

AAMI International Travel Insurance – Medical Information Form

How to complete this form

Part A of this form should be completed by the Claimant or the Executor of the Claimant's estate if applicable. Part B of this form should be completed by the Patient or the Executor of the Patient's estate if applicable. Part C of this form should be completed by the Patient's Medical Practitioner or Dentist at the Claimant's expense.

When all three sections of this form are completed it should be returned to:

AAMI International Travel Claims
PO Box 14180
Melbourne City Mail Centre
Victoria 8001

Alternatively, you can choose to email the form to: travelclaims@aami.com.au

We suggest that you keep a copy of the form and all supporting documents for your own records. If we require further information we will contact you.

The privacy of your personal information

Australian Associated Motor Insurers Limited (ABN: 92 004 791 744) (AAMI) is committed to protecting the privacy of your personal information. We are required by the Privacy Act 1988 and other privacy laws to tell you that AAMI collects your personal information in order to process the claim made by the Claimant/Executor (Claim). We may have to disclose your personal information to third parties such as other insurers, the insurance reference service, claims assessors, medical practitioners, investigators, legal practitioners, our service providers or as required by law. You have the right to seek access to, and to ask us to correct, your personal information at any time. Please call us on 13 22 44 for access.

For further information about how we protect your personal information please visit our website aami.com.au or call us on 13 22 44 for a copy of our "AAMI Travel and Your Personal Information" brochure.

PART A – to be completed by the Claimant/Executor

Claim Number:

Policy Number:

First Name:

Surname:

PART B – to be completed by the Patient/Executor

I consent to the collection, use and disclosure of my/the Patient's personal information to handle the Claim.

I acknowledge that if I do not agree to the collection, use and disclosure of this personal information then AAMI may not be able to process or pay the Claim.

I understand that AAMI may disclose my/the Patient's personal information to third parties such as other insurers, the insurance reference service, claims assessors, medical practitioners, investigators, legal practitioners, service providers or as required by law.

I understand that I have the right to seek access to, and to ask AAMI to correct, my/the Patient's personal information at any time.

I authorise AAMI and its representatives to obtain from any person or organisation any personal information about me/the Patient, including sensitive information in accordance with the Privacy Act, in respect of treatment for the condition/s which resulted in or are related to this Claim.

I acknowledge that a copy of this authorisation shall be considered as valid as the original.

Name of Patient/Executor:

Signature of Patient/Executor:

Date:



PART C – Medical Certificate. To be completed by Medical Practitioner or Dentist.

IMPORTANT: The Medical Practitioner or Dentist is respectfully requested to provide as much detail as possible in order to assist the Claimant and avoid the necessity of additional inquiries.

1. Full name of Patient:

2. Date of Birth:
Day Month Year

3. Please give precise diagnosis of the condition, illness or injury:

4. Date on which you were first consulted for this condition, illness or injury:

5. Are you the Patient's usual General Practitioner or Dentist? Yes No

5.1. If yes to 5, for how long?

5.2. If yes to 5, have you previously referred the Patient to a Specialist/ Surgeon in respect of the same/similar/related condition, illness or injury as described at question 3? Yes No

5.3. If yes to 5.2, what date did you refer the Patient to a Specialist/ Surgeon?

5.4. If yes to 5.2, what is the name of Specialist/ Surgeon?

5.5. If yes to 5.2, what is the address of Specialist/ Surgeon?

5.6. If no to 5, please provide full details of the Patient's usual GP:

5.7. If no to 5, do you have access to the Patient's medical records? Yes No

6. Have you previously observed, treated or advised this patient in respect of the same/similar/related illness or injury as described in question 3? Yes (please provide details below) No

6.1. If yes to 6, please state if same illness or injury, or specify similar/related illness or injury:

6.2. If yes to 6, please state when was the last time, prior to the occurrence which gave rise to this Claim, and what treatment and/or medication was prescribed:

6.3. If yes to 6, was the Patient advised to continue this treatment and/or medication?

6.3.1. Until departure on this journey? Yes No

6.3.2. Whilst on the journey? Yes No

7. Did the Patient travel against your advice? Yes No

8. Are you aware if any other Medical Practitioner or Dentist treated this Patient for the same/similar/related condition, illness or injury? Yes (please provide details below) No

8.1. If yes to 8, name of Medical Practitioner or Dentist:

8.2. If yes to 8, address of Medical Practitioner or Dentist:

I certify that the statements contained in this Medical Certificate are true and correct.

Name of Medical Practitioner or Dentist:

Signature of Medical Practitioner or Dentist:

Date:

Qualification:

Telephone:

Facsimile:

Address:

State:

Postcode: