Supplementary Report

Accident or Sickness for Continuing Disability

The furnishing of this form shall not be held to be a waiver or any breach of any of the conditions of the policy.
All Questions Must Be Fully Answered. Dashes Are Not Acceptable.

Accident or Sickness Supplementary Report For Continuing Disability

Policy number with prefix

Full Name:

Telephone Number [ ] Reference Number

Address: Street, (City) (State)

1. On what dates since the last statement furnished by you were you treated by a doctor?

   Names and addresses of current attending doctors

2. For what period were you continuously disabled according to the following definitions?

   Total Disability means disablement which entirely prevents an Insured from attending to his business or occupation.

   Totally and continuously from / / 20 ☐ am ☐ pm Through / / 20 ☐ am ☐ pm

   Partial Disability mean inability to perform or attend to a substantial part of claimants business or occupation.

   Partially and continuously from / / 20 ☐ am ☐ pm Through / / 20 ☐ am ☐ pm

3. Have you retired from your business or occupation ☐ Yes ☐ No If Yes, When?

4. If your total disability has not terminated, when do you anticipate that it will?

5. Are you making any other claim as a result of this condition ☐ Yes ☐ No

   If Yes, give details Claim No

6. Have you received payment in respect of Worker Compensation/ Workcare or similar legislation

   Dept. of Social Security (Give Details)

   Superannuation

   Motor Accident Board/Transport Accident Commission or similar legislation

   Pension (Give Details)

   Other (Give Details)

7. Since incapacity started have you performed duties in your usual or other occupation for Payment? ☐ Yes ☐ No

   If so, give details

8. What work do you now consider you could perform?

Claim Form

Accident or Sickness for Continuing Disability

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 Australia Limited or its represenatives 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 records 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 warranty that the foregoing particulars are true and correct in every details and acknowledges that the 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.

I also declare that I have:

(1) *No other travel insurance with any insurance company.

(2) *Travel insurance with (name of insurance company). _____

**Please delete wichever is not applicable*

Signature _____

Date / /

Claim Form

Accident or Sickness for Continuing Disability

To Be Completed By Your Attending Physician Attending Physician's Statement Of Disability

Attending Physician's Statement Of Disability

The Insured Is Responsible For Completion Of This Form Without Expense To The Company

Patient's name and address

1. What Is Disabling Patient Age Sex ☐ M ☐ F

2. History:

(a) When did present sickness begin or injury occur? / /

(b) Date patient was obliged to cease work? / /

(c) Is there a prior history of the same or similar condition? Explain

3. Present Condition:

(a) Subjective Symptoms:

(b) Objective Findings:

Give report of x-rays, ECG's or other tests (dates)

(c) Is Patient: Ambulatory ☐
Bed Confined ☐
House Confined ☐
Hospital Confined ☐ Date of Admission / / Date of Discharge / /

4. Treatment Of Present Condition:

(a) Date of first consultation / / 20

(b) Date of Latest consultation / / 20

(c) Frequency of consultations

(d) Date of last hospitalization / / 20 Name of hospital

(e) Nature of surgical procedure, if any Performed:

Contemplated:

5. Progress: Improved ☐
Unimproved ☐
Retrogressed ☐

Please explain

6. Degree of Disability:

Based on the Patient's occupation of

Has the patient resumed part of all of his normal occupational duties? ☐ Yes ☐ No

(a) If so, from what date did the patient resume:
(i) partial duties / /
(ii) full duties / /

(b) If not, when do you anticipate the patient will be fit to resume?
(i) partial duties / /
(ii) full duties / /

7. Other Treatment:

(a) If seen in consultation by other physician, please give date, name and address of physician

(b) If no longer under your care, date your services terminated / /

8. Other Conditions:

Describe any other disease, infirmity or problem affecting present condition

Is it impeding recovery? If yes, please detail

Do you recommend referral to another Practitioner or Authority?

9. Prognosis

Is there any permanent residual disability? ☐ Yes ☐ No

If Yes, please explain giving your estimation of percentage loss of function

10. Remarks

Date: / /

Signature

Degree:

Telephone Number: [ ]

Street Address:

City or Town:

State:

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

Australia wide
T 1300 030 886
F 1300 634 940

International
T +61 3 9522 4000
F +61 3 9522 4645

www.aig.com.au