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CORPORATE



MEDICAL CONDITION AND ACCIDENT FORM

	ase use black pen and print upper case. ABCD
	A Health has received information from you or your health care provider that a claim you recently lodged may be for treatment at you received as a result of an accident.
	u may be entitled to compensation for that accident, so to assess your claim correctly, please complete this form providing A Health with all relevant information.
Pa	tient information
nu Pa na	ember mber tient me te of birth \\ \\ \/ \/ \/ \/ \/ \\
	etails of condition (this must be completed)
De	scribe how the condition or accident occurred
	etails of accident (if applicable)
Pla	ace of accident Date of accident Time of accident
De	etails of claim
1.	Did this accident or injury occur whilst at work or travelling to or from work?
	If yes, have you or will you lodge a claim with your employer/workers compensation? If self-employed, provide full name of business ABN
2.	Did this accident/injury occur when travelling in a vehicle or on public transport?
	If yes, have you or will you lodge a claim with a motor vehicle accident compensation scheme or third party?
3.	Was this accident/injury the result of negligence or violence by another person?
	If yes, do you intend to pursue a Common Law Personal Injuries claim or Criminal Injuries Compensation?
4.	Have you received a Common Law, Third Party or Workers Compensation settlement in regard to this accident? If yes, name of solicitor or other third party Telephone (include area code)
	Name of insurance company involved

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I declare that the information on this form is true and correct. I authorise AIA Health to check any of these services with the relevant providers and authorise AIA Health to contact the provider to obtain any necessary information to either verify or audit this claim.			
Signature of member	Date		

Please return your completed and signed form to AIA Health via email: corporatehealth.claims@aia.com.au or post: AIA Health, PO Box 7302, Melbourne VIC 3004

Member declaration