Journey Report Form
Claim Form

This form must be accompanied by an Attending Physicians Statement, which can be obtained by telephoning any of our offices listed. By furnishing this Form the Company makes no admission of Liability or Waiver of its Rights.

All questions must be fully answered, dashes are not acceptable.

Full name of Policyholder | Policy Number

To be completed by Policyholder

Are you registered for GST purposes? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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%) %

Name

Position/Title

Company

Date

Signature

Workers Full Name

Street Address | Postcode

Date of Birth | Height | Weight | Sex ☐ M ☐ F

Phone No (Home) [ ] | Phone No (Business) [ ]

Email Address

Occupation Prior to Disablement

Describe Usual Duties

Give a full description of the injury suffered

Have you ever suffered a similar injury before? ☐ Yes ☐ No
If so, nature of conditions/s; date/s

Treated by:

The Journey

Where did the accident occur? Street/Road Suburb

What address did the journey commence from?

What address were you travelling to?

What time did the journey commence? ☐ am ☐ pm

Were you travelling to or from work? ☐ Yes ☐ No Following your usual route? ☐ Yes ☐ No

What time did you commence work? ☐ am ☐ pm

What time did you finish work? ☐ am ☐ pm

Were you travelling to or from a trade or technical school? ☐ Yes ☐ No Following your usual route? ☐ Yes ☐ No

What time do you commence trade or technical school? ☐ am ☐ pm

What time do you finish trade or technical school? ☐ am ☐ pm

Describe the route and method of transport taken between home and work or vice versa, naming streets in order

Did you divert from your usual route? ☐ Yes ☐ No Was the journey broken for any reason? ☐ Yes ☐ No

If so, for what reason and to what extent?

What days of the week do you work?

How many hours a week do you work?

a) When did you first consult a doctor for the condition which you are claiming? Date Time ☐ am ☐ pm

b) When did you become totally disabled (unable to work)? Date Time ☐ am ☐ pm

c) If still totally disabled, when do you expect to return to work? Date Time ☐ am ☐ pm

d) If you have returned to work, when were you able to again perform

1. part of your occupational duties? Date Time ☐ am ☐ pm
2. all of your occupational duties? Date Time ☐ am ☐ pm

The Journey (continued)

Hospitals

If you were admitted to hospital, or treated as an outpatient, please give details

a) Inpatient

Name

Address From To

b) Outpatient

Name

Address From To

Give details of all attending physicians

Name	Address	Telephone
		[ ]
		[ ]
		[ ]

Who is your usual doctor?

Name	Address	Telephone
		[ ]

The Accident

Date and time of accident Date Time ☐ am ☐ pm

How did the accident occur?

Names and addresses of witnesses

In your opinion, who was responsible for the accident. And Why?

Are you making any other insurance or compensation claim in respect of this disability?

Worker's Comp/Workcare ☐ Yes ☐ No Government Benefits ☐ Yes ☐ No

Motor Accident Law ☐ Yes ☐ No Other ☐ Yes ☐ No

N.B If you were involved in a TRAFFIC ACCIDENT please complete this section.

The Vehicle

Registration Number | State of Registration

Driver's Name

Address | Phone [ ]

Owner's Name

Address | Phone [ ]

Police Station to which the accident was reported | Date reported

Police Officer's Name | Did police attend the scene? ☐ Yes ☐ No

Police action taken or proposed

Had you consumed any alcohol or drugs? ☐ Yes ☐ No

If "Yes", how much?

If you were a passenger, had the driver consumed any drugs or alcohol prior to the accident? ☐ Yes ☐ No

If "Yes", how much?

If you were a driver/passenger were you wearing a seatbelt? ☐ Yes ☐ No

If you were a rider/passenger were you wearing a helmet? ☐ Yes ☐ No

Other Vehicles (If more than two vehicles, attach a separate list)

Registration Number | State of Registration

Driver's Name

Address | Phone [ ]

Owner's Name

Address | Phone [ ]

Using the symbols below, draw a diagram of the accident scene showing the position of all vehicles and indicate by arrows directions of travel.


Your vehicle


Other vehicle


Pedestrian, Cyclist, etc.


Intersection

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 Signature

Name of Supervisor or Paymaster

Telephone No. [ ] Date

* Delete whichever is not applicable

Electronic Funds Transfer (EFT) details

1. Do you want the benefit to be deposited directly into a financial institution account via EFT? ☐ Yes ☐ No
2. Name the account is held in:
3. BSB number (6 digits in total) Financial institution account number (up to 9 digits only)

(If you are unsure of the BSB number, please contact the financial institution where the account is held.)

4. Financial Institution: Branch:

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 AIG or its representatives with:

- All copy hospital and medical reports/notes;
- All copy employment records and income tax returns; and
- 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 AIG relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Privacy Notice

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.

AIG may disclose your information to:

- your or our agents, AIG related entities, reinsurers, contractors or third party providers providing services related to the administration of the claim;
- assessors, third party administrators, emergency providers, retailers, medical providers or travel carriers, or any third parties or insurer from whom AIG seeks recovery related to the claim;
- 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.

Consent

I consent to AIG collecting, using and disclosing personal information as set out in this notice. If I have provided or will provide information to AIG about any other individuals, I confirm that I am authorised to disclose his or her personal information to AIG and also to give this consent on both my and their behalf.

Name _____ Signature _____

Date _____

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

AIG recognises that some customers require additional support when dealing with us. AIG has a range of inclusive support initiatives to assist customers with specific needs. If you have a physical or mental illness, financial challenges, difficulty understanding or reading English we can help. Please visit https://www.aig.com.au/customer-care for more information on how we can assist you. Alternatively, you can speak to our Customer Care team by calling 1300 295 016 or email us at aucustomercare@aig.com

AIG

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