Personal Accident or Sickness Scheme (Individual or Group)

Claim Form

Please print out for signatures and post original to your broker if applicable or direct to The AIG Building, PO Box 1745, Shortland Street, Auckland, 1140

If emailing, please submit to claimsnz@aig.com

- Section marked "Policyholder" must be completed and signed by a principal of the Insured Person if not the policyholder.
- Section marked "Attending Physicians Statement" to be completed by the patient's Doctor.
- Please attach a separate sheet if insufficient space.
- ALL QUESTIONS MUST BE FULLY ANSWERED - DASHES ARE INSUFFICIENT.

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 (if not living in New Zealand)

Bank Branch Country

Account details

AIG no longer issues cheques. To confirm transfer of funds, an auto email will be sent to your broker or direct
Email: Broker/Payee

I Agree

Section 1: Scheme Policyholder to Complete

Full Name of SCHEME

SCHEME Policy number expiry date / /

Policyholder Policyholder certificate number

SCHEME Contact Name Phone: [ ]

Email Address

Is the benefit under this policy payable to A) the Insured person OR B) the Policyholder? A / B

Specify payee's full name

Section 2: Insured person to complete

Full Name of Insured Person

Street Address

Email address

Business Phone (Area code) [ ] Home phone [ ]

Date of Birth / / Weight Height (cms) Sex: Male / Female

Occupation prior to Disablement

Describe your usual duties

Describe the injury or sickness for which you are claiming

On what date did your sickness commence, or injury occur? / /

If injured, what were you doing at the time?

Have you ever suffered a similar sickness or injury in the past? YES / NO

If yes, give full details regarding nature of incapacity/ severity:

Period of time off work: from / / to / /

When did you first consult a doctor for the condition for which you are claiming? / / at AM /PM

When did you become totally disabled for work? / / at AM /PM

If still totally disabled, when do you expect to return to work? / / at AM /PM

If you have returned to work, when were you able to again perform:-

1. Part of your occupational duties? / / at AM /PM
2. All of your occupational duties? / / at AM /PM

Give details below of all attending physicians and hospitals attended.

Date of consultation/Treatment / /

Name of hospital

Name of Doctor Phone [ ]

Address/Email

Date of consultation/Treatment / /

Name of hospital

Name of Doctor Phone [ ]

Address/Email

Name of Your usual Doctor Phone [ ]

Address/Email

Have you ever lodged a Personal Accident or Sickness claim before? YES / NO

If YES, On what date? / /

What injury or illness did you suffer?

Give details of incapacity

Insurer Details : Address/Claim No/Policy

Do you have private health insurance? YES / NO

If yes, please provide Name of Health fund and Level of cover

Are you making any other insurance or compensation claim in respect of this disability? YES / NO

If so, please provide full details of cover

Please specify whether Government Benefits / Superannuation or Life Insurance / or other

NB: All injury claims must first be notified to ACC

ACC record number:

Section 3: Insured person: If Self Employed

Please submit documentation to validate earnings.

What are your average weekly earnings, net of expenses, but before tax? $

Do you operate as a Limited Liability Coy? YES / NO

Do you or your Company pay ACC Levy? YES / NO

What is your Business Trading Name?

Address Phone (include area code) [ ]

What Date did you Commence Trading? / /

What is your Accountant's Name ?

Address Phone [ ]

Section 4: Employer/Paymaster to complete

(If Insured person is a wage earner or contractor in scheme)

I hereby certify that has been unable to attend to his/her usual occupation with the Company as a result of *An injury/Injuries/Sickness suffered whilst on / /

He/She has been Incapacitated since / / 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. $ Per .Week. During the period of incapacity he/she received

Normal Pay $ from / / to / /

Sick Pay *$ from / / to / /

ACC Pay *$ from / / to / /

Other (Please Specify) *

$ from / / to / /

He/she has been employed with the Company since / /

Name of Company

Company Stamp

Name of Employer / Paymaster Phone [ ]

Email Address

I Agree Date / /

(print name and position of authority)

Section 5: Sports Injury claim

to be completed by the Club Secretary / Treasurer.

Name of Club

Secretary / Treasurer's Name Phone [ ]

Address/Email Address

I certify that was injured on / /

whilst playing (sport) at Grade with the club

I Agree Date / /

(print name and position of authority)

Declaration- Authority & Privacy Consent

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 | Phone [ ]

Position of Authority to sign – Nature of Relationship

Declaration

I/we (print name/s)

declare that the above answers and those contained in any attachments 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 provide AIG Insurance New Zealand Limited (AIG) with assistance in dealing with this matter and understand that failure to co-operate with AIG and to provide all information relevant to the circumstance may result in my/our claim being denied.

I also declare that I/we have:

(1) *No other accident of sickness insurance with any Insurance Company

OR

(2) * Accident of sickness Insurance with (print name of Insurance Company)

*Delete whichever is not applicable

Authority:

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

II. copies of employment records and income tax returns to the extent that AIG considers they are relevant to the claim; and

III. 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 and valid 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 specialists, 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. Insured persons 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

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

I/we consent to AIG's assistance provider recording of all calls to the assistance service provided under the Travel Insurance for quality assurance, training and verification purposes.

I Agree ☐ | Date / /

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 / /

If not, when will he/she be able to work? Full duties / / Restricted Duties / /

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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 / /