MEDICAL CONDITION AND ACCIDENT FORM

AIA Health

Please use black pen and print upper case.
Avoid contact with the edge of the box. A B C D

AIA Health has received information from you or your health care provider that a claim you recently lodged may be for treatment that you received as a result of an accident.

You may be entitled to compensation for that accident, so to assess your claim correctly, please complete this form providing AIA Health with all relevant information.

Patient information

Member number 3 1 3 7 2

Patient name A N N E T T E L E S K I

Date of birth 2 5 / 0 1 / 5 5

Details of condition (this must be completed)

Describe how the condition or accident occurred

Accident occured whilst on a walk.

Details of accident (if applicable)

Place of accident: Balaclava Rd, Caulfied North.

Date of accident: 1 9 / 1 2 / 2 4

Time of accident: 11 am

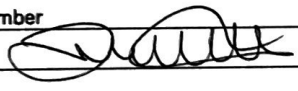
Details of claim

1. Did this accident or injury occur whilst at work or travelling to or from work? ☐ Yes ☑ No
   If yes, have you or will you lodge a claim with your employer/workers compensation? ☐ Yes ☐ No
   If self-employed, provide full name of business
   ABN
2. Did this accident/injury occur when travelling in a vehicle or on public transport? ☐ Yes ☑ No
   If yes, have you or will you lodge a claim with a motor vehicle accident compensation scheme or third party? ☐ Yes ☐ No
3. Was this accident/injury the result of negligence or violence by another person? ☐ Yes ☑ No
   If yes, do you intend to pursue a Common Law Personal Injuries claim or Criminal Injuries Compensation? ☐ Yes ☑ No
4. Have you received a Common Law, Third Party or Workers Compensation settlement in regard to this accident? ☐ Yes ☑ No
   If yes, name of solicitor or other third party
   Telephone (include area code)

Name of insurance company involved

Member declaration

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 23/03/25

Please return to AIA Health either via post: PO Box 7302, Melbourne VIC 3004 or via email at: Health.Claims@aia.com.au