Claim for Income Protection Disablement Benefit

CLAIMANT'S INITIAL STATEMENT

To be completed by, or on behalf of, the claimant.

- Please print clearly and complete all sections A through H.
- If there is insufficient space for answers, please attach additional information to this form.
- Please note that AIA Australia reserves the right to release a copy of this statement to the relevant Superannuation Fund Trustees (if any).

Plan name | Policy number | Member number

Return completed documents to Essential Super Claims (on behalf of AIA), Reply Paid 86495, SYDNEY NSW 2001

Section A – Claimant details

Surname | Given names | Date of birth (/ /)

Residential address (note we do not accept PO Boxes)

State Postcode

Postal address – if different from above

State Postcode

Marital status

☐ Married ☐ Single ☐ Other (de facto etc.) _____

Dependants

☐ No ☐ Yes ▶ Number of dependants ____ Age of dependants ____

Left or right hand dominant? ____ Weight ____ kg Height ____ cm

Home number ( ) | Mobile number | Work number ( )

Email address

Preferred contact method | Languages spoken

Do you have legal representation?

☐ No ☐ Yes ▶ If 'Yes', provide details of legal representative

Is someone acting as a Power of Attorney or Guardian of your interests?

☐ No ☐ Yes ▶ If 'Yes', please provide further details including a copy of the relevant legal document.

Section B – Details of disability

1. Outline the cause of your disablement and/or reason for ceasing work.

☐ Injury ☐ Illness

Provide details of how and when the injury or illness first occurred and progressed.

2. What is the medical condition(s) restricting your capacity to work?

3. Date of injury or first symptoms of condition

/ /

4. Date of diagnosis of your condition

/ /

5. Date you first sought treatment for your injury or condition from a health practitioner

/ /

6. Who is currently managing your care and how often do you attend?

Health practitioner's name	Specialty	Date of first visit	Date of last visit	Address and phone number	Frequency of attendance (e.g. weekly fortnightly)
		/ /	/ /		
		/ /	/ /		
		/ /	/ /		

7. Provide the following details of medical practitioners that you have attended for treatment of your current conditions but no longer attend.

Name	Speciality	Date of first visit	Date of last visit	Address and phone number
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

8. Give the details of your planned attendances for assessments, procedures or any other treatment of your condition.

Name	Speciality	Date	Phone number
		/ /	
		/ /	
		/ /	

9. Provide the details of any other health practitioners (physiotherapist, chiropractor, psychologist, alternative providers etc) you have attended for your current conditions but no longer attend.

Name	Speciality	Date of first visit	Date of last visit	Address and phone number
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

10. Outline below all procedures (e.g. surgery), including day stay procedures, undertaken to date or expected to take place.

Procedure details	Dates of hospitalisation	Hospital/facility attended
	/ / to / /	
	/ / to / /	
	/ / to / /	
	/ / to / /	

Section B – Details of disability (continued)

11. Provide details of all medication prescribed to you in relation to your injury or illness, including any that you have ceased.

Name of medication	Current dosage	Date commenced medication	Date ceased medication (if applicable)
		/ /	/ /
		/ /	/ /
		/ /	/ /

12. Have you as a direct result of this condition been incapable of performing your usual occupation?

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

	Date from	Date to	Hours per week
Period(s) of partial disability	/ /	/ /	
	/ /	/ /	
Period(s) of total disability	/ /	/ /	
	/ /	/ /	

13. Have you ever performed light, alternative or modified duties?

No ☐ Yes ☐ ▶ If 'Yes', please provide full details of the duties and dates these were performed:

	Date from	Date to	Duties performed	Hours per week
Period(s) of partial disability	/ /	/ /		
	/ /	/ /		

14. What date did you cease all work and indicate whether any of the following occurred.

/ / Termination of employment ☐ Resignation ☐ Redundancy ☐

15. Have you been able to return to work in any capacity since the date you ceased work?

No ☐ Yes ☐ ▶ If 'Yes', please provide further details **including copies of payslips**.

Date returned from	Date to	Part-time or Full-time	Income
/ /	/ /		
/ /	/ /		
/ /	/ /		

16. Do you consider that you will be able to return to your normal occupation in the near future?

No ☐ ▶ If 'No', please outline the reason why

Yes ☐ ▶ If 'Yes', please indicate the date you consider this will occur

17. Have you undertaken or participated in any formal rehabilitation or a return to work plan?

No ☐ Yes ☐ ▶ If 'Yes', please provide further details including providers' details and dates of attendance.

Section C – Employment and occupation details

1. What was your occupation immediately prior to ceasing work due to your condition(s)?

Job title/position	Industry	Employment address (suburb only)

2. Employer contact details

Address	Phone number	Contact person

3. What date did you commence with your current employer?

/ /

Section C – Employment and occupation details (continued)

4. Was your occupation permanent full-time, permanent part-time or casual? And how many hours do you normally work per week?

Full time (hours per week)	Part-time (hours per week)	Casual (Hours per week)

5. What was your gross annual income averaged over the past 12 months of your occupation?

Annual income $ Hourly rate $

6. How far from home was your place of employment?

Km

7. How did you normally travel to and from work?

8. Are any income producing duties performed at home?

No ☐ Yes ☐ ▶ If 'Yes', please provide details, including amount of hours worked at home and duties performed.

9. Were you employed in a supervisory role?

No ☐ Yes ☐ ▶ If 'Yes', how many people did you supervise?

10. Comment on the activities relevant to your usual position prior to onset of illness or injury and comment on your current capability.

Activity	Did you perform this activity? Yes or No	% of time spent daily	% of time spent weekly	Are you currently capable of completing this activity? Yes or No
Example: Lifting > 20 kg	Yes	10%	35%	No
Walking on even ground				
Walking on uneven ground				
Climbing Stairs				
Sitting				
Standing				
Computer work				
Customer Service				
Kneeling				
Bending				
Climbing/Working at heights				
Driving				
Lifting < 9 kg				
Lifting 9 kg – 20 kg				
Lifting > 20 kg				
Carrying < 9 kg				
Carrying 9 kg – 20 kg				
Carrying > 20 kg				
Reaching (above shoulder)				
Reaching (below shoulder)				

Please comment on any other activities you may perform in the course of your normal daily duties. Also indicate which of these you are currently unable to complete or perform.

Section C – Employment and occupation details (continued)

11. Has there been a significant change in your job, duties and/or hours during the course of your employment?

No ☐ Yes ☐ ▶ If 'Yes', please advise changes in hours, duties. Also provide dates and reasons for these changes.

12. Provide details of all your academic qualifications, valid licences and memberships of professional bodies.
Alternatively, please attach your Resume showing these details

13. Are you currently undertaking any further study or education? If 'Yes', please provide further details.

Section D – Self employed

1. Are you or have you ever been self-employed and or owned a business, company or worked for a family business?

No ☐ Yes ☐ ▶ If 'Yes', complete the below:

Type of business	First traded from	Last traded to	ABN
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

2. If you are a director, owner, or have any other relationship in this, or any other business, please outline your gross annual income before tax for the past 12 months.

a. Gross income from occupation per annum.	$
b. Business expenses.	$
c. Any Income from other sources.	$

Please be advised we may require further information from you, including but not limited to, Business Activity Statements, Company Tax Returns, Individual Tax Returns etc.

Section E – Additional information

1. Please outline any interests or hobbies you have outside of your employment, including details of any sporting or recreational clubs you are a member of.

2. At the time of becoming incapacitated were you on maternity leave, paternity leave, carers leave, career break, study leave, holiday, unemployment or any other form of paid or unpaid leave? If 'Yes', please provide further details below including when you were to return to work.

Section E – Additional information (continued)

1. Please outline any interests or hobbies you have outside of your employment, including details of any sporting or recreational clubs you are a member of.

2. At the time of becoming incapacitated were you on maternity leave, paternity leave, carers leave, career break, study leave, holiday, unemployment or any other form of paid or unpaid leave? If 'Yes', please provide further details below including when you were to return to work.

3. Are you receiving or do you expect to receive any income or benefits from any of these sources whilst you are disabled?

a. Workers Compensation ☐ No ☐ Yes
b. Motor Accident Compensation ☐ No ☐ Yes
c. Your superannuation fund ☐ No ☐ Yes
d. Centrelink ☐ No ☐ Yes
e. Redundancy Payout ☐ No ☐ Yes
f. Department of Veteran Affairs ☐ No ☐ Yes
g. Benefits from any other Life Insurer ☐ No ☐ Yes
h. Any other source ☐ No ☐ Yes ▶ If 'Yes', please specify: _____

4. If you have answered 'Yes' to any of the above please provide further details below:

Provider	Reference number	Gross amount ($)	Period from	Period to
			/ /	/ /
			/ /	/ /
			/ /	/ /

Please ensure that you have carefully considered each question and fully completed this claim form. Incomplete claim forms may result in delays of assessing and managing your claim.

Please use the following checklist to ensure you have attached the required documents, where relevant:

☐ Certified copy of your driver licence or passport (required)
☐ Certified colour photograph of you (required)
☐ Copy of your Resume (where relevant)
☐ Hospital admission and discharge summary (where relevant and accessible)
☐ X-ray, MRI, CT scan reports (where relevant and accessible)
☐ Pathology reports (where relevant and accessible)
☐ If you ceased work more than 12 months ago please provide tax returns including PAYG summaries, Personal Tax returns covering this period, copies of letters and details of any insurance benefits you may be claiming (including Centrelink, Workers Compensation etc).

Please feel free to provide any other information that you feel would be beneficial to the assessment of your claim. Please enclose an extra sheet if you need more space to write.

Section F – Consent for accessing health information

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 (AIA Australia) 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.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

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.

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 AIA Australia, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form AIA Australia 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.
- AIA Australia 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 AIA Australia 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

Signature ✗ Date / /

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 AIA Australia, or to third parties they engage, only if AIA Australia 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:

- AIA Australia 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 AIA Australia 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

Signature ✗ Date / /

Section G – Privacy of your personal information

Our privacy policy contains information on how we collect, use and disclose your personal information (including disclosure to overseas recipients). Visit **aia.com.au/privacy** for a copy.

Section H – Declaration

I declare that the answers to all questions on this form are true and correct, including those not in my own handwriting and I have not withheld any information relevant to this claim.

I understand that if I make false or misleading statements or recklessly or intentionally fail to disclose information, AIA Australia may:

- Refuse to pay this claim.
- Recover benefits paid that were based on false or misleading information I provided.
- Be obliged to refer such cases to the relevant Authority.

I authorise and consent to AIA Australia and its authorised representatives seeking information from:

- my private insurer or other insurers,
- my past and present employers,
- my accountant or financial institution, and
- any relevant government bodies.

I authorise the release to AIA Australia or its authorised representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatments, and copies of all hospital or medical records, employment records and financial records relevant to my insurance cover or claim.

I have read and understood the “Privacy of your personal information” and I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section.

I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Name of claimant (please use block letters)

Claimant signature

✗

Date

/ /

Claim for income protection disablement benefits

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 completed documents to Essential Super Claims (on behalf of AIA), Reply Paid 86495, Sydney NSW 2001

Section A – Patient's details

Patient's full name

Patient's date of birth / /

Address

State Postcode

Patient's record number for your practice

On what date were you first professionally acquainted with your patient? / /

On what date did your patient first attend and/or consult with any other medical practitioner in your practice, if earlier than the above?

/ /

Did you know your patient personally before they consulted you professionally?

☐ No ☐ Yes ▶ If 'Yes', since when and in what capacity?

What is your patient's: Weight kg Height cm

Section B – Details of medical condition(s)

1. List all medical diagnoses causing impairment preventing your patient from working, and the dates of diagnosis. List any complications as secondary diagnosis. (Please note that the terms like 'stress' and 'psychological condition' are not acceptable and the use of them will delay the assessment of your patient's claim). **If the member is suffering from a psychological or psychiatric condition, the diagnosis should be from the Diagnostic and Statistical Manual of Mental Disorders and must meet the manual's criteria.**

Primary diagnosis	Date of diagnosis	1st consultation date
	/ /	/ /
	/ /	/ /
Secondary diagnosis	Date of diagnosis	1st consultation date
	/ /	/ /
	/ /	/ /
	/ /	/ /

2. How frequently do you consult with your patient in relation to these condition(s)?

3. Has your patient ever suffered the same or similar or comparable condition(s) previously?

☐ No ☐ Yes ▶ If 'Yes', please provide details, including dates of onset and presentation, previous treatment undertaken, effects on work capacity and any other outcomes.

Section B – Details of medical condition(s) (continued)

4. If your patient has suffered this condition previously were they able to continue working, either part-time or full-time?

☐ Yes ☐ No ▶ If 'No', please include relevant periods of work cessation.

5. Outline any ongoing complications, incapacity or other clinical issues arising from any previous condition(s), as listed above, or from any other illness or injury.

6. What tests, examinations or reports have led you to formulate your diagnosis as outlined in Q1?
Provide copies of any relevant reports or test results that support the above diagnosis. (Pathology, imaging, operation notes etc). To help avoid follow up requests, ensure that critical reports, such as histopathology of solid neoplasms, have been included.

7. What were the presenting symptoms of the current condition and when did they first arise?

Symptoms	Severity	Date from
		/ /
		/ /
		/ /
		/ /

8. How have these symptoms changed over time?

9. In relation to persisting symptoms, including pain and fatigue, are there any that you cannot correlate well with any examination findings or investigations?

☐ No ☐ Yes ▶ If 'Yes', please give details.

10. What were the presenting clinical signs?

11. How have these clinical signs changed over time?

12. Have there been any inconsistencies between any of the symptoms or signs as noted by you or others? Have there been any other reasons for you to question the validity of any of the symptoms or signs displayed?

☐ No ☐ Yes ▶ If 'Yes' to either, please provide further details.

Section C – Treatment and management plan

1. What initial management did you advise and what was the outcome?

2. Have there ever been concerns about compliance with any health practitioner's treatment advice? Include compliance with advice about any tobacco, alcohol or other substance use.

☐ No ☐ Yes ▶ If 'Yes', provide details, including details of current compliance.

3. If the patient has ever been hospitalised in relation to the current condition please provide details of the hospital, including admission and discharge dates. **Attach a copy of all admission and discharge summaries in your records.**

Hospital	Reason for admission	Admission	Discharge
		/ /	/ /
		/ /	/ /
		/ /	/ /

4. If your patient has undergone surgery or any other procedural intervention, provide further details.
Provide copies of relevant operation notes in your records.

Surgeon's name	Procedure	Date
		/ /
		/ /
		/ /

5. If not included in any other response, list all medication used in management.

Medication (prescribed or unprescribed)	Dosage	Date of commencement	Date of changes and reason
		/ /	
		/ /	
		/ /	

6. Apart from those outcomes noted in any other response, what have been the outcomes of treatments to date? List responses to medications, results of procedural interventions.

7. What changes to management do you anticipate in the future and when? Include details of any planned medication changes, investigations, referrals, hospital admissions, surgery or other procedural intervention.

8. Provide details of any other Health Practitioner's involvement including specialists or allied health professionals attending your patient for treatment or management of their condition.

Name of specialty	Reason for involvement	Contact details (phone)

Section D – Occupation and current capacity to work

1. What is your understanding of your patient's occupation?

2. To the best of your knowledge please advise the patient's occupational background.

3. To the best of your knowledge, your patient's pre-disability work capacity was;

Full-time ☐ ____ hours per week
Part-time ☐ ____ hours per week
Casual ☐ ____ hours per week

4. Comment on activities relevant to your patient based on their usual occupation **before illness or injury** and list any related restrictions **following their injury or illness** commenting on current capability.

Pre-Injury activity					**Current capacity**	
Activity	Never	Rarely	Often	Every workday	Comment on capacity to perform activity yes,no or 'N/A'	Comment on restriction if not capable of pre-injury function. If Permanent indicate permanence with a 'P'.
Example: Lifting > 20 kg			✗			
Walking on even ground						
Walking on uneven ground						
Climbing Stairs						
Sitting						
Standing						
Computer work						
Customer Service						
Kneeling						
Bending						
Climbing/Working at heights						
Driving						
Lifting < 9 kg						
Lifting 9 kg – 20 kg						
Lifting > 20 kg						
Carrying < 9 kg						
Carrying 9 kg – 20 kg						
Carrying > 20 kg						
Reaching (above shoulder)						
Reaching (below shoulder)						

5. Does your patient have a psychological or psychiatric diagnosis listed in Section B?

☐ No ☐ Yes ▶ If 'Yes', please complete the following:

Psychological Function	**Is there a restriction?**		**Details of restrictions where applicable.**
Follow basic instructions	☐ No	☐ Yes	
Perform work tasks	☐ No	☐ Yes	
Maintain concentration	☐ No	☐ Yes	
Maintain energy	☐ No	☐ Yes	
Relate to others (socialise)	☐ No	☐ Yes	
Problem solving	☐ No	☐ Yes	
Retention of information	☐ No	☐ Yes	
Other	☐ No	☐ Yes	

Section D – Occupation and current capacity to work (continiued)

6. Since becoming incapacitated, the patient has been able to work:

☐ Normal duties from / / to / / Hours per week:

☐ Restricted duties from / / to / / Hours per week:

Provide full details of the restrictions and hours per week that apply to your patient during this period

☐ No duties from / / to / /

7. If your patient is still incapacitated, please give the approximate date your patient should be able to return to work.

☐ Normal duties from / / to / / Hours per week:

☐ Restricted duties from / / to / / Hours per week:

Provide the expected restrictions that will apply to your patient during this period

☐ No duties from / / to / /

8. Never return to their usual duties. Provide the reasons why you have concluded this.

Section E – Rehabilitation and additional information

1. Has your patient undertaken any formal rehabilitation assistance to aid in a possible return to work?

☐ No ▶ If 'No', please outline details why.

☐ Yes ▶ If 'Yes', please provide details below including details of the rehabilitation provider, the period rehabilitation was undertaken and the outcome.

2. If **no** to the above, would your patient benefit from a referral to a rehabilitation provider to assist in developing a return to work plan?

☐ No ☐ Yes ▶ Please give your reasons for this conclusion

3. Are there any anticipated barriers to recovery of work capacity that are not directly related to the diagnosed medical condition? Include known details of past, current or future work and family circumstances that may affect recovery. Comment on ability to travel to, from and as part of any work. Comment on litigation and other claims (see question 5 in this section)

Section E – Rehabilitation and additional information (continued)

4. Do you believe maximum rehabilitation has been achieved in each impairment?

☐ No ☐ Yes ▶ Please explain your responses

5. Have you completed any other claim forms for your patient, or are you otherwise aware of your patient receiving or seeking any income or benefits from any of the following sources while disabled?

a. Any other life insurance policy ☐ No ☐ Yes

b. Workers Compensation ☐ No ☐ Yes

c. Compulsory Third Party Insurer ☐ No ☐ Yes

d. Superannuation Fund ☐ No ☐ Yes

e. Centrelink ☐ No ☐ Yes

f. Department of Veteran Affairs ☐ No ☐ Yes

g. Any other source _____

If you have completed any claim forms or reports as noted above, please attach a copy of each.

Provide any further remarks you believe relevant. Attach any additional information that we have not requested but you think will facilitate AIA Australia's understanding of your patient's condition.

To assist with the assessment and ongoing management of your patient's claim we would appreciate if you could complete the checklist below, and provide relevant documentation where applicable:

☐ Specialist reports.
☐ Any test results and reports (Imaging e.g. MRI, histopathology, pathology reports).
☐ Any admission and discharge summaries.
☐ Any other information that may assist your patients claim.

Section F – Medical attendant's details and declaration

Name of Medical Attendant (please print)

Practice address

State Postcode

Postal address (if different)

State Postcode

Email address

Telephone number ( )

Facsimile number ( )

Mobile number

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

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

X

Date

/ /

Claim for Income Insurance Benefit

EMPLOYER'S STATEMENT

To be be completed by the appropriate representative of the Claimant's Employer.

To enable the Fund Trustee and Insurer to consider a claim for your employee, could you please complete the following document.

Plan name | Member number | Policy number

Return the completed documents to Essential Super Claims (on behalf of AIA), Reply Paid 86495, Sydney NSW 2001

Section A – Employer details

Employer name | Employer's ABN

Employer address where claimant is working

State | Postcode

Section B – Claimant's employment details

1. On what date did this employee commence employment?

/ /

2. On commencement of employment was the employee ☐ Full time ☐ Part time ☐ Casual?

Number of hours per week

3. On termination of employment (if applicable) was the employee ☐ Full time ☐ Part time ☐ Casual?

Number of hours per week

4. If there has been a change in the number of hours worked please provide details, including dates of when this change occurred

5. Gross annual salary as at date of disability?

$

6. On what date was this employee first unable to perform all of their normal duties because of the present disablement? (Medical Certificate supplied on cessation of work should be attached).

/ /

7. What was the last date the employee physically attended work in any capacity?

/ /

8. From your knowledge of the situation do you believe the employee will ever return to work? ☐ No ☐ Yes

9. What was the exact job title of the employee's usual occupation?

10. Please describe the exact duties performed (Please attach a job description and any additional information).

11. Please list below any machines or special equipment used by the employee. Were these machines operated manually or automatically?

12. Was the employee employed in a supervisory capacity?

☐ No ☐ Yes ▶ If 'Yes', how many staff did the employee supervise?

Section B – Claimant's employment details (continued)

13. Was the employee responsible for training and employing staff?

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

14. In what area did the employee work. e.g. office, loading dock, in the field, factory etc.?

15. What level of education or other qualifications does this job require, e.g. special courses etc?

16. Are you currently or have you previously been paying compensation benefits or other remuneration to the employee or, has any benefit been paid, or is any benefit due to be paid under the superannuation plan?

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

17. Are you aware of any benefits arising from the current disablement which the employee has claimed or is entitled to claim from any other source(s)?

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

18. Please indicate the status of the employee and provide copies of relevant correspondence if applicable.

On sick leave

☐ No ☐ Yes ▶ If 'Yes', please provide reason for sick leave

Has any sick leave been paid ☐ No ☐ Yes ▶ If 'Yes', please refer to question 20

Terminated

☐ No ☐ Yes ▶ If 'Yes', please provide reason and official date for termination

Retired (ill health)

Retired –ill health ☐ No ☐ Yes ▶ If 'Yes', what was the official date / /

Workers compensation

☐ No ☐ Yes ▶ If 'Yes', dates (from & to) / / / /

Other

☐ No ☐ Yes ▶ If 'Yes', please provide details, including any relevant dates

19. Has the employee been paid any benefits (e.g. sick leave)?

☐ No ☐ Yes ▶ If 'Yes', for what periods and amounts?

Type of benefit	From	To	Amount
	/ /	/ /	$
	/ /	/ /	$
	/ /	/ /	$

20. Does any of this benefit represent accrued sick leave? ☐ No ☐ Yes ▶ If 'Yes', please specify?

From	To	Amount
/ /	/ /	$
/ /	/ /	$
/ /	/ /	$

Section B – Claimant's employment details (continued)

21. If the employee had more than one job/position in his/her time with your organisation, please list all job titles and the time spent in each position.

Job titles	Dates
	/ /
	/ /

22. Could the employee's skills be used in any other type of work within your organisation?

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

23. If the employee should not be able to return to his/her regular occupation, do you have any alternative job openings?

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

24. What similar types of work would the employee's skills qualify him/her for?

25. Has the employee ever performed any light, alternate or modified duties?

☐ No ☐ Yes ▶ If 'Yes', please provide details of the duties performed and the dates these were performed?

Details	From	To
	/ /	/ /
	/ /	/ /
	/ /	/ /

26. Has the employee undergone any rehabilitation or a return to work plan?

☐ No ☐ Yes ▶ If 'Yes', please provide dates and full details, including provider names and contact details:

27. Did the employee resume pre disability duties and hours?

☐ No ☐ Yes ▶ If 'Yes' what date did they resume? / /

Remarks and/or additional information:

I declare that the answers to all questions on this form are true and correct and I have not withheld any relevant information.

Full name (please print in block letters)

Phone number ( )

Job title

Signature of person completing questionnaire

✗

Date / /

Please attach to this form copies of relevant duty statement(s) and position description(s), records or any other information that you are not able to provide above.

EFT details for Income Protection claims

For your Income Protection benefits (after PAYG tax) to be paid directly into your nominated bank account, proof of ownership of your nominated bank account is required. Please attach one of the following:

- a copy of your bank statement; or
- a copy of a cheque showing your BSB number, Account number and Account name; or
- a pre-printed bank deposit slip showing your BSB number, Account number and Account name; or
- a copy of another type of bank correspondence showing your BSB number, Account number and Account name. If sufficient proof is not provided we will issue your payment by cheque.

Please tick (✔) appropriate box

☐ New EFT request ☐ Modify existing EFT request

Plan name | Policy number | Member number

Return completed form to: Essential Super Claims (on behalf of AIA), Reply Paid 86495, Sydney NSW 2001

Section A – Personal details

Name of insured (please print)

Address of insured

State Postcode

Section B – Details of account to be credited

Bank name and branch location

Account name

BSB number Account number

Signature of authorised signatory Date

✗ / /

Section C – Declaration

I declare that the information given in this form is true and correct in every detail

Signature of insured Date

✗ / /

AIA Australia use only

Please tick (✔) appropriate box

☐ EFT to member ☐ EFT to fund

Plan name Policy number