# Claim for Income Protection progress certificate

## CLAIMANT'S STATEMENT

Colonial First State

- Please complete this Claimants statement (pages 1 & 2) and arrange for your treating Medical Practitioner to complete the Medical Attendant's statement (pages 3 & 4).
- If there is insufficie nt space for answers, please attach additional information to this form.

Plan name | Policy number | Member number

**Return the completed documents to Colonial First State, Reply Paid 27, Sydney NSW**

## Section A – Claimant's details

Surname | Given name(s)

Residential address

Postcode

Postal address (if different from above)

Postcode

Current occupation | Phone number

## Section B – Medical details

Since your last report to us, have any of the following occurred?

**1.** Have you sought medical treatment?

No ☐ Yes ☐ ▶ Please provide details:

| Name of treatment provider | Where was treatment provided | Dates treatment provided |
|---|---|---|
| | | |
| | | |
| | | |

**2.** Have you been hospitalised?

No ☐ Yes ☐ ▶ Please provide details:

| Reason for hospitalisation | Date from | Date to | Hospital name and address |
|---|---|---|---|
| | / / | / / | |
| | / / | / / | |
| | / / | / / | |

**3.** Have you had an operation?

No ☐ Yes ☐ ▶ Please provide details:

| Operation | Surgeon | Date |
|---|---|---|
| | | / / |
| | | / / |
| | | / / |

## Section C – Occupational details

Date ceased duties / / Since then:

**1.** Have you been able to perform any occupational duties?

No ☐ Yes ☐ ▸ Please provide details:

**2.** Have you earned any income from your own occupation or from any other business or occupation?

No ☐ Yes ☐ ▸ How much? (Please provide pay slips)

$

**3.** In relation to personal injury or illness, have you claimed or received money from any other Insurance Company, Social Security, Workers Compensation, or from any other source?

No ☐ Yes ☐ ▸ Please provide written confirmation on a separate page

**4.** Have you returned to work?

No ☐ ▸ When do you expect to return to work?

Part-time / / Full-time / /

Yes ☐ ▸ Part-time / / Full-time / /

**5.** Remarks and/or additional information

**Failure to provide complete information will delay the claim assessment.**

## Section D – 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 health 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” as detailed in my previously completed Claimant’s Initial Statement document.

I consent to the disclosure of my claim to the distributor of this product.

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

X

Date

/ /

# Income Protection progress certificate

## MEDICAL ATTENDANT'S STATEMENT

Colonial First State

To assist in continued assessment of this claim, please complete the following (information to be provided at the expense of the patient)

**Return the completed documents to Colonial First State, Reply Paid 27, Sydney NSW**

### Section A – To be completed by medical attendant (please print answers clearly)

| Patient's Surname | Patient's Given names | Patient's date of birth |
|---|---|---|
| | | / / |

Since your last report to us, have any of the following occurred?

**1.** Diagnosis

Be specific as non-specific terms, such as 'stress', 'stress condition' and 'psychological condition' are not acceptable.

**2.** Date of last attendance for assessment and/or treatment by you.

/ /

**3.** What is your patient's most recently recorded weight?

kg Date recorded / /

**4.** Describe any change in patient's condition since last report:

**5.** If a condition causing disability has extended beyond the originally anticipated period, give details including an explanation for this extension.

**6.** Give details of the treatment being provided, including that by any specialist, physiotherapist or other health practitioner. If you are not currently providing any of this treatment, state when you last provided any.

▶ **Section A** continued overleaf

## Section A – To be completed by medical attendant (continued)

**To the best of your knowledge**

**7.** Is the patient still totally disabled and unable to work?

No ☐ Please provide the dates the patient returned to work:

Part-time / / Full-time / /

Yes ☐ Please provide the approximate dates the patient should be able to return to work:

Part-time / / Full-time / /

**8.** 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 | ☐ No | ☐ Yes ▶ If 'Yes', please specify: |

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

**9.** 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. Attach copies of any clinical reports, e.g. investigation results, specialist letters, discharge summaries, operation notes, etc., that have not previously been provided to AIA Australia.

Name of medical attendant (please print in block letters)

Address

Postcode

Phone number ( )

Fax number ( )

Specialist

No ☐ Yes ☐

Qualifications

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

/ /