

Any questions?
Please call us

 1300 880 750

Where required under Part B, please complete the 'Authority to release personal Medicare claims information to a third party' form and also have your Medical Practitioner complete the attached 'Bill Relief Initial Medical Report' form.

Please ensure that:

1. All questions are answered fully to avoid undue delays to your claim.
2. You complete this form in black/blue ink and that answers are clear and legible.
3. You're aware that any fee for the completion of the Initial Medical Report is your responsibility.

Part A – Personal details

Policy Number	<input type="text"/>	Date of Birth	<input type="text" value="dd / mm / yyyy"/>
Full Name	<input type="text" value="First name"/>	<input type="text" value="Surname"/>	
Current Residential Address (Not Post Office Box)	<input type="text"/>		
	<input type="text" value="Suburb"/>	<input type="text" value="State"/>	<input type="text" value="Postcode"/>
Postal Address (if different from above)	<input type="text"/>		
	<input type="text" value="Suburb"/>	<input type="text" value="State"/>	<input type="text" value="Postcode"/>
Email Address	<input type="text"/>		
Contact Numbers	<input type="text" value="Home"/>	<input type="text" value="Work"/>	<input type="text" value="Mobile"/>

Please provide bank account details for the claim benefit payments to be paid.

BSB Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>							
Account Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Account Name	<input type="text"/>													

Part B – Claim type

Please only complete the sections and forms relevant to your type of claim

- Sickness (complete parts C, D, G, H, Medicare Authority form, Bill Relief Initial Medical Certificate)
- Injury (complete parts C, E, G, H, Medicare Authority form, Bill Relief Initial Medical Certificate)
- Kids Injury Cover (complete parts F, G, H, Medicare Authority Form, Bill Relief Initial Medical Certificate)

Part C – Occupational/daily activity details

1. What occupation/daily activity were you performing immediately prior to your disability?

2. Please advise the time spent performing the following tasks in your position prior to disability.

Manual duties

Sedentary duties (i.e. sitting)

Part C – Occupational/daily activity details cont.

3. Please provide details of ALL the duties that you performed in this occupation/daily activity during an average day and the approximate time spent performing these duties.

Duties Performed	% of working day
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Total = 100%

4. How long had you been in this occupation/daily activity and performing these duties?

5. What is the average number of hours you spent per week over the last 12 months in the occupation/daily activity?

6. Do you do any unpaid work? Yes No

7. Have you returned to work/your daily activity yet? Yes No

8. If "yes" on what date did you return to work/your daily activity?

9. If "no" what currently prevents you from returning to work/your daily activity?

10. If you have not returned to work/your daily activity, when do you expect to be able to do so?

Full-time Part-time

11. If you are an employee, is your job currently being held open? Yes No

12. Is it your intention to return to work with the same employer? Yes No

If not please explain why?

Part D – Sickness claim

Nature of sickness

Date the symptoms began

Date Doctor first consulted

Date ceased work/regular activity

What are your current symptoms?

Have you previously had the same or similar condition or symptoms? Yes No

Part D – Sickness claim cont.

If 'yes', please provide full details.

Details of all the Doctors/Medical Practitioners you have seen about your condition.

Full Name	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text" value="Suburb"/>	<input type="text" value="State"/>	<input type="text" value="Postcode"/>
	<input type="text"/>		
Contact Number	<input type="text"/>		
Full Name	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text" value="Suburb"/>	<input type="text" value="State"/>	<input type="text" value="Postcode"/>
	<input type="text"/>		
Contact Number	<input type="text"/>		
Full Name	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text" value="Suburb"/>	<input type="text" value="State"/>	<input type="text" value="Postcode"/>
	<input type="text"/>		
Contact Number	<input type="text"/>		

What treatments are you currently receiving (e.g. physiotherapy) and how frequently?

What medications, if any, are you taking at present? Please provide the names and dosages of this medication?

Medication	Dosage/Frequency per day	Recent changes/side effects
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

How are you responding to the treatment and medication that you are receiving?

IMPORTANT

Please attach copies of reports received from Specialists, other Treating Doctors and Health Professionals.

Part E – Injury claim

Nature of Injury

How did the injury occur?

Date of injury

Date Doctor first consulted

Part E – Injury claim cont.

Date ceased work/regular activity

Details of all the Doctors/Medical Practitioners you have seen about your injury.

Full Name

Address

Contact Number

Full Name

Address

Contact Number

Full Name

Address

Contact Number

Location where the Incident/Accident occurred

What treatments are you currently receiving (i.e. physiotherapy) and how frequently?

What medications, if any, are you taking at present? Please provide the names and dosages of this medication?

Medication	Dosage/Frequency per day	Recent changes/side effects
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

How are you responding to the treatment and medication that you are receiving?

IMPORTANT

Please attach copies of reports received from Specialists, other Treating Doctors and Health Professionals.

Part F – Kids Injury claim

Full Name of the child

Nature of Injury

How did the injury occur?

Date of injury

Part F – Kids Injury claim cont.

Date Doctor first consulted dd / mm / yyyy

Doctor/Medical Practitioner details.

Full Name			
Address			
	Suburb	State	Postcode
Contact Number			
Full Name			
Address			
	Suburb	State	Postcode
Contact Number			
Full Name			
Address			
	Suburb	State	Postcode
Contact Number			

Did the child stay in hospital as a result of the injury? Yes No

If yes, length of hospital stay? days

What treatments is the child currently receiving (i.e. physiotherapy) and how frequently?

What medications, if any, is the child taking at present? Please provide the names and dosages of this medication?

Medication	Dosage/Frequency per day	Recent changes/side effects

IMPORTANT

Please attach copies of reports received from Specialists, other treating Doctors and Health Professionals as well as copies of the discharge summary.

Declaration

I hereby declare that the information in this form is complete and correct. I understand and agree that if I make any false or fraudulent statements or fail to advise TAL Life Limited of any relevant information regarding my claim, TAL Life Limited may refuse to pay this claim.

Full Name

Sign here Date dd / mm / yyyy

Medical authority

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, the insurer, TAL Life Limited (TAL), collect and use your health information to assess your application for Cover, to assess and manage your claim, or to confirm the information you gave us when you applied for Cover or made a claim. This is why we need your consent.

Each time you apply for Cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for Cover or a claim.

Medical consent authority 1

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to TAL Life Limited (TAL), or to third parties they engage.

I agree to all the following:

- My health information can be released in the form TAL asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- TAL can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while TAL is assessing my claim or application for Cover, or is verifying disclosures I made in connection with the Cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full Name

Sign here

Date

dd / mm / yyyy

Medical authority cont.

Medical consent authority 2

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to TAL Life Limited (TAL), or to third parties they engage, only if TAL has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within 4 weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- TAL can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while TAL is assessing my claim or application for Cover, or is verifying disclosures I made in connection with the Cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full Name

Sign here

Date

dd / mm / yyyy

Information authority

Where we require information from other sources, such as your accountant or employer, we require your authority to obtain information about you from them. We will only use your authority to obtain information that we reasonably believe is relevant to your policy or claim.

I authorise any insurer (including workers compensation/CTP insurer), government agency or body (including Centrelink/Department of Veteran's Affairs), employer, accountant or other relevant holder of information, to release to TAL Life Limited, its related bodies, corporate, its agents or its representatives and my superannuation fund or its administrator, information which they require for the purpose of assessing or investigating my claim or application for Cover, or verifying disclosures I made in connection with the Cover.

A copy of this authority is to be regarded as if it were the original signed authority.

Full Name

Sign here

Date

dd / mm / yyyy

Privacy

The ways in which Insuranceline and Hallmark General Insurance collect, use, disclose and secure your personal information are set out in their respective Privacy Policies at www.insuranceline.com.au/Privacy-Policy and www.hallmarkinsurance.com.au, which are available free of charge on request.

How to return your documents



Reply Paid 5380, Sydney NSW 2001



claims@insuranceline.com.au