Accident Insurance

Claim Form

Please print out for signatures and post original to The AIG Building, PO Box 1745, Shortland Street, Auckland, 1140

If emailing, please submit to claimsnz@aig.com

Scheme:

Full policy Number with Prefix :

Full Name of Member:

Phone [ ] Email:

Full Name of Patient:

Phone: [ ] Date of Birth / /

Full Residential Address:

Email:

Patient's Relationship to member Patient's Occupation

Settlement Details

Payee name

Option 1: Direct credit to NZ bank account. Please complete bank details and account number below

OFFICE USE
Bank a/c checked

Option 2 Overseas Bank Transfer

Bank Branch Country

Account details

AIG no longer issues cheques. To confirm transfer of funds, an auto email will be sent to you directly.

Email: Broker Payee

I Agree ☐

Accident

When did the accident occur? / /

Describe the Accident

Describe the Injuries

Illness

When did the first symptoms Appear? / /

What Is the medical diagnosis of your condition?

When did you first see a doctor for this condition? / /

Doctor's Name and Address

Name

Address

Dates hospitalised: Admitted / / Discharged / /

Name and Address of hospital

Name

Address

Name of your regular family doctor Phone [ ]

Address

Have you ever had this, or a similar condition, in the past? YES / NO

(attach separate statement if insufficient space)

All Doctors Names and addresses and dates consulted/treated

Date	Name	Address
/ /		
/ /		
/ /		

Your hospital admission / discharge summary must be provided with the five fully completed pages of this claim.

Declaration by Insured Person

I/we (print full name/s of insured/s) Print Name

declare that the above answers and those contained in any attachments are true, and to the best of my knowledge, those in the Physician's Statement are true and note that the Insurer may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to render AIG Insurance New Zealand Limited, ('AIG') every assistance in dealing with the matter and acknowledge that failure to co-operate with AIG and to provide all information relevant or potentially relevant to the circumstance may result in my/our claim being denied.

Authorisaton:

I/we hereby authorise any hospital, physician or other person who has attended me, to furnish AIG or its representatives with:-

i. copies of hospital and medical reports/notes which AIG considers relevant to the claim;

ii. information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment) which AIG considers relevant to the claim.

I/we agree that a photocopy of this authorisation shall be considered as effective as the original and authorise its use as such.

Privacy:

I/we consent to AIG in accordance with the Privacy Act 2020:

1. collecting holding and using personal information including information by audio, photographic or video surveillance, provided for purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
2. disclosing personal information submitted to another AIG company located overseas, its staff members, the insured, other insurers and re-insurers, law enforcement agencies, investigators, medical professionals, lawyers, assessors, advisors and the agent of any of these, insurance broker, insurance agent or intermediary, employer or other service provider to AIG for the purpose of administering my claim, including providing a report, data management and/or data analytics or claims recovery.

Information is provided voluntarily however if we do not collect this information we may not be able to assess a claim. IInsured person have rights under the Privacy Act 2020 to access and correct their personal information. Further information about this or making a privacy complaint can be obtained by emailing : Privacy.officerNZ@aig.com

I/We consent to AIG's assistance provider recording of all calls to the assistance provider under the insurance for quality assurance, training and verification purposes.

NOTE: AIG will only seek information which in its opinion it believes to be relevant to investigation of the claim.

Name Please Print

Date / /

I Agree ☐

If you are signing on behalf of the Insured person please state your authority to do so and relationship. Please print your name and contact phone:

Name Please Print

Phone [ ]

Position of Authority to sign – Nature of Relationship

Please also have the physician's statement overpage completed and attached.

Attending Physician's Statement

This form must be completed without expense to the Insurer

Please print clearly If there is insufficient space for any answers please attach a separate sheet.

Patient's Name _____ Age _____

Medical Condition

Diagnosis

_____

Any Complications? ◯ YES / NO ◯

If yes give details

_____

What are the factors causing disablement? _____

When did patient first receive medical attention for the above? / /

By whom? _____ Qualifications _____

Dates discharged from your care / / OR What treatment is proposed ongoing? _____

Injury

If an injury, when did the accident occur? / /

Has injury described above resulted in any residual disability? ◯ YES / NO ◯

If Yes please give full details and provide copies of specialist or other reports

_____

Hospitalisation

Dates hospitalised: Admitted / /

Name and location of hospital _____

What Operation if any was performed? _____

Were there any other doctors or consultants attending? ◯ YES / NO ◯ If insufficient space please attach separate sheet

Name _____ Speciality [ ]

Address/Email _____ Phone [ ]

Prognosis / Extent Of Disability:

Based upon Patient's occupation of : (specify) _____

a. Has the patient been able to do ANY work? ◯ YES / NO ◯

b. If so from what date? Full duties / / Restricted Duties / /

Prior History

Are you the usual family doctor for this Patient? YES / NO Since what date? / /

Has patient ever had the same or a similar condition previously? YES / NO

Date / / Condition

Were you the treating physician? YES / NO

If not please give name and contact details of other Treating Physician

Name Phone [ ]

Address Email

Prior Defects

Does Patient have any defects or chronic conditions? YES / NO If yes, when originated / /

Is there anything else you can tell us or recommend which would assist in our assessment or the most effective treatment?

Your name Your Qualifications:

Phone [ ] Email

Address

I Agree ☐ Date / /