CLAIM REPORT FORM

Personal 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 on page 6.
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 (To be completed by Policyholder)

Full name of Policyholder:		Policy No.:
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? ☐ Yes ☐ No

If 'Yes' please complete the below:

☐ 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 III. 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 IV. 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 V. 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 VI. 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 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
* His/Her average weekly salary **(including overtime payments and other allowances)** for the 12 months prior to the injury or sickness:	$	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

Attending Physician's Statement

Please arrange for this form to be completed by **the patient's usual doctor**.
The Insured Person/Claimant is responsible for any fee for the completion of this form

You can return it to us via the contact details listed below.

Important:
We respectfully request that this form is completed with as much detail as possible in order to assist our processing and avoid the necessity of additional enquiries.

Claimant Name:		**Claim Reference Number:**			
Policy Number:		Sex: ☐ Male ☐ Female		Age:	
Patient's Name:					
Address:					

Please give a complete diagnosis of this condition:

History

1.	When did the patient first receive medical treatment?	
2.	Was there a previous history of this or a similar condition? ☐ Yes ☐ No If 'Yes', please state condition and advise when previous treatment was given:	
3.	a) How long have you known the patient?	
	b) Are you the regular general practitioner? ☐ Yes ☐ No If 'No', please advise who is:	

Injury

1.	When did patient suffer the injury?	
2.	What were the circumstances surrounding the injury?	

If Sickness

1. When was the sickness first contracted?	
2. When did symptoms become evident?	

Degree of Disability

1. Patient's Occupation?	
2. When was patient obliged to cease work?	

3. If patient is still disabled, when approximately will the patient be able to resume

a) Some Duties?	
b) Full Duties?	

OR

4. If patient has recovered, when was patient able to resume

a) Some Duties?	
b) Full Duties?	

Treatment of Present Condition

1. When were you consulted?	(a) Initially:	(b) Most Recently:
2. How often has patient consulted you?		

3. Was patient confined to hospital? ☐ Yes ☐ No
If 'Yes', please advise:

1. Name and address of hospital:	
2. Period of confinement:	

4. Was confinement in a convalescent home necessary after hospitalisation? ☐ Yes ☐ No
If 'Yes', give details:

5. What are the current subjective symptoms?

6. Please give results of any objective findings:
   1. X-Rays

2. Other Tests – Please advise tests done and findings:	1.	
	2.	

7. What surgical procedures have been performed?	1.	
	2.	
8. What surgical procedures are contemplated?	1.	
	2.	

9. What other treatment has patient undergone?

10. What other treatment is required?

11. Are there any underlying conditions affecting recovery from the current condition? ☐ Yes ☐ No
    If 'Yes', please advise nature of underlying conditions and how they affect disability and recovery:

12. Has the patient any other physical or mental impairment? ☐ Yes ☐ No
    If 'Yes', please describe:

13. Please advise names and addresses of other treating physicians:

14. If you have terminated treatment, please advise date:	D D M M Y Y Y Y

15. What was the current prognosis?

16. Are there any further remarks which may assist in assessing this condition?

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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.

Signature:	
Patient's treating Doctor:	
Qualifications:	
Date:	D D M M Y Y Y Y

Name (Please print):			
Street Address:			
City or Town:		State:	
Phone No.:			

Please submit your claim form and supporting documents to:
Email: austclaims@aig.com
Telephone: 1800 331 013
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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PERSONALACCIDENTORSICKNESSCLAIMFORM2025MAY

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