Claim Form
Trauma

Statement by LIFE INSURED. Please answer ALL relevant questions fully, not doing so could result in delays in processing your claim.

SECTION A – Personal Details

Name of Life Insured

Plan Name | Policy Number MP

Residential Address

Telephone (home) | (business) | (mobile)

Date of Birth / / | Occupation

SECTION B – Details of this Condition

1. What is the exact nature of your condition? (Please refer to the Medical Condition definitions in your Policy Document.)

2. When did the symptoms first occur? / / | What was your last physical day at work? / /

3. Have you ever suffered from the same or a similar condition in the past? ☐ Yes ☐ No If 'Yes', please provide details.

4. (a) When did you first consult a doctor or medical provider for your condition? / /

Name of the doctor or medical provider consulted

Address

Field of Practice (ie. GP, cardiologist, etc.)

(b) When did you last consult this doctor? / /

(c) Is this your usual doctor or medical provider? ☐ Yes ☐ No
If 'No', please provide the name and address of your usual doctor or medical provider.

Name

Address

(d) Have you consulted any other doctors and/or medical providers for your condition? ☐ Yes ☐ No
If 'Yes', please provide details below (attach a separate sheet if required).

Date first consulted	Date last consulted	Doctor's name/Field of practice	Address
/ /	/ /		
/ /	/ /		
/ /	/ /		

SECTION B – Details of this Condition (continued)

5. Were you hospitalised? If 'Yes', please provide details below (attach a separate sheet if required). ☐ Yes ☐ No

Hospital name	Address	Date admitted	Date discharged
		/ /	/ /
		/ /	/ /

6. What is your current treatment?

SECTION C – Medical History

7. Give the dates and reasons for all other consultations with your usual doctor or medical provider during the last 5 years.

Date	Reason

8. Have you attended any other doctor or medical provider (other than your usual doctor or medical provider) during the last 5 years? ☐ Yes ☐ No If 'Yes', give details below.

Date	Reason	Name and address of doctor

9. What medications have you taken during the last 5 years (other than for colds or influenza)?

SECTION D – Other Insurances

10. Have you previously made a claim against us (AIA Australia) in respect of this condition or any other injury, sickness or disability? ☐ Yes ☐ No If 'Yes', please provide details.

11. Are you insured elsewhere for trauma, crisis, illness, injury or income protection benefits? ☐ Yes ☐ No
If 'Yes', please provide details.

DECLARATIONS AND AUTHORITIES

DECLARATION AND CONSENT

I declare that the information in this claim form is true, correct and complete.

I understand and agree that if I make any false or fraudulent statements, or fail to advise the insurer, AIA Australia Limited, of any relevant information regarding my claim, AIA Australia Limited may refuse to pay benefits and proceed to cancel my claim and/or my insurance cover.

I declare that I have read and understood the Privacy Statement attached to this claim form and I consent to the collection, use and disclosure of my personal and sensitive information in the manner described in that Privacy Statement.

I confirm my consent for AIA Australia Limited or its representatives to use my personal and sensitive information (whether received by AIA Australia Limited from me or a third party) to investigate, assess and manage my claim and to disclose that information to medical, or health professionals and institutions and:

a. other insurers (including Workers' Compensation insurers);
b. investigators;
c. the ambulance service;
d. AIA Australia Limited's service providers;
e. statutory bodies including law enforcement agencies;
f. insurance or credit reference agencies;
g. financial institutions; and
h. such other third parties as is necessary for that purpose.

AUTHORITY TO OBTAIN INFORMATION

I hereby authorise any individual, organisation or entity within any of the above categories (a to h) that holds my personal and sensitive information to release that information to AIA Australia Limited on request, for the purpose of investigating, assessing and managing my claim.

I hereby authorise any medical practitioner, medical provider, health professional, hospital, dentist or other person who has attended me, to release to AIA Australia Limited or its representatives all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records.

I authorise any previous and my current employer to provide AIA Australia Limited with details of my employment and pay history.

I agree that a copy of this authorisation shall be considered as effective and valid as the original.

Name *(please print)*	Insured's signature	Date
	✗	/ /

Privacy Statement

AIA Australia Limited ('AIA Australia') follows the National Privacy Principles of the Privacy Act 1988 (Cth) including the Privacy Amendment (Private Sector) Act 2000 (Cth).

AIA Australia provides you with the following information regarding its privacy procedures and your rights.

Purpose of Collection

AIA Australia collects personal information about you to:
a. process your application(s) for insurance cover; and
b. administer and manage your insurance cover under the policy including claims; and
c. facilitate AIA Australia's business operations.

If you do not wish to provide AIA Australia with all or part of the personal information it requests from you, AIA Australia may not be able to provide you with insurance cover or assess and manage your claim.

Access to Your Information

You are entitled at any time to request access to your personal information held by AIA Australia. All requests should be made in writing to:

The Group Administration Manager
PO Box 6111
St Kilda Road Central VIC 8008

You can ask AIA Australia to update your personal information at any time if it is inaccurate, incomplete or out of date. In some circumstances, AIA Australia may not permit access to your personal information. Circumstances where access may be denied include where access would be unlawful or denying access is authorised by law. In these cases, AIA Australia will provide you with written reasons for denial of access or a refusal to correct personal information.

Disclosure of Your Information

AIA Australia may disclose your personal information to:
a. the policy owner (including superannuation fund trustee or employer);
b. administrator of the policy;
c. another member of the AIA or AIG Group of companies (whether in Australia or overseas);
d. your adviser (if any);
e. AIA Group contractors and third party service providers, eg. medical practitioners and reinsurers;
f. your employer;
g. financial institutions you nominate; and
h. mail-houses and archive companies.

AIA Australia will only disclose your personal information to these parties for the primary purpose for which it was collected. In some circumstances, AIA Australia is entitled to disclose your personal information to third parties without your authorisation, such as law enforcement agencies or government authorities where disclosure is required by legislation, or to report illegal activities.

Any Questions or Concerns

If you have any questions or concerns about your personal information, please write to:

The Group Administration Manager
PO Box 6111
St Kilda Road Central VIC 8008

AIA Australia has established an internal dispute resolution process for handling customer complaints about company compliance with the National Privacy Principles. This dispute resolution mechanism is designed to be fair and timely to all parties and is free of charge.

If you have a complaint about AIA Australia's handling of your personal information, you should submit it in writing to the Group Administration Manager. You will receive a letter from AIA Australia within 5 working days which documents AIA Australia's complaints handling process. Your complaint will be referred to the Internal Dispute Resolution Committee at AIA Australia who will try to resolve your complaint within 45 days of receipt. Should your complaint not be resolved to your satisfaction by its internal dispute resolution process, you may take your complaint to the Privacy Commissioner. The Privacy Commissioner's contact details are:

Office of the Privacy Commissioner
PO Box 5218
Sydney NSW 2001

or call the Privacy Hotline on 1300 363 992.

For further information or to view AIA Australia's full privacy policy and procedures go to www.aia.com.au

Medical Attendant's Statement
Trauma

To be completed by the doctor or medical provider you have mainly consulted for this disability.
If there is a charge for completing this form, the payment is the responsibility of the patient.

Patient's Name | Occupation

1. How long have you known this patient? Professionally | Personally

2. What is the nature and full extent of the patient's condition?

3. When did you first consult the patient in relation to this condition? / /

4. What were the symptoms?

5. What tests/procedures were carried out? **(Please attach copies of all the results.)**

6. What was the diagnosis?

7. Has the patient been hospitalised or consulted any other doctors or medical providers? ☐ Yes ☐ No If 'Yes', please provide details.

8. Has the patient previously suffered from the same or a related condition? ☐ Yes ☐ No If 'Yes', please provide details.

9. Have any of the patient's family members suffered from this condition? ☐ Yes ☐ No If 'Yes', please provide details.

10. Has the patient ever had hepatitis B or C or was he/she a carrier of Hepatitis B or C? ☐ Yes ☐ No

11. Did the patient smoke tobacco or any other substance? ☐ Yes ☐ No If 'Yes', please provide details.

ADDITIONAL INFORMATION

12. Please provide any additional information or comments you feel are relevant to this claim.

DECLARATION

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true, correct and complete.
I agree that AIA Australia may provide copies of this statement to any medical specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim.
I understand that AIA Australia may be required to submit a copy of my report to the patient for comment or to a mediator, solicitor, Complaints Resolution Tribunal, court or to any other person necessary for determination of the claim.
I further understand that the patient may access a copy of my report from AIA Australia under Government Privacy Legislation.

Name *(please print)* | Qualification(s)

Signature | Date / /

Address | Postcode

E-mail

Telephone | Facsimile