



American Home Assurance Company
 ABN 67 007 483 267
 Incorporated with Limited Liability in the USA
 A Member of American International Group, Inc.

Melbourne: 549 St. Kilda Road, Vic. 3004. (03) 9522 4000 GPO Box 4363, Melbourne 3001.
 Sydney: 220 George Street, NSW 2000. (02) 9240 1711
 Brisbane: Level 32, 10 Eagle Street, QLD 4000. (07) 3220 0700
 Perth: Level 13, Allendale Square, 77 St. George's Terrace, WA 6000. (08) 9202 1366

ACCIDENT OR SICKNESS REPORT FORM

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? _____

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? _____

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%) _____ %

Signed _____

Print name _____

Position / Title _____

Company _____

Date _____

Insured Person's Full Name _____

Street Address and Postcode _____

Home _____

Telephone (including area code) _____
 Business _____

Email Address _____

Date of Birth ____ / ____ / ____ Weight _____

Height _____ 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? 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? If so, give 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 American Home Assurance Company 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 the American Home Assurance Company relies upon the truthfulness of the particulars supplied by me in respect of the claim.

PRIVACY CONSENT

I consent to American Home Assurance Company ("AHAC"):

- 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 AHAC, their staff members located outside Australia, the insured, 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 Insurance Enquiries & Complaints Ltd for the purposes of administering my claim or providing a report.
- c. I understand that American Home Assurance Company is a signatory to the General Insurance Information Privacy Code and that a copy of the AHAC 's privacy policy statement, including information about access, may be obtained by writing to the Privacy Manager American Home Assurance Company 549 St Kilda Road Melbourne or by e-mailing australia.privacy.manager@aig.com

Signed _____ Date _____

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 _____

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 _____

Telephone No. _____

Address _____

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 _____

Address _____

Telephone _____

Signature _____

Print Name _____

Position / Title _____

Date _____

Witness _____

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