CLAIM FORM

Student Personal Accident

Important Information

The provision of this form by AIG is not an admission of liability or acceptance by AIG of your claim.

1. The Privacy consent and Information Authority and Warranty consent must be completed for all claims.
2. To avoid delay in processing your claim please ensure all sections are completed and necessary documentation specified in the section relevant to your claim is sent with this claim form.

How to ensure Your Claim is managed effectively

Please ensure you provide the following documentation:

- **Please ensure you have your treating Doctor complete the Certificate of Attending Physician on page 6.**
- **Dental claims.** Your dentist must provide a written statement confirming:
  - The treatment was due to an accident
  - The extent of treatment
  - Any future treatment
- **Original itemised accounts or receipts for claimable expenses.**
- **Declaration on page 4 to be completed by Student/Parent/Guardian.**
- **Declaration on page 5 to be completed by School/College.**
- **Please submit your claim form and supporting documents to: Email: austclaims@aig.com or**
- **Post: AIG Claims Dept. GPO Box 4363, Melbourne, VIC 3001 Telephone: 1800 331 013**

Please note: AIG does not pay for the cost of obtaining documentation to support a claim.

STOP

IMPORTANT NOTE:

AIG Australia Limited is prohibited by Federal Health Legislation (including the *Health Insurance Act 1973* (Cth)) from paying any Medicare rebate including the Medicare Gap

For Example:

A student breaks their arm whist playing on the school playground

Doctor's Fee	$100.00	
Less Medicare Rebate	$60.00	
Medicare Gap	$40.00	* The Medicare Gap is NOT claimable under this policy

Check List For Students/Parents/Guardians

Please check

- ☐ That all questions have been answered
- ☐ That you have not included any Medicare claimable items or Medicare "gap" items
- ☐ That all supporting documentation is attached
- ☐ That you have signed the declaration on page 4

Check List For Schools & Colleges

Please check

- ☐ That all questions have been answered
- ☐ That all supporting documentation is attached
- ☐ That the parent/guardian have signed the declaration on page 4
- ☐ That the School/College has signed the declaration on page 5

To Be Completed By Student or Parent/Guardian

Personal Details

1. Student Title:	Surname:	Given name/s:

2. Student's date of birth: D D M M Y Y Y Y

Parent/Guardian

3. Title:	Surname:	Given name/s:

4. Parent/Guardian email address:

5. Postal address:	Postcode:

6. Phone – Work:	Home:	Mobile:	Fax:

7. School/College name:

8. School/College address:	Postcode:

9. ☐ Kindergarten ☐ Primary ☐ Secondary ☐ Other

Electronic Funds Transfer (EFT) details

If you would like the claims settlement to be paid via EFT into your account, please complete your details below.

Account name:

Bank:	Branch:
BSB number: ☐☐☐–☐☐☐	Account number: ☐☐☐☐☐☐☐☐☐

Incident Details (must be completed)

This policy is designed to provide specified benefits to students suffering bodily injury as a result of an accident.
No benefits are provided for illness related incidents or costs.

10. Date of incident: D D M M Y Y Y Y	Time: ☐ am ☐ pm

11. **Place of incident:** (Please tick ✓)

☐ Home ☐ School ☐ Excursion/camp ☐ Road ☐ Sports venue (school)
☐ Sports venue (other) ☐ Other (Please give details below)

Incident Details (continued)

12. **Occurrence Period:** (Please tick ✓)

☐ School hours ☐ School holidays ☐ Public holidays ☐ Weekend ☐ Before school ☐ After School

13. Describe how the accident occurred:

14. Date of first treatment: D D M M Y Y Y Y | Further treatment required: ☐ Yes ☐ No

Please claim here for Non-Medicare Medical Expenses. Do not include Medical expense items where a Medicare rebate has been applied or you are claiming the Medicare Gap (refer below Important Note).

IMPORTANT NOTE:
AIG Australia Limited is prohibited by Federal Health Legislation (including the *Health Insurance Act 1973* (Cth)) from paying any claim where a Medicare rebate has been paid or is payable including the Medicare Gap.

15. Is the student covered by Private Health Insurance? Hospital: ☐ Yes ☐ No Extras: ☐ Yes ☐ No
If 'Yes', please provide name and membership number below:

Name: | Membership number:

16. Have you claimed medical expenses under Private Health Insurance? ☐ Yes ☐ No

(If you are a member of a Private Health Insurance Fund please lodge your claim prior to submitting this accident claim.)

Please ensure you attach all medical expense receipts for the amounts you are claiming.

Provider of service	Nature of service provided	Amount claimed
		$
		$
		$
		$
		$
		$
		$

Information Authority and Warranty

I

hereby authorise any hospital, physician or other person who has attended me, or the claimants school to furnish AIG or its representatives with:

(i) All copies of hospital and medical reports/notes;

(ii) All copies of employment records and income tax returns; and

(iii) All information pertaining to the claimants medical history (any sickness or disease or injury, consultation, prescription or treatment), employment history and income tax returns.

(iv) 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 relies upon the truthfulness of the particulars supplied by me in respect of the claim

Privacy

AIG collects personal information from you, your agents and people involved in this claim to assist in investigating or processing the claim, improve customer service and products and carry out research and analysis, including data analytics. This may include third parties claiming under the policy, witnesses and medical practitioners. Please note that we will only request for and rely on information that is relevant in assisting us to process your claim. However, failure to disclose information required may result in AIG not being able to administer or declining the claim. AIG may disclose your information to:

- your or our agents, 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;
- entities to which AIG is related and third party providers for data analytics functions; 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, Canada, Bermuda, United Kingdom, Ireland, Belgium, The Netherlands, Germany, France, 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.

Parent or Guardian's Name:			
Parent or Guardian's Signature:		Date:	D D M M Y Y Y Y

AIG recognises that some customers require additional support when dealing with us. AIG has a range of inclusive support initiatives to assist customers with specific needs. If you have a physical or mental illness, financial challenges, difficulty understanding or reading English we can help. Please visit https://www.aig.com.au/customer-care for more information on how we can assist you. Alternatively, you can speak to our Customer Care team by calling 1300 295 016 or email us at aucustomercare@aig.com

Declaration (to be completed by School/College)

School/College/Details

15. School/College name:			
16. School/College address:			Postcode:
17. School/College phone:		Email:	
18. Contact name (and title):		Position:	
19. Policy number:			

20. Period of cover: D D M M Y Y Y Y to: D D M M Y Y Y Y

21. Did the accident occur during a school activity? ☐ Yes ☐ No

22. Do you consider the information given by the parents/guardians on this claim form to be accurate? ☐ Yes ☐ No
If no, please comment

GST Declaration (to be completed by School/College)

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%)	

Signature of Authorised Representative of School/College:		Date: D D M M Y Y Y Y
Print name:		Position:
Email:		

Certificate of Attending Physician

To be completed by attending Physician

The claimant must obtain, at his/her own expense, the completion of this certificate from a duly qualified and registered medical practitioner. In the event of the medical practitioner being unable to answer from their own personal knowledge any of the following questions, they are requested to state so.

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.

Patient's Name:		Sex: ☐ Male ☐ Female	Age:
Address:			

Please give a complete diagnosis of this condition:

History

1.	When did the patient first receive medical treatment for this condition?		
2.	Do you consider the Claimant's injury to be a NEW injury?	☐ Yes	☐ No
3.	Do you consider the Claimant's injury to be a recurrence of a previous injury? If 'Yes', please provide details and a description:	☐ Yes	☐ No
4.	Was there a previous history of this or a similar condition? If 'Yes', please state condition and advise when previous treatment was given:	☐ Yes	☐ No
5.	a) How long have you known the patient?		
	b) Are you the regular general practitioner? If 'No', please advise who is:	☐ Yes	☐ No

Injury

1.	When did patient suffer the injury?	
2.	What were the circumstances surrounding the injury?	

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:	

4. Please give results of any objective findings:
1. X-Rays

2. Other Tests – Please advise tests done and findings:	1.	
	2.	

5.	What surgical procedures have been performed?	1.	
		2.	
6.	What surgical procedures are contemplated?	1.	
		2.	

7. What other treatment has patient undergone?

8. Have you referred the patient to any other services or treatment? ☐ Yes ☐ No
If 'Yes', please provide details below:

Physiotherapy:	☐ Yes	☐ No	If 'Yes', approximate number of treatments required?	
Chiropractics:	☐ Yes	☐ No	If 'Yes', approximate number of treatments required?	
Other:	☐ Yes	☐ No	If 'Yes', please provide details:	

9. 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:

10. Has the patient any other physical or mental impairment? ☐ Yes ☐ No
If 'Yes', please describe:

11. Please advise names and addresses of other treating physicians:

12. If you have terminated treatment, please advise date:	D D M M Y Y Y Y

13. What was the current prognosis?

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

Name of treating Physician:			
Qualifications:			
Date:	D D M M Y Y Y Y		
Signature of treating Physician:			
Street Address:			
City or Town:			State:
Phone No.:		Email:	

aig.com.au

AIG

Contact:

AIG Australia Limited
Head Office
NEW SOUTH WALES
Level 19, 2 Park Street
Sydney, NSW 2000, Australia

General customer service
Tel: +61 2 9240 1711