



This form must be accompanied by an Attending Physicians Statement, which can be obtained by telephoning any of our offices listed. By furnishing this Form the Company makes no admission of Liability or Waiver of its Rights.

All questions must be fully answered, dashes are not acceptable.

Full name of Policyholder [input] Policy Number [input]

To be completed by Policyholder

Are you registered for GST purposes? [input] Yes [input] No

If YES, what is your Australia Business Number (ABN) [input]

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? [input] Yes [input] 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%) [input] %

Name [input]
Position/Title [input]
Company [input]
Date [input]
Signature [input]

Workers Full Name [input]
Street Address [input] Postcode [input]
Date of Birth [input] Height [input] Weight [input] Sex [input] M [input] F
Phone No (Home) [input] Phone No (Business) [input]
Email Address [input]
Occupation Prior to Disablement [input]
Describe Usual Duties [input]

Give a full description of the injury suffered
[injury description box]

Have you ever suffered a similar injury before? [input] Yes [input] No

If so, nature of conditions/s; date/s
[nature of conditions box]

Treated by: [input]

The Journey

Where did the accident occur?

What address did the journey commence from?

What address were you travelling to?

What time did the journey commence? am pm

Were you travelling to or from work? Yes No Following your usual route? Yes No

What time did you commence work? am pm

What time did you finish work? am pm

Were you travelling to or from a trade or technical school? Yes No Following your usual route? Yes No

What time do you commence trade or technical school? am pm

What time do you finish trade or technical school? am pm

Describe the route and method of transport taken between home and work or vice versa, naming streets in order

Did you divert from your usual route? Yes No Was the journey broken for any reason? Yes No

If so, for what reason and to what extent?

What days of the week do you work?

How many hours a week do you work?

a) When did you first consult a doctor for the condition which you are claiming? Date Time am pm

b) When did you become totally disabled (unable to work)? Date Time am pm

c) If still totally disabled, when do you expect to return to work? Date Time am pm

d) If you have returned to work, when were you able to again perform

1. part of your occupational duties? Date Time am pm

2. all of your occupational duties? Date Time am pm

The Journey (continued)

Hospitals

If you were admitted to hospital, or treated as an outpatient, please give details

a) Inpatient

Name

Address From To

b) Outpatient

Name

Address From To

Give details of all attending physicians

Name	Address	Telephone
<input type="text"/>	<input type="text"/>	[<input type="text"/>]
<input type="text"/>	<input type="text"/>	[<input type="text"/>]
<input type="text"/>	<input type="text"/>	[<input type="text"/>]

Who is your usual doctor?

Name	Address	Telephone
<input type="text"/>	<input type="text"/>	[<input type="text"/>]

The Accident

Date and time of accident Date Time am pm

How did the accident occur?

Names and addresses of witnesses

In your opinion, who was responsible for the accident. And Why?

Are you making any other insurance or compensation claim in respect of this disability?

Worker's Comp/Workcare Yes No Government Benefits Yes No
 Motor Accident Law Yes No Other Yes No

N.B If you were involved in a TRAFFIC ACCIDENT please complete this section.

Your Vehicle

Registration Number State of Registration

Driver's Name

Address Phone

Owner's Name

Address Phone

Police Station to which the accident was reported Date reported

Police Officer's Name Did police attend the scene? Yes No

Police action taken or proposed

Had you consumed any alcohol or drugs? Yes No

If "Yes", how much?

If you were a passenger, had the driver consumed any drugs or alcohol prior to the accident? Yes No

If "Yes", how much?

If you were a driver/passenger were you wearing a seatbelt? Yes No

If you were a rider/passenger were you wearing a helmet? Yes No

Other Vehicles (If more than two vehicles, attach a separate list)

Registration Number State of Registration





Driver's Name

Address Phone

Owner's Name

Address Phone

Using the symbols below, draw a diagram of the accident scene showing the position of all vehicles and indicate by arrows directions of travel.

-  Your vehicle
-  Other vehicle
-  Pedestrian, Cyclist, etc.
-  Intersection



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"/>	Signature
Date	<input type="text"/>	



Bring on tomorrow

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