

Income Protection Plus

Sickness or injury initial claim form

Insuranceline

Need any help completing this form? Call us on 1300 880 750 8am-8pm AEST

Please answer ALL questions. Use black/blue ink and ensure answers are clear and legible.

Any fee for the completion of the Initial Medical Report by your Medical Practitioner is your responsibility.

In addition to this form, please provide:

1. An 'Authority to release personal Medicare claims information to a third party' form.
2. Initial Medical Report (to be completed by your Medical Practitioner).

Part A – Self assessment

1. Have you been off work or unable to perform Regular Daily Activities for longer than the waiting period? Yes – Complete and Submit this form No – Answer Q2
2. Has a medical practitioner confirmed that you are likely to be off work for longer than the waiting period? Yes – Complete and Submit this form No – Please wait before claiming.
3. Have you experienced this condition, or a related condition, in the past? Yes – Please check your policy exclusions No

Part B – Personal details Insured

Policy Number:	<input type="text"/>	Date of Birth:	<input type="text"/> dd:	<input type="text"/> mm:	<input type="text"/> yyyy:
Surname:	<input type="text"/>	First name:	<input type="text"/>		
Current Residential Address: (Not Post Office Box)	<input type="text"/>				
	<input type="text"/> suburb:	<input type="text"/> state:	<input type="text"/> postcode:		
Postal Address: (if different from above)	<input type="text"/>				
	<input type="text"/>				
Email Address:	<input type="text"/>				
Phone Numbers:	<input type="text"/> (H)	<input type="text"/> (W)	<input type="text"/> (Mob)		

Part C – Banking details

Please provide bank account details for the claim benefit payments to be paid to upon approval:

BSB:	<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 D – Occupational/daily activity details

1. What occupation or daily activities were you performing prior to your sickness or accident?

2. 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	Please explain if/how/why you are currently restricted from performing these duties?
e.g. Driving	e.g. 25%	e.g. Broken leg prevents ability to use brakes
<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"/>	<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"/>

3. If employed, how long had you been in this occupation and performing these duties?

4. What is the average number of hours you spent per week over the last 12 months in the occupation?

5. Do you do any unpaid work?

Yes No

6. Have you returned to work/your daily activity yet?

Yes No

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

dd: mm: yyyy:

8. If "no":

a. what currently prevents you from returning to work/your daily activity?

b. when do you expect to be able to do so?

Full-time Part-time

9. If you are an employee, is your job currently being held open?

Yes No

10. Is it your intention to return to work with the same employer?

Yes No

If not please explain why?

Part E – Income details

1. What was your annual income in the last financial year?

\$

2. What was your average monthly income in the 12 months before you became unable to work?

\$

3. What income have you received since you became unable to work?

\$

4. Do you have any other source of income?

Yes No

If "yes" please provide the details of the amount you are receiving and when these payments commenced:

Part E – Income details continued

This section is to be completed if you are **EMPLOYED**

IMPORTANT!

If you are **employed** please ATTACH all of the following:

a. Your income tax return for the last financial year.

b. Your Notice of Assessment from the Tax Office for the last financial year.

c. A copy of your pay-slips for the 12 months prior to your sickness or injury. (If you are unable to supply any of these, please call us on 1300 880 750 to discuss.)

5. Company name of Employer
6. Employer's Address
7. Employer's Phone Number
8. Manager/HR Representative's Name:

This section is to be completed if you are **SELF-EMPLOYED**. Please complete the appropriate questions

IMPORTANT!

If you are **self-employed** please ATTACH

a. your personal Tax Return and Business Tax return (if applicable)

b. notice of Assessment from the Tax Office and

c. a Profit and Loss Statement and a Balance Sheet for the 12 months prior to your sickness or injury.

(if you are unable to provide documentation for the 12 months prior to your accident or illness, please provide documentation for the last financial year)

9. What is the name of your business entity?
10. What is your trading name?
11. What is your business structure (please tick appropriate boxes)?
Sole Trader Partnership Trust Or Complete below company details
Company ACN ABN
12. What is your % of ownership of the business?
13. Is your business continuing in your absence? Yes No
14. If yes, who is completing your role/duties?

Part F – Other claims income

1. Have you made, or do you intend to make, a sickness or injury claim with any of the following?

If so, please tick the appropriate answer and provide details.

- | | | | | |
|---------------------------------|------------------------------|-----------------------------|------------------|----------------------|
| a. Any other insurers | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Name of Company: | <input type="text"/> |
| b. Centrelink / Social Security | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Branch: | <input type="text"/> |
| c. Workers' Compensation | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Organisation: | <input type="text"/> |
| d. Common Law Claim | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Details: | <input type="text"/> |
| e. DVA | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Details: | <input type="text"/> |
| f. Any other organisation | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Details: | <input type="text"/> |
| g. CTP Insurer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Details: | <input type="text"/> |
2. What is the total benefit you have received, or are entitled to, from the above?
3. Please provide the date you first started receiving this benefit
- | | | | | | |
|-----|----------------------|-----|----------------------|-------|----------------------|
| dd: | <input type="text"/> | mm: | <input type="text"/> | yyyy: | <input type="text"/> |
|-----|----------------------|-----|----------------------|-------|----------------------|

Part G – Sickness claim (please complete either G: Sickness claim or H: Injury claim)

1. Nature of sickness:

2. Date the symptoms began: dd: mm: yyyy:
Date Doctor first consulted: dd: mm: yyyy:
3. Date ceased work/regular activity: dd: mm: yyyy:

4. What are your current symptoms?

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

If 'yes', please provide full details:

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

Name:
Address:
Phone Number:

Name:
Address:
Phone Number:

Name:
Address:
Phone Number:

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

8. 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 H – Injury claim

1. Nature of Injury:

2. How did the injury occur?

3. Location where the Incident/Accident occurred:

4. Date of injury:
5. Date Doctor first consulted for this condition:
6. Date ceased work/regular activity:

7. Details of all the Doctors/Medical Practitioners you have seen about your conditions:

Name:
Address:
Phone Number:

Name:
Address:
Phone Number:

Name:
Address:
Phone Number:

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

9. 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"/>

10. 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

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.

Name:

Sign here:

Date: dd / mm / yy

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.

Name:

Sign here:

Date: dd / mm / yy

Medical authority continued

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 four 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.

Name:

Sign here:

Date: dd / mm / yy

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.

Name:

Sign here:

Date: dd / mm / yy


Privacy


The ways in which Insuranceline & St Andrew's collect, use, disclose and secure your personal information is set out in their respective Privacy Policies available at www.insuranceline.com.au and www.standrews.com.au.

HOW TO RETURN YOUR DOCUMENTS

 FREE Post Reply Paid GPO Box 5380, Sydney NSW 2001

 FREE Fax 1800 245 662

 1300 880 750

 claims@insuranceline.com.au