date of diagnosis. / /
11. What defects or chronic disease does patient have and when did they originate? (Use this space to amplify)
12. Degree of Temporary Disability: Based on Patient's occupation of

    a. Has the patient been able to do any work? ☐ Yes ☐ No Full Duties Suitable Duties

    b. If so, from what date? / / / /

    c. If not, when will he/she be able to work? (Approximately) / / / /
13. Has injury described in 1. Above resulted in any residual disability? ☐ Yes ☐ No If "yes", please give details

Signed Signature Name Please Print

Date / / Qualifications Phone Number [ ]

Address

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Certificate of Bed Care

This hereby confirms that

Was/is under the continuous care of a registered nurse for ____ days

from ____/____/____ time ____:____ ☐ am ☐ pm

to ____/____/____ time ____:____ ☐ am ☐ pm

Place of continuous care:

Nature of condition:

Signature

Name Please Print Date ____/____/____

Title/Qualifications Telephone No: [ ]

Address

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

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