Claim Report

Accidental Injury

Information Authority and Warranty

I,

hereby authorise any hospital, physician or other person who has attended me, to furnish AIG Australia Limited or its representatives with:-

(i) Copies of hospital and medical reports/notes; and

(ii) All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

(iii) The completion of all documentation and forms as required by my Insurer.

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 Australia Limited relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Privacy Consent:

I consent to AIG:

(a) Collecting and using my personal information for the purposes of administering my claim including investigating, assessing and paying any claim made by me or on my behalf. (If we do not collect this information we may not be able to process your claim.)

(b) Disclosing my personal information to related entities of AIG, their staff members located outside Australia, the insured (if not myself), other insurers and reinsurers, insurance reference bureaus, law enforcement agencies, investigators, lawyers, assessors, repairers, advisors and the agent of any of these, insurance broker, insurance agent or other intermediary, my employer or Financial Ombudsman Service Limited (FOS) for the purposes of administering my claim or providing a report.

(c) I understand that a copy of the AIG privacy policy statement, including information about access, may be obtained by writing to: The Privacy Manager, AIG, GPO Box 4363, Melbourne VIC 3001, or by downloading from AIG website www.aig.com.au

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 on the front of this form. The furnishing of this form does not constitute an admission of liability.

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Claim Report

Accidental Injury

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:

Claim Report

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

AIG Australia Limited ABN 93 004 727 753 AFSL 381686. Copyright 2013.

This form must be completed without expense to the Insurer

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 ______ (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

Bring on tomorrow

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