



American Home Assurance Company
ABN 67 007 483 267
Incorporated with Limited Liability in the USA
A Member of American International Group, Inc.

Melbourne: 549 St. Kilda Road, Vic. 3004. (03) 9522 4000 GPO Box 4363, Melbourne 3001.
Sydney: 220 George Street, NSW 2000. (02) 9240 1711
Brisbane: 307 Queen Street, QLD 4000. (07) 3220 0700
Perth: 250 St. George's Terrace, WA 6000. (08) 9481 2855

ACCIDENT OR SICKNESS REPORT FORM

This form must be accompanied by an Attending Physicians Statement, which can be obtained by telephoning any of our offices listed.

Full name of Policyholder	University of Technology, Sydney
Policy Number	2200032832
To be completed by Policyholder Are you registered for GST purposes?	Yes
If YES, what is your Australia Business Number (ABN)	77257686961
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
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%)	100%
Signed	
Print name	Gary Laker
Position / Title	Manager Tax & Insurance
Company	University of Technology, Sydney
Date	

Insured Person's Full Name

Street Address and Postcode

Telephone (including area code)

Home

Business

Email Address

Date of Birth

___ / ___ / ___

Height

Weight

Sex

Occupation prior to disablement

Describe usual duties

Describe the injury or sickness for which you are claiming

On what date did your sickness commence or injury occur?

___ / ___ / ___

If injury, what were you doing at the time?

Have you ever suffered a similar sickness or injury in the past? If yes, give details.

When did you first consult a doctor for the condition for which you are claiming? (Date & Time)

___ / ___ / ___ at ___ : ___ AM / PM

When did you become totally disabled (unable to work)? (Date & Time)

___ / ___ / ___ at ___ : ___ AM / PM

If still totally disabled, when do you expect to return to work? (Date & Time)

___ / ___ / ___ at ___ : ___ AM / PM

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

Part of your occupational duties? (Date & Time)

___ / ___ / ___ at ___ : ___ AM / PM

All of your occupational duties? (Date & Time)

___ / ___ / ___ at ___ : ___ AM / PM

Give details of all attending physicians and hospitals attended.

Name/Address/Telephone

Who is your usual doctor? Name/Address/Telephone

Have you ever lodged a Personal Accident or Sickness claim before? If so, give details. Insurer / Address / Claim No / Policy No / Details

Are you making any other insurance or compensation claim in respect of this disability? Workers Compensation / Government Benefits / Motor Accident Law / Superannuation or Life Insurance / Other.

Do you have private health insurance? YES / NO

If yes, please provide name of health fund and level of cover. _____

Information Authority and Warranty

I, _____ hereby authorise any hospital, physician or other person who

has attended me, or my employer, my accountant or insurer to which

a claim has been submitted, to furnish American Home Assurance Company or its representatives with:-

- i. All copy hospital and medical reports/notes;
- ii. All copy employment records and tax returns; and
- iii. All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment), employment history, income tax returns or claims history.

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.

I declare and warrant that the foregoing particulars are correct in every detail and acknowledge that American Home Assurance Company relies upon the truthfulness of the particulars supplied by me in respect of the claim

Signed _____ Date _____

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

Name of Supervisor or Paymaster (please print)

Telephone No.

Date

Delete whichever is not applicable

If claiming under a Sports Injury Insurance Policy, the following is to be completed by the Club Secretary / Treasurer.

I certify that _____ was injured on _____ / _____ / _____

whilst playing _____ Grade with the club.

Name of Club _____

Secretary / Treasurer's Name _____

Telephone No. _____

Address _____

Signature _____

Date _____

Witness _____

If claiming under a Student Accident Policy, the following is to be completed by the Registrar/Principal or Student Union.

I certify that _____ was injured on _____ / _____ / _____

during the following school / university organised activity:

Name of School / University _____

Address _____

Telephone _____

Signature _____

Print Name _____

Position / Title _____

Date _____

Witness _____

Please return the completed form to: **Insurance Officer (Sadhna Sharma)**

**UTS-Financial Services Unit
Level 6, 235 Jones Street
PO Box 123, Broadway
NSW 2007**

**Tel (02) 9514 2874
Fax (02) 9514 2880
e-mail S.Sharma@uts.edu.au**

Important Notes:

Personal Accident Insurance Cover

The cover is for accident only, not sickness. This policy provides benefits for death, disability, hospitalisation, loss of wages and medical expenses arising from accidental injury whilst either a student or staff member is engaged in a University approved activity.

Disablement and treatment claims must be certified by a qualified medical practitioner who is not the insured person or a family member.

Medical Expenses

This policy provides cover only for medical expenses that cannot be claimed in part or full through Medicare. As you can only claim for treatment that is certified by a legally qualified medical practitioner, you must consult a doctor before obtaining a referral for further treatment.

This insurance does not apply where other compensations such as Medicare, private health insurance, workers compensation etc is claimable. Insurance may cover benefit shortfalls except in the case of the 'Medicare Gap' (for example, if you have private health cover and following an accident you attend physiotherapy appointments – which are not covered by Medicare – you could claim through your private health insurer and then AIG insurance policy could cover the remaining 'gap').

To make a claim

1. You must report an accident by completing Incident Report form, which is available from security office at each campus.
2. Ensure all sections of the form are complete.
3. Attach your Doctor's certification to the claim form.
4. Submit the completed form to UTS Insurance Officer.

Note: UTS does not have the capacity to determine whether or not a claim is eligible for payment of benefits, and cannot make any guarantees that a claim will be accepted or that payments will be made. The decision to accept or make payments against a claim is at the discretion of AIG Insurance.