Claim Form

Accident or Sickness Report 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 **The University of Adelaide - Adelaide University Sport** Policy Number **2300110172**

To be completed by Policyholder

Are you registered for GST purposes? ☑ Yes ☐ No

If YES, what is your Australia Business Number (ABN) **61 249 878 937**

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%) **100** %

Name Please Print

Position/Title Please Print

Company Please Print

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? / /

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.

Claim Form

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, and maintain and improve customer service. 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:

- 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; 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, United Kingdom, 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 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 Signature

Name of Supervisor or Paymaster Please Print

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 _____ was injured on / /

whilst playing _____ Grade with the club.

Name of Club _____

Secretary/Treasurer's Name _____

Address _____

Telephone No. [ ]

Signature Signature

Date / / Witness _____

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 / /

during the following school/university organised activity: _____

Name of School/University _____

Telephone No. [ ]

Address _____

N/A

Signature Signature

Print Name Please Print Position/Title _____

Date / / Witness _____

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

AIG Bring on tomorrow

Head Office
Sydney Level 19, 2 Park Street Sydney NSW 2000 Australia
GPO Box 9933 Sydney NSW 2001 Australia
Melbourne GPO Box 9933 Melbourne VIC 3001 Australia
Brisbane GPO Box 9933 Brisbane QLD 4001 Australia
Perth GPO Box 9933 Perth WA 6848 Australia

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

www.aig.com.au

Accident & Injury Report Form

Attending Physician's Statement

Please arrange for this form to be completed by **the patient's usual doctor**.

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 **2300110172** Sex ☐ Male ☐ Female Age

The Insured is responsible for completion of this form without expense to the company

Patient's name

Address

Please give a complete diagnosis of this condition

History

1. When did the patient first receive medical treatment?
2. a) Was there a previous history of this or a similar condition? ☐ Yes ☐ No
   b) 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 not, please advise who is

If 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?

Accident & Injury Report Form

Attending Physician's Statement

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 From to
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?

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

Has the patient any other physical or mental impairment? ☐ Yes ☐ No

If Yes, please describe

Please advise names and addresses of other treating physicians

If you have terminated treatment, please advise date

What was the current prognosis?

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

Accident & Injury Report Form

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- assessors, third party administrators, emergency providers, medical providers or travel carriers, or any third parties or insurer from whom AIG seeks recovery related to the claim; 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, United Kingdom, Singapore, Malaysia, the Philippines, India, Hong Kong, New Zealand as well as a country in which the claimant has a claim and such other countries as may be notified in our Privacy Policy from time to time.

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TO BE SIGNED BY ATTENDING PHYSICIAN

Signed

Date / /

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

AIG Bring on tomorrow

Head Office
Sydney Level 19, 2 Park Street Sydney NSW 2000 Australia
GPO Box 9933 Sydney NSW 2001 Australia
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