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

Section A – Patient's details

Patient's full name

Date of birth / /

Patient's residential address

State Postcode

1. How long have you known your patient?

Years Months

2. How long has your patient attended the practice?

Years Months

3. Does the patient attend any other practice or practices?

☐ No ☐ Yes ▶ If 'Yes', please provide details including name of practice and address (If known)

Name of practice	Practice address

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /

5. Please provide the following details for each of the conditions listed in Q4 above.
Please also provide copies of the results for all tests performed and any reports completed.

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?

6. To the best of your knowledge and assuming optimal treatment, what is your patient's expected survival period or prognosis as at today's date. (Please tick (✔) the appropriate box)

☐ Less than 6 months ☐ 6 to 24 months ☐ Greater than 24 months

Section A – Patient's details (continued)

7. a. To the best of your knowledge and assuming optimal treatment, what is the likelihood of recovery or remission (as a percentage)?

%

b. Are there any other factors that influence or impact your patient's life expectancy (e.g. response to treatment, secondary condition)?

8. When did you first diagnose your patient to be suffering from this condition? Date / /

9. Has the patient ever had the same or similar condition (If known)?

☐ No ☐ Yes ▶ If 'Yes', please provide details below

Diagnosis	Date of diagnosis	Treatment provided/ received	Name of health professional consulted
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you previously (or will you be) completing forms/reports regarding this patient for another party (e.g. another insurer)?

☐ No ☐ Yes ▶ If 'Yes', please provide details below

Section B – Medical practitioner's details

Title | Surname | Given name(s)

Qualifications, Specialty and Specialty subtype as registered with The Australian Health Practitioner Regulation Agency

Business address

State Postcode

Phone number ( )

Fax number

Email

I certify that I have examined the patient and that all statements made in this document are correct in all aspects. I consent to AIA Australia providing copies of this document to any medical specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of the claim. I further consent to AIA Australia's Chief Medical Officer contacting me to discuss this patient's claim.

Signature ✗

Date / /

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

Section A – Patient's details

Patient's full name

Date of birth / /

Patient's residential address

State Postcode

1. How long have you known your patient?

Years Months

2. How long has your patient attended the practice?

Years Months

3. Does the patient attend any other practice or practices?

☐ No ☐ Yes ▶ If 'Yes', please provide details including name of practice and address (If known)

Name of practice	Practice address

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /

5. Please provide the following details for each of the conditions listed in Q4 above.
Please also provide copies of the results for all tests performed and any reports completed.

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?

6. To the best of your knowledge and assuming optimal treatment, what is your patient's expected survival period or prognosis as at today's date. (Please tick (✔) the appropriate box)

☐ Less than 6 months ☐ 6 to 24 months ☐ Greater than 24 months

Section A – Patient's details (continued)

7. a. To the best of your knowledge and assuming optimal treatment, what is the likelihood of recovery or remission (as a percentage)?

%

b. Are there any other factors that influence or impact your patient's life expectancy (e.g. response to treatment, secondary condition)?

8. When did you first diagnose your patient to be suffering from this condition? Date / /

9. Has the patient ever had the same or similar condition (If known)?

☐ No ☐ Yes ▶ If 'Yes', please provide details below

Diagnosis	Date of diagnosis	Treatment provided/ received	Name of health professional consulted
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you previously (or will you be) completing forms/reports regarding this patient for another party (e.g. another insurer)?

☐ No ☐ Yes ▶ If 'Yes', please provide details below

Section B – Medical practitioner's details

Title | Surname | Given name(s)

Qualifications, Specialty and Specialty subtype as registered with The Australian Health Practitioner Regulation Agency

Business address

State Postcode

Phone number ( )

Fax number

Email

I certify that I have examined the patient and that all statements made in this document are correct in all aspects. I consent to AIA Australia providing copies of this document to any medical specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of the claim. I further consent to AIA Australia's Chief Medical Officer contacting me to discuss this patient's claim.

Signature ✗

Date / /