Expatriate Medical Expenses

Report Form

Please print out for signatures and post original to The AIG Building, PO Box 1745, Shortland Street, Auckland, 1140.
Attach copies of substantiating documentation including all original accounts and receipts.
If emailing, please submit to **claimsnz@aig.com.**

- Please attach a separate sheet if insufficient space
- The issue of this form is not an admission of liability and is without prejudice.

Employer/ Group: Policy No:

Address: Phone: [ ]

Insured Employee:

Phone / Email

Postal Address:

Please complete a separate PATIENT section for each person who has received medical treatment

Please complete All sections

Section One: Insured Employee Consent

If you are signing on behalf of the Insured person please state your authority to do so and relationship.

Name Phone: [ ]

Position of Authority to sign – Nature of Relationship

I/we (print signatory name) Print Name

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 which AIG considers 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 agree that a photocopy of this authorisation shall be considered as effective and valid as the original and specifically 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 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

If 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 insurance for quality assurance, training and verification purposes.

I Agree: ☐ Date: / /

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

Section Two: Insured Employee Declaration

If you are signing on behalf of the Insured person please state your authority to do so and relationship.

Name Print Name Phone: [ ]

Position of Authority to sign – Nature of Relationship

I/we (print signatory name) Print Name

declare that all the answers in this claim report and those contained in any attachments are true, and I/we acknowledge that the Insurer may rely on such answers in determining indemnity. I/we have not concealed any material fact relating to this circumstance.

I/we undertake to render AIG assistance in dealing with the matter. I /we understand 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.

I Agree ☐ Date: / /

Section Three: Payments

IMPORTANT:

Bank transfer: Payments can be made into New Zealand or overseas bank accounts as you wish.

Bankdraft: We do not encourage payment overseas by bankdraft due to the extra cost, poor security and delivery delays. However if you specifically request us to pay you in this way, the cost to obtain bankdraft/s will be deducted from your settlement and the risk of loss lies with You.

Cheque: If you do not fully complete one of these options below we will automatically post any payment to you by New Zealand cheque to the address on this form and any costs incurred to convert the currency must be borne by You. AIG does not accept responsibility for delivery failure.

Bank Transfer

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

I Agree ☐

Section 4: Patient One

Name of patient: Date of Birth: / /

Medical Items Claimed

Date of injury or illness	Condition for which treatment obtained	Currency	Amount
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

Attach all original accounts and receipts.

Name and Address of usual Doctor:

Have any of the conditions above or a similar condition been suffered previously? ◯ YES / NO ◯
If YES, please give dates and details of treating doctor , including name and address

INJURY :

Date and circumstances surrounding any injuries:

Is there an entitlement to compensation for this under ACC or any Government Statute, Fund, Plan Benefit Scheme or any other Medical Insurance?

◯ YES / NO ◯ If YES, please give details:

Section 4: Patient Two

Name of patient: Date of Birth: / /

Medical Items Claimed

Date of injury or illness	Condition for which treatment obtained	Currency	Amount
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

Attach all original accounts and receipts.

Name and Address of usual Doctor:

Have any of the conditions above or a similar condition been suffered previously? ◯ YES / NO ◯
If YES, please give dates and details of treating doctor , including name and address

INJURY :

Date and circumstances surrounding any injuries:

Is there an entitlement to compensation for this under ACC or any Government Statute, Fund, Plan Benefit Scheme or any other Medical Insurance?

◯ YES / NO ◯ If YES, please give details:

Section 4: Patient Three

Name of patient: Date of Birth: / /

Medical Items Claimed

Date of injury or illness	Condition for which treatment obtained	Currency	Amount
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

Attach all original accounts and receipts.

Name and Address of usual Doctor:

Have any of the conditions above or a similar condition been suffered previously? ◯YES / NO◯
If YES, please give dates and details of treating doctor , including name and address

INJURY :

Date and circumstances surrounding any injuries:

Is there an entitlement to compensation for this under ACC or any Government Statute, Fund, Plan Benefit Scheme or any other Medical Insurance?
◯YES / NO◯ If YES, please give details:

Section 4: Patient Four

Name of patient: Date of Birth: / /

Medical Items Claimed

Date of injury or illness	Condition for which treatment obtained	Currency	Amount
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

Attach all original accounts and receipts.

Name and Address of usual Doctor:

Have any of the conditions above or a similar condition been suffered previously? ◯YES / NO◯
If YES, please give dates and details of treating doctor , including name and address

INJURY :

Date and circumstances surrounding any injuries:

Is there an entitlement to compensation for this under ACC or any Government Statute, Fund, Plan Benefit Scheme or any other Medical Insurance?
◯YES / NO◯ If YES, please give details: