

Claim for terminal illness benefit MEDICAL ATTENDANT'S STATEMENT

To be completed by treating medical practitioner

If there is a charge for the completion of this form or for associated copying of your records, it is the responsibility of your patient. Please note that AIA Australia reserves the right to release a copy of this statement and all attachments to the relevant Superannuation Fund Trustees (if any). With your authority and your patient's authority, AIA Australia may share this information with other Medical Practitioners and others involved in assessing this claim. Failure to provide complete information will delay the assessment of your patient's claim.

Return the fully completed form to: Group Super GPO Box 4758, SYDNEY NSW 2001

Patient's full name					Date of birth	
					/ /	
Patient's residential address	i					
				Ctoto Do	stcode	
				State Po	sicode	
How long have you known y		antho				
Years		onths				
How long has your patient a						
Years	Mo	onths				
Does the patient attend any	other practice	or practices?				
☐ No ☐ Yes ► If 'Yes'	, please provid	e details including	name of practice a	and address (If known)		
Name of practice		ce address				
Please list the diagnosed co	ndition or cond	itions suffered by	your patient and de	etails for each condition liste	d	
	Date of first	Date of	Date of			
	onset of	earliest	your initial		Date first	
Diagnosed condition(s)	symptoms	diagnosis	consultation	Place of consultation	hospitalised	
Diagnosed condition(s)						
Diagnosed condition(s)	1 1	1 1	1 1		/ /	
Diagnosed condition(s)	1 1	1 1	/ / / /		1 1	
	1 1	1 1	1 1			
Please provide the following	/ / / details for eac	/ / // h of the conditions	/ / / / s listed in Q4 above		1 1	
Please provide the following	/ / / details for eac	/ / // h of the conditions	/ / / / s listed in Q4 above		1 1	
Please provide the following Please also provide copies Name of medical	/ / / details for eac	/ / // h of the conditions	s listed in Q4 above	eports completed.	1 1	
Please provide the following Please also provide copies Name of medical practitioner making	/ / / details for eac	/ / / / h of the conditions s for all tests per	s listed in Q4 above formed and any re	eports completed.	1 1	
Please provide the following Please also provide copies Name of medical	/ / / details for eac s of the results	/ / / / h of the conditions s for all tests per	s listed in Q4 above	eports completed.	1 1	
Please provide the following Please also provide copies Name of medical practitioner making	/ / / details for eac s of the results	/ / / / h of the conditions s for all tests per	s listed in Q4 above formed and any re	eports completed.	1 1	
Please provide the following Please also provide copies Name of medical practitioner making	/ / / details for eac s of the results	/ / / / h of the conditions s for all tests per	s listed in Q4 above formed and any re	eports completed.	1 1	
Please provide the following Please also provide copies Name of medical practitioner making diagnosis	/ / / details for eac s of the results Qualification	/ / / / h of the conditions s for all tests per	l / / s listed in Q4 above formed and any re How was this dia (e.g. investigatio	eports completed. agnosis reached ns performed)?		
Please provide the following Please also provide copies Name of medical practitioner making	/ / / details for eac s of the results Qualification ge and assuming	/ / / / h of the conditions s for all tests per	l / / s listed in Q4 above formed and any re How was this dia (e.g. investigatio	eports completed. agnosis reached ns performed)?		

Section A – Patient's details (continued)

7.a. To the best of your knowledge and ass	suming optimal treatmen	t, what is the likelihood	of recovery or remission (as a percentage
%			
b. Are there any other factors that influer condition)?	nce or impact your patier	nt's life expectancy (e.g	. response to treatment, secondary
8. When did you first diagnose your patient	to be suffering from this	condition? Date	
9. Has the patient ever had the same or sin	nilar condition (If known))?	1
No Yes ► If 'Yes', please prov	ride details below		
, p		Treatment provided/	
Diagnosis	Date of diagnosis	received	Name of health professional consulted
	1 1	1 1	
	1 1	1 1	
	1 1	1 1	
Section B - Medical practitioner's d	etails	Given name(s)	
Qualifications, Specialty and Specialty sub	type as registered with T	The Australian Health Pr	ractitioner Regulation Agency
Business address			
			State Postcode
Phone number Fax numbe	r		
Email			
I certify that I have examined the patient to AIA Australia providing copies of this d report or to any other person deemed ne Chief Medical Officer contacting me to dissignature	ocument to any medica cessary to assist in the	al specialist from whom assessment of the cla	AIA Australia seeks an independent
	/ /		

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Return the fully completed form to: Group Super GPO Box 4758, SYDNEY NSW 2001

Patient's full name				Date of birth		
ratient's full hame					/ /	
					1 1	
Patient's residential address						
				State F	Postcode	
				State F	rosicode	
How long have you known you Years		20				
	Month					
How long has your patient atte						
Years	Month					
Does the patient attend any ot	her practice or p	practices?				
No Yes If 'Yes', p	lease provide d	letails including	name of practice a	and address (If known)		
Name of practice	Practice a	Practice address				
Please list the diagnosed cond	lition or conditio	ons suffered by y	our patient and de	etails for each condition list	ted	
Please list the diagnosed cond	lition or conditio	ons suffered by y	your patient and de	etails for each condition list	ted	
		Date of earliest	Date of your initial		Date first	
Please list the diagnosed cond	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	etails for each condition list	Date first hospitalised	
	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation		Date first	
	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation		Date first hospitalised	
	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation		Date first hospitalised	
Diagnosed condition(s) Please provide the following de	Date of first onset of symptoms / / / / / / etails for each of	Date of earliest diagnosis / / / / / of the conditions	Date of your initial consultation / / / / / / listed in Q4 above	Place of consultation	Date first hospitalised	
Diagnosed condition(s) Please provide the following de	Date of first onset of symptoms / / / / / / etails for each of	Date of earliest diagnosis / / / / / of the conditions	Date of your initial consultation / / / / / / listed in Q4 above	Place of consultation	Date first hospitalised	
Diagnosed condition(s) Please provide the following de Please also provide copies of Name of medical	Date of first onset of symptoms / / / / / / etails for each of	Date of earliest diagnosis / / / / / of the conditions	Date of your initial consultation / / / / / / / / listed in Q4 above formed and any re	Place of consultation Place of consultation	Date first hospitalised	
Diagnosed condition(s) Please provide the following de Please also provide copies of Name of medical practitioner making	Date of first onset of symptoms / / / / / / etails for each of the results for	Date of earliest diagnosis / / / / / of the conditions	Date of your initial consultation / / / / / / listed in Q4 above formed and any re	Place of consultation Place of consultation Place of consultation	Date first hospitalised	
Diagnosed condition(s) Please provide the following de Please also provide copies of Name of medical	Date of first onset of symptoms / / / / / / etails for each of	Date of earliest diagnosis / / / / / of the conditions	Date of your initial consultation / / / / / / / / listed in Q4 above formed and any re	Place of consultation Place of consultation Place of consultation	Date first hospitalised	
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Diagnosed condition(s) Please provide the following de Please also provide copies of Name of medical practitioner making	Date of first onset of symptoms / / / / etails for each of the results for Qualifications	Date of earliest diagnosis / / / / / of the conditions or all tests perf	Date of your initial consultation / / / / / / listed in Q4 above formed and any real the consultation How was this dia (e.g. investigation	Place of consultation e. eports completed. egnosis reached as performed)?	Date first hospitalised / / / / / /	

Section A – Patient's details (continued)

7.a. To the best of your knowledge and assu	ming optimal treatment	, what is the likelihood	of recovery or remission (as a percentage)
%			
b. Are there any other factors that influenc condition)?	e or impact your patien	t's life expectancy (e.g.	response to treatment, secondary
8. When did you first diagnose your patient to	be suffering from this	condition? Date	,
9. Has the patient ever had the same or simil	ar condition (If known)?	?	1
☐ No ☐ Yes If 'Yes', please provid	e details below		
Diagnosis	Date of diagnosis	Treatment provided/ received	Name of health professional consulted
	1 1	1 1	
	1 1	1 1	
	1 1	1 1	
No Yes ▶ If 'Yes', please provi	de details below		
Section B - Medical practitioner's det	ails		
Title Surname		Given name(s)	
Qualifications, Specialty and Specialty subty	pe as registered with T	he Australian Health Pr	ractitioner Regulation Agency
Business address			
		5	State Postcode
Phone number Fax number			
Email			
I certify that I have examined the patient are to AIA Australia providing copies of this docreport or to any other person deemed necestified Medical Officer contacting me to discussions are the contacting me to discuss and the contacting me to discuss are the contacting me to discuss and the contacting me to disc	cument to any medical ssary to assist in the	specialist from whom assessment of the cla	AIA Australia seeks an independent
	1 1		

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