Attending Physician's Statement

Claim Form

Please arrange for this form to be completed by **the patient's usual doctor**.

You can return it to us via the contact details listed below.

Important:
We respectfully request that this form is completed with as much detail as possible in order to assist our processing and avoid the necessity of additional enquiries.

Claimant Name: **Claim Reference Number:**

Policy Number Sex ☐ Male ☐ Female Age

The Insured is responsible for completion of this form without expense to the company

Patient's name

Address

Please give a complete diagnosis of this condition

History

1. When did the patient first receive medical treatment?
2. a) Was there a previous history of this or a similar condition? ☐ Yes ☐ No
   b) If Yes, please state condition and advise when previous treatment was given
3. a) How long have you known the patient?
   b) Are you the regular general practitioner? ☐ Yes ☐ No

If not, please advise who is

If Injury

1. When did patient suffer the injury?
2. What were the circumstances surrounding the injury?

If Sickness

1. When was the sickness first contracted?
2. When did symptoms become evident?

Degree Of Disability

1. Patient's Occupation?
2. When was patient obliged to cease work?
3. If patient is still disabled, when approximately will the patient be able to resume
   a) Some Duties?
   b) Full Duties?

OR

4. If patient has recovered, when was patient able to resume
   a) Some Duties?
   b) Full Duties?

Treatment Of Present Condition

1. When were you consulted? (a) Initially (b) Most Recently
2. How often has patient consulted you?
3. Was patient confined to hospital? ☐ Yes ☐ No
   If Yes, please advise
   1. Name and address of hospital
   2. Period of confinement From to
4. Was confinement in a convalescent home necessary after hospitalisation? ☐ Yes ☐ No
   If Yes, give details
5. What are the current subjective symptoms?
6. Please give results of any objective findings
   1. X-Rays
   2. Other Tests - Please advise tests done and findings
      1
      2
7. What surgical procedures have been performed?
      1
      2
8. What surgical procedures are contemplated?
      1
      2
9. What other treatment has patient undergone?
10. What other treatment is required?

Are there any underlying conditions affecting recovery from the current condition? ☐ Yes ☐ No

If Yes, please advise nature of underlying conditions and how they affect disability and recovery

Has the patient any other physical or mental impairment? ☐ Yes ☐ No

If Yes, please describe

Please advise names and addresses of other treating physicians

If you have terminated treatment, please advise date

What was the current prognosis?

Are there any further remarks which may assist in assessing this condition?

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AIG collects personal information from you, your agents and people involved in this claim to assist in investigating or processing the claim, improve customer service and products and carry out research and analysis, including data analytics. This may include third parties claiming under the policy, witnesses and medical practitioners. Please note that we will only request for and rely on information that is relevant in assisting us to process your claim. However, failure to disclose information required may result in AIG not being able to administer or declining the claim.

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- entities to which AIG is related and third party providers for data analytics functions; and
- government, law enforcement, dispute resolution, statutory or regulatory bodies, or as required by law.

Some of these entities may be located overseas, including in United States of America, Canada, Bermuda, United Kingdom, Ireland, Belgium, The Netherlands, Germany, France, Singapore, Malaysia, the Philippines, India, Hong Kong, New Zealand as well as a country in which you have a claim and such other countries as may be notified in our Privacy Policy from time to time.

Our Privacy Policy is available at www.aig.com.au or by contacting us on 1300 030 886 and contains information about how you may access and correct your personal information, how to complain about a breach of the applicable privacy principles and how AIG will deal with such a complaint.

Signed

Date

Degree

Name (Please print)

Street Address

City or Town

State

Phone No [ ]

PLEASE KEEP A PHOTOCOPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORD

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