AIG **Claim Form**

Willis

School Student Accident Report

To be completed by the Student or Guardian

Name of school | Policy Prefix and Number

Students Full Name | Street Address

City | State | Postcode

Date of Birth / / | Height and Weight | Sex | Telephone ( )

1. Give full description of injury from which you are now suffering. State when, where and how it happened.

Injury

How Sustained
Full Description **Where**

2. (a) Have you ever had this, or a similar condition, in the past?

(b) If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics

☐ Yes
☐ No

Condition(s)
Dates:
Treated By:

3. (a) Give exact date when injury occured — (a) Date / / Time ☐ am ☐ pm

(b) When did you first consult a physician for this condition? — (b) Date / / Time ☐ am ☐ pm

(c) When did you become totally disabled (unable to attend school)? — (c) Date / / Time ☐ am ☐ pm

(d) When were you able to return school? — (d) Date / / Time ☐ am ☐ pm

(e) If still totally disabled, when do you expect your disability to terminate? (e) Date / / Time ☐ am ☐ pm

4. (a) Give names, addresses and telephone numbers of all attending physicians.

Names	Addresses	Telephone

(b) Give name, address and telephone number of usual family physician.

Names	Addresses	Telephone

5. Are you covered by Private Health Insurance? ☐ Yes ☐ No Have you claimed yet? ☐ Yes ☐ No

Give Membership No. and Branch

To be completed by the Insured School

I certify that _____ is/was enrolled at this school at the time of the injury.

Was the student injured during a school organised activity? ☐ Yes ☐ No

Name of school

Name | Position

Address

Phone number ( )

I hereby certify that the particulars shown on this form, are to the best of my belief and knowledge, true and correct,

Signature

Name

Date / /

Witness

Claim Form

School Student Accident Report

Information Authority and Warranty

I _____

hereby authorise any hospital, physician or other person who has attended me/the Insured Person, to furnish AIG Australia Limited or its representatives with any hospital and medical reports/notes and/or any information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment). I agree that a Photocopy 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 the 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 _____ Signature _____

Date / / _____

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: _____

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

Attending physician's statement of disability

To be completed by your attending physician
The insured is responsible for completion of this form without expense to the company

Patient's Name And Address

Name

Address

1. When did patient suffer the injury?
2. What were the circumstances surrounding the injury?
3. When did patient first receive medical treatment?
4. Please give a complete diagnosis of this condition
5. Please give results of any objective findings
   (a) X-Rays
   (b) Other Tests - Please advise tests done and findings 1.
   2.
6. Was patient confined to hospital? ☐ Yes ☐ No
   If YES please advise: (a) Name and address of hospital
   (b) Period of Confinement From / / To / /
7. What other treatment has patient undergone?
8. What other treatment is required?

History

1. (a) Was there a previous history of this or a similar condition? ☐ Yes ☐ No
   (b) If yes, please state condition and advise when previous treatment was given
2. (a) How long have you known the patient?
   (b) Are you the regular general practitioner? ☐ Yes ☐ No
   If not, please advise who is

Attending physician's statement of disability (continued)

Degree Of Disability

1. When was patient obliged to cease school?

2. If Patient is still unfit for school, when approximately will the patient be able to resume?

3. If Patient has recovered, when was patient able to resume school?

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

Please advise names and addresses of other treating physicians

If you have terminated treatment, please advise date / /

What is the current prognosis?

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

Is there any permanent disability at presents? ☐ Yes ☐ No

If YES, please explain giving estimated percentage loss of function

Date / / Signature Degree

Name (Please print)

Street Address

City or Town State

Phone No ( )

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