



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 [] Policy Number []

To be completed by Policyholder

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 [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.



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	<input type="text" value="Please Print"/>	Signature <input type="text"/>
Date	<input type="text" value="/ /"/>	



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

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

Signature

Print Name Please Print Position/Title

Date / / Witness

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



Bring on tomorrow

Head Office

Sydney Level 19, 2 Park Street Sydney NSW 2000 Australia
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