# Claim for total & permanent 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** AIA Australia Wholesale Life Claims, PO Box 322, SILVERWATER NSW 2128

### 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.

| |
|---|
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| |
| |

**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 of visit | Address and 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 | Dosage | Date commenced medication | Date ceased medication (if applicable) |
|---|---|---|---|
| | | / / | / / |
| | | / / | / / |
| | | / / | / / |

**12.** First date you were unable to perform your **usual** occupation / /

**13.** What date were you physically unable to attend work in **any** capacity? / /

**14.** 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.

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

**15.** 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.

**16.** Indicate if any of the following have occurred:

☐ Termination of employment ☐ Resignation ☐ Redundancy

Provide further details including dates and reasons.

## 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?

/ /

**4.** Was your occupation permanent full-time, permanent part-time or casual?

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

**5.** How far from home was your place of employment km

**6.** How did you normally travel to and from work?

## Section C – Employment and occupation details (continued)

**7.** 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.

**8.** Were you employed in a supervisory role?

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

**9.** 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 | Are you currently able to do this? Yes or No |
|---|---|---|---|
| **Example:** Lifting > 20 kg | *Yes* | *10%* | *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.

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

☐ No ☐ Yes ▶ If 'Yes', please outline these changes including dates and reasons.

## Section C – Employment and occupation details (continued)

**11.** Provide a full employment history including occupations, names of employers, full duties and dates employed.
**Alternatively, please attach your Resume showing these details.**

| Employer | Occupation/Main duties | Period of employment | | Reason for leaving |
|---|---|---|---|---|
| | | From | To | |
| | | / / | / / | |
| | | / / | / / | |
| | | / / | / / | |
| | | / / | / / | |
| | | / / | / / | |

**12.** Provide details of all your qualifications, valid licences and memberships of any professional bodies and are they current.
**Again alternatively, please attach copies showing these details.**

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|---|
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| |

**13.** Are you currently undertaking any further study or education?

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

| |
|---|
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| |
| |

## 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?

☐ No ☐ Yes ▶ 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 | **e.** Redundancy payout | ☐ No | ☐ Yes |
| **b.** Motor Accident Compensation | ☐ No | ☐ Yes | **f.** Department of Veteran Affairs | ☐ No | ☐ Yes |
| **c.** Your superannuation fund | ☐ No | ☐ Yes | **g.** Benefits from any other life insurer | ☐ No | ☐ Yes |
| **d.** Centrelink | ☐ No | ☐ Yes | **h.** Any other source (please specify) | _____ | |

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

| Provider | Reference number | Gross amount | Period from | 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's licence or passport

☐ Certified colour photograph of you

☐ Copy of your resume (where relevant)

☐ Hospital 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.

▶ Form continued next page

## 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:

- 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

X

Date

/ /