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: University of Sydney

Policy Number: 2200103822

To be completed by Policyholder

Are you registered for GST purposes? Yes Yes ☐ No

If YES, what is your Australia Business Number (ABN): N/A

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 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 University of Sydney

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.

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 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 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.

Please have the relevant authority who approved the placement i.e. Head of School/ Faculty, Director, or Dean complete this.

I certify that _____ was injured on / /

during the following school/university organised activity: _____

Name of School/University _____

Telephone No. [ ] _____

Address _____

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

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Sydney Level 19, 2 Park Street Sydney NSW 2000 Australia
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