Accident & Health
International Underwriting
Pty Ltd (AHI)
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Claim Form
Personal Accident &/Or Sickness

Important: Please read before you complete this form

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. Please note that Section 1, 2, 5, 6, 7 & 8 are compulsory.
3. Note: This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by AHI.

01. Policy and Personal Information

All Questions Require Completion

Policy Number

Expiry Date

Member Number (if applicable)

Name of Insurance Broker *(if known)*

Name of Insured Company

Title

Given Name(s)

Gender

M F Other

Family Name

Date of Birth

Residential Address (cannot be a PO Box)

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

Occupation, Trade or Profession

Usual Duties

02. Payment Details

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Please provide bank and account details for payment

Account Holder's Name

BSB Number (6-Digits)

Account Number

Bank

03. Details of Accident

Complete If As A Result Of An Accident

Date of Accident

Time

AM / PM

Address where accident occurred

Were there any witnesses to the accident? Yes No

Witness Name

Witness Address

Please describe how the accident / injury occurred

What were the injuries?

Have you previously been treated for any serious injury? Yes No

If Yes, please give details

Give details of any previous claim made for any previous injury against any insurance company (please attach separate sheet if insufficient space)

04. To Be Completed If Disability Is as a Result of an Illness / Sickness

The nature of illness

When did the illness begin?

Have you had this complaint before? Yes No

If Yes, how long were you disabled? Days Months Years

05. Treatment

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Was hospital treatment required? Yes No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

When did you stop work? Time AM / PM

When did you first obtain treatment from doctor? Time AM / PM

Name of Doctor Address

Is this doctor still treating you for the injury / illness? Yes No

Is this doctor your regular doctor? (If No, please give details) Yes No

Name of Regular Doctor Address

Is there any condition (past or present) affecting your current disability? Yes No

If Yes, please give details

Are you now:

Recovered Yes No When did you return to work?

Partially Disabled Yes No When did you return to work undertaking partial duties?

Totally Disabled Yes No When do you expect to return to work?

Have you made, or will you make, a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury? Yes No

If Yes, please give details

	Claim Number (if known)	Name	Address
Employer			
Workers Comp/Transport Insurer			

Are you entitled to claim benefits for this Injury / Illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? Yes No

If Yes, please give details

Name	Address

06. To Be Completed Only If Claiming for Loss of Income

We are unable to process benefit payments without confirmation of income

1. If self employed please indicate by ticking the box ☐ Confirmation of earnings MUST be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

2. -If employed as a wage earner the following is to be completed by your employer (or attach pay slip).

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an

Injury / Illness suffered whilst _____ on the ____ ____ ____ ____

He/She has been incapacitated since ____ ____ ____ ____ ____ ____ ____ ____ and is expected to/did resume duties on ____ ____ ____ ____ ____ ____ ____ ____

His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was $ _____ per week

During the period of incapacity he/she received $ _____ from ____ ____ ____ ____ ____ ____ ____ ____ to ____ ____ ____ ____ ____ ____ ____ ____

Please specify type of pay _____

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

Name of Company _____ Has been employed since ____ ____ ____ ____ ____ ____ ____ ____

Address _____

Signature of Supervisor or Paymaster _____ Date ____ ____ ____ ____ ____ ____ ____ ____

Name (Please Print) _____ Telephone Number _____

07. Declaration

Compulsory

General Insurance Code of Practice
AHI proudly support the General Insurance Code of Practice (the 'Code'). The purpose of the Code is to raise the standards of practice and service in the general insurance industry. For further information on the Code, please visit www.codeofpractice.com.au.

Complaints and Disputes Resolution
If you have a dispute and after talking to AHI, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within 15 business days in accordance with the General Insurance Code of Practice. If you still remain dissatisfied after proceeding with the above, our process includes advising you on how to contact the insurance industry's external independent complaints scheme, the Australian Financial Complaints Authority (AFCA). Access to this scheme is free of charge to you.

Privacy Declaration
I/We agree that, by submitting this form, the personal information I/we provide to AHI in this form or otherwise may be collected, held, used and disclosed in the manner set out in the AHI Privacy Policy found at www.ahiinsurance.com.au, including for the processing of this claim.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:
I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

Authority
I authorise any hospital and/or physician who has treated me to provide AHI with copies of medical records or of my past medical history, as requested.

Signature of Claimant _____

Date ____ ____ ____ ____ ____ ____ ____ ____

Signature of the Insured (if other than claimant) _____

Date ____ ____ ____ ____ ____ ____ ____ ____

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Medical Certificate

The claimant must obtain at own expense from the patient's usual doctor in all cases
Important: the medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries

08. Patient Details

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Name

Date of Birth

Please give complete diagnosis of this condition

History

When did the patient first receive medical treatment?

Is there a previous history of this or a similar condition? Yes No

If Yes, please provide details

How long have you known the patient? Days Months Years

Are you the regular general practitioner? Yes No If not, please advise who is

Sickness

When was sickness first contracted?

OR

When did symptoms become evident?

Injury

When did the patient first suffer the injury?

What was the cause of the injury?

Degree of Disability

When was patient obliged to cease work?

Date

When was / will the patient be able to return to:

Some Duties?

Full Duties?

Treatment of Present Condition

When were you consulted?

Initially

Most recently

Was patient confined to hospital? Yes No

From

To

If Yes, please advise name and address of hospital

What other surgical or medical procedures are possibly contemplated?

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

If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery

What is the current prognosis?

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

Print Name

Qualification

Signature

Address

Phone

Fax

Date