Retail Income Protection Claim Form

Statement by LIFE INSURED. All relevant questions MUST be answered fully.

SECTION A – Personal Details

Name of Life Insured | Policy Number

Residential Address (Postcode)

Postal Address (Postcode)

Telephone (home) | (business) | (mobile)

E-mail (for correspondence) | Date of Birth / /

Do you hold citizenship(s) other than an Australian citizenship? ☐ Yes ☐ No | Age

If 'Yes', please advise your other country of citizenship(s)

When did you cease work? / / | When did you first consult a doctor or medical provider after you ceased work? / /

Please provide the name, address and telephone contact details of this doctor or medical provider you consulted.

SECTION B – Claim Details (complete part A in case of injury or part B in case of sickness)

A: Injury Claim – Answer all of Section A (questions 1 to 5 below), if your claim is in respect of an injury.

1. What is your injury? (Please provide full details of the nature and extent of your injuries. E.g. If to a limb, specify whether left or right.)
2. When did the injury occur? Date / / Time am/pm
3. Where did the injury occur? (Please provide the full address details of the place where the injury occurred.)
4. How did the injury happen and what caused it?
5. Were there any witnesses to the injury? If '**Yes**', please provide their names and contact details (if known)..... ☐ Yes ☐ No

B: Sickness Claim – Answer all of Section B (questions 1 to 5 below), if your claim is in respect of a sickness.

1. What is the nature of your sickness?
2. When did your symptoms first occur? Date / /
3. Please describe your current symptoms and their severity.
4. When was a diagnosis made? Date / /
5. Please provide the name, address and telephone contact details of the doctor or medical provider who made the diagnosis.

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, Melbourne VIC 3004 Phone: 1800 333 613 Fax: 1800 832 266

SECTION C – Treatment for this Condition

1. (a) When did you first consult a doctor or medical provider for your condition? / /

Name, address and telephone contact details of the doctor or medical provider consulted.

Field of Practice (GP, cardiologist, etc.)

(b) When did you last consult this doctor or medical provider? / /

(c) Is this your usual doctor or medical provider? ☐ Yes ☐ No
If '**No**', please provide the name, address and telephone contact details of your usual doctor or medical provider.

(d) How long have you attended your usual doctor or medical provider?

(e) Have you consulted any other doctors and/or medical providers for your condition? ☐ Yes ☐ No
If '**Yes**', please provide details below (attach a separate sheet if required).

Date first consulted	Date last consulted	Doctor's name/Field of practice	Address and telephone contact details
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

(f) Do you have a Return to Work Plan or have you discussed one with your doctor? ☐ Yes ☐ No
If '**Yes**', please provide full details.
If '**No**', please provide the reason and whether you believe occupational rehabilitation (e.g. Return to work program, studying, re-training, up-skilling etc) could assist you.

2. Were you hospitalised? ☐ Yes ☐ No
If '**Yes**', please provide details below (attach a separate sheet if required).

Hospital name	Address and telephone contact details	Date admitted	Date discharged
		/ /	/ /
		/ /	/ /
		/ /	/ /

SECTION C – Treatment for this Condition (continued)

3. Are you entitled to receive sick leave from your employer for your present disablement? ☐ Yes ☐ No
If '**Yes**', what period(s) are you entitled to and how much sick leave have you, or are you entitled to receive?

4. Have you ever had the same or similar injury or sickness before? ☐ Yes ☐ No
If '**Yes**', please advise the dates of when the injury or sickness occurred, what the nature of the injury/sickness was and the names of all doctors or medical providers you consulted (attach a separate sheet if required).

SECTION D – Medical History

1. Please provide the dates and reasons of all consultations with your usual doctor or medical provider during the last 5 years.

Date	Reason

2. Have you attended any other doctor or medical provider (other than your usual doctor or medical provider) during the last 5 years? If '**Yes**', please provide reasons below. ☐ Yes ☐ No

Date	Reason	Name, address and telephone contact details of doctor

3. What medications have you taken during the last 5 years (other than for colds or influenza)?

4. Have you been disabled or incapacitated through any other injury or sickness in the last 12 months? ☐ Yes ☐ No
If '**Yes**', please advise the nature of the injury or sickness and how many days leave you required.

SECTION E – Occupational Details

A: Employees (Answer questions 1 to 13 if you are an employee.)

1. What is your Employer's name, address and telephone contact details?

2. What was your job title when you ceased work?

3. Please provide details of your work duties and responsibilities.

Duties and responsibilities	% (totalling 100%)

4. (a) Was your employment ☐ Full-time? ☐ Part-time? ☐ Casual? ☐ Contractor?

(b) If contractor, please provide the term of contract. From / / to / /

5. Where did you work (e.g. office, factory, building site)?

6. How long have you been in that job? Years Months

7. How many hours per week did you work?

8. Did you supervise other employees? ☐ Yes ☐ No If '**Yes**', how many?

9. Did you operate machines or any special equipment? If '**Yes**', please provide details. ☐ Yes ☐ No

10. Please indicate (✔) the following requirements of your usual occupation, where applicable.

	A	B	C	D		A	B	C	D
Lifting, 20 kg and over	☐	☐	☐	☐	Carrying, 20 kg and over	☐	☐	☐	☐
Lifting, 5 to 19 kg	☐	☐	☐	☐	Carrying, 5 to 19 kg	☐	☐	☐	☐
Lifting, under 5 kg	☐	☐	☐	☐	Carrying, under 5 kg	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐					

***A** = continuous (more than 2/3 of time), **B** = frequently (1/3 to 2/3 of time), **C** = occasional (1/3 of time or less), **D** = never*

11. What percentage of time, on average, did you spend in the following activities while performing your usual occupation?

%	Sitting	%	Standing	%	Walking	%	Bending	%	Lifting
%	Driving	%	Climbing	%	Crawling	%	Kneeling		

12. Were you required to travel as part of your usual occupation? ☐ Yes ☐ No

If '**Yes**', how may kilometres per week and type of vehicle.

13. How far from home was your place of employment and how did you get there?

SECTION E – Occupational Details (continued)

B: Self-Employed (Answer questions 1 to 12 if you are self employed.)

1. Are you a ☐ Sole trader? ☐ Partnership? ☐ Company? ☐ Trust?

2. What is the name of your business?

3. (a) **If a partnership**, what is your share of partnership (income and expenses) distribution? %

(b) How many partners are there?

4. What duties did you normally perform in the business prior to your disability?

Duties	% (totalling 100%)

5. Please indicate (✔) the following requirements of your usual occupation, where applicable.

	A	B	C	D
Lifting, 20 kg and over	☐	☐	☐	☐
Lifting, 5 to 19 kg	☐	☐	☐	☐
Lifting, under 5 kg	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐

	A	B	C	D
Carrying, 20 kg and over	☐	☐	☐	☐
Carrying, 5 to 19 kg	☐	☐	☐	☐
Carrying, under 5 kg	☐	☐	☐	☐

***A** = continuous (more than 2/3 of time), **B** = frequently (1/3 to 2/3 of time), **C** = occasional (1/3 of time or less), **D** = never*

6. What percentage of time, on average, did you spend in the following activities while performing your usual occupation?

% Sitting % Standing % Walking % Bending % Lifting

% Driving % Climbing % Crawling % Kneeling

7. How many hours per week did you work?

8. (a) How many employees does your business have?

(b) What are their work responsibilities?

9. Since your disablement, has your business continued to operate in any way? ☐ Yes ☐ No

If '**Yes**', please detail what activities have continued.

10. If your business has continued, what impact has your disability had on the business?

11. Who has been operating your business in your absence?

12. How long will your business continue to operate during your absence?

SECTION F – Level of Disability

1. Please list which of your usual occupation duties you can and cannot do solely due to your injury or sickness.

Work duties you **can** do	Work duties you **cannot** do

2. When will you be able to return to work? ☐ Part-time / / ☐ Full-time / /

3. When did you resume work in any capacity (full or part-time, paid or unpaid)?

Part-time / / Full-time / /

4. How many hours a week are you working?

5. Who has been your employer/s since returning to work? (list name, address and telephone contact details)

6. What occupation/s have you been working in?

7. What duties have you been performing?

8. What is your income for the work performed?* $

**When advising details of your earnings, please note that if there was a delay between the time you generated the income and when you actually received it, the income generated for the work performed should be advised.*
If required, please refer to the Product Disclosure Statement/Policy Document for the definition of income.

9. (a) Have you applied for any jobs since ceasing work? ..... ☐ Yes ☐ No
If '**Yes**', please provide details (including dates, employer and job title).

(b) If successful please provide details of your new employer and job title.

SECTION G – Financial Information

1. What were your average monthly earnings for the last 12 months? $ *

2. What were your earnings for the last financial year (1 July to 30 June)? $ *

** Please refer to the Product Disclosure Statement/Policy Document for the definition of income.*
Financial evidence may be required to confirm these figures.

3. Please provide your Accountant's name, address and telephone number.

Name

Address

Telephone

SECTION H – Other Insurances

1. As a result of your disability are you entitled to claim and/or receive, or are you receiving any other benefit?
(e.g. Workers Compensation, Transport Accident Commission, Third Party Insurance, Centrelink, Income Protection, Superannuation, Salary Continuance, common law or any other insurance or any other source) ..... ☐ Yes ☐ No

If '**Yes**', please provide the following:

Type of claim

Insurer (if applicable)

Reference number

Gross amount of claim $ per week

Period the payment refers to: From / / to / /

Contact person

Contact number

2. Do you have any other sources of income? If '**Yes**', please provide details. ..... ☐ Yes ☐ No

3. Have you previously made a claim against us (AIA Australia) in respect of this or any other injury, sickness or disability? ☐ Yes ☐ No
If '**Yes**', please provide details.

SECTION I – Declarations and Authorities

DECLARATION AND CONSENT

I declare that the information in this Claim Form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise AIA Australia Limited of any relevant information regarding my claim, AIA Australia Limited may refuse to pay benefits and proceed to cancel my claim and/or my insurance cover.

I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy section of this form and the Privacy Policy on the AIA Australia website www.aia.com.au as updated from time to time, including (without limitation) for the purposes of investigation, assessment and management of my claim and related purposes, and the collection and exchange of my personal and sensitive information from and with the following (where relevant):

a. the life insured, policy owner or beneficiaries of my insurance policy;
b. my representatives (including my financial adviser), employer and financial institution;
c. other insurers (including workers' compensation insurers), insurance brokers and intermediaries and insurance and credit reference agencies;
d. medical and health providers, including the ambulance service;
e. AIA Australia's investigators, service providers, partners and reinsurers;
f. regulatory and law enforcement agencies;
g. the trustee and administrator of my superannuation fund; and
h. other third parties assisting with the investigation, assessment and management of my claim.

I authorise my previous and current employer to provide AIA Australia Limited details of my employment history.

I agree that a copy of this authorisation shall be considered as effective and valid as the original.

Name of Life Insured *(please print)*	Signature of Life Insured	Date
	✗	/ /

AUTHORITY TO OBTAIN INFORMATION

I hereby authorise any insurer or other institution to release to AIA Australia Limited or its representatives all information which AIA Australia Limited requests for the purpose of assessing or investigating my claim.

I agree that a copy of this authorisation shall be as effective and valid as the original.

Name of Life Insured *(please print)*	Signature of Life Insured	Date
	✗	/ /

ACCOUNTANT/FINANCIAL ADVISER AUTHORITY

I hereby authorise my previous and current accountant/financial adviser to release to AIA Australia Limited or its representatives all information which AIA Australia Limited requests for the purpose of assessing or investigating my claim.

I agree that a copy of this authorisation shall be as effective and valid as the original.

Name of Life Insured *(please print)*	Signature of Life Insured	Date
	✗	/ /

MEDICAL AUTHORITY

I hereby authorise any medical practitioner, medical provider, health professional, hospital, dentist or other person who has attended me, to release to AIA Australia Limited or its representatives all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records.

I agree that a copy of this authorisation shall be as effective and valid as the original.

Name of Life Insured *(please print)*	Signature of Life Insured	Date
	✗	/ /

Privacy

This section summarises key information in the AIA Australia Privacy Policy, which may be updated from time to time. For further information, please review the most up to date full version of the AIA Australia Privacy Policy on AIA Australia's website at www.aia.com.au.

AIA Australia Limited is part of the AIA Group. Your privacy is important to us and AIA Australia Limited is bound by the privacy principles which apply to private sector organisations under the Privacy Act, and other laws which protect your privacy. AIA Australia Limited, AIA Financial Services Limited, AIA Group and their related bodies corporate and joint venture partners (together referred to as "AIA Australia", "we", "us" and "our") provide you the following notification and information about our Privacy Policy and your rights.

Why we collect personal information

We collect, use and disclose personal information (including sensitive information) for purposes set out in our Privacy Policy, including to process your applications, enquiries and requests in relation to insurance and other products, for underwriting and reinsurance purposes, to administer, assess and manage your insurance and other products, including claims, and to provide, manage and improve our products and services. We may not be able to do these things without your personal information. We may also collect, use and disclose personal information to understand your needs, interests and behaviour, personalise our dealings with you, to verify your identity, authority to act on behalf of a customer and personal information, maintain and update our records, manage our relationship with you, comply with local and foreign laws and regulatory requests, detect, manage and deal with improper conduct and commercial risks and for reporting and research purposes. Where you agree or we are otherwise permitted by law, we may also notify you of offers and other information about products or services we think may interest you. If you do not wish to receive these direct marketing communications, you may indicate this where prompted or by contacting us as set out in our Privacy Policy.

How we collect, use and disclose personal information

We may collect your personal information from various sources including forms you submit and our records about your use of our products and services and dealings with us, including any telephone, email and online interactions. We may also collect your information from public sources, social media and from the parties described in our Privacy Policy. We are required or authorised to collect personal information under various laws including the Life Insurance Act, Insurance Contracts Act, Corporations Act and other laws set out in our Privacy Policy. Where you provide us with personal information about someone else, you must have their consent to provide their personal information to us in the manner described in our Privacy Policy.

We may collect your personal information from, and exchange your personal information with, our affiliates and third parties, including the life insured, policy owner or beneficiaries of your insurance policy, our service providers, your representatives (including your financial adviser), the trustee and administrator of a superannuation fund, your employer or bank, health providers, partners used in our activities or business initiatives, reinsurers, insurance brokers and intermediaries, regulatory and law enforcement agencies, and other parties as described in our Privacy Policy. Parties to whom we disclose personal information may be located in Australia, South Africa, the US, Europe, Asia and other countries including those set out in our Privacy Policy and you acknowledge that Australian Privacy Principle 8.1 (which relates to cross-border disclosures) will not apply to the disclosure, we will not be accountable for those overseas parties under the Privacy Act and you may not be able to seek redress under the Privacy Act.

Where we provide your personal information to a third party, the third party may collect, use and disclose your personal information in accordance with their own privacy policy and procedures. These may be different to those of AIA Australia.

Other important information

By providing information to us or your adviser (and the licensed dealer or broker they represent), the trustee or administrator of a superannuation fund, or other representative or intermediary, submitting or continuing with a form or claim, or otherwise interacting or continuing your relationship with us, you confirm that you agree and consent to the collection, use (including holding and storage), disclosure and handling of personal information (including sensitive information) in the manner described in the most up to date version of our Privacy Policy on our website and that you have been notified of the matters set out in the AIA Australia Privacy Policy before providing personal information to us. You agree that we may not issue a separate notice each time personal information is collected.

You must obtain and read the most up to date version of the AIA Australia Privacy Policy from our website at www.aia.com.au or by contacting us on 1800 333 613 to obtain a copy. You have the right to access the personal information we hold about you, and can request the correction of your personal data if it is inaccurate, incomplete or out of date. Requests for access or correction can be directed to us using the details in the 'Contact us' section below. Our Privacy Policy provides more detail about our collection, use (including handling and storage), disclosure of personal information and how you can access and correct your personal information, make a privacy related complaint and how we will deal with that complaint, and your opt-out rights.

For the avoidance of doubt, the Privacy Policy applicable to the management and handling of personal information will be the most current version published at www.aia.com.au shall supersede and replace all previous Privacy Policies and/or Privacy Statements and privacy summaries that you may receive or access, including but not limited to those contained in or referred to in any telephone recordings and calls, applications, underwriting and claim forms, Product Disclosure Statements and other insurance and disclosure statements and documention.

Contact us

If you have any questions or concerns about your personal information, please contact us as set out below:

The Compliance Manager
AIA Australia Limited
PO Box 6111
Melbourne VIC 3004
Phone 1800 333 613

Retail Medical Attendant's Statement
Income Protection

To be completed by the doctor or medical provider you have mainly consulted for this disability.
If there is a charge for completing this form, its payment is the responsibility of the patient.

Privacy
In completing this form you may be providing AIA Australia Limited with personal information (including sensitive information). This information must be handled, collected, used and disclosed in accordance with the Privacy Act 1988 (Cth) and the AIA Australia Privacy Policy as updated from time to time. For more information about the AIA Australia Privacy Policy (including notification) please refer to www.aia.com.au or contact 1800 333 613 to request a copy. AIA Australia may, if requested by the patient, require that you consider a request for personal and sensitive information and act accordingly.

Patient's Name _____ Date of Birth / /

Address _____

Occupation _____

1. How long have you known this patient? Professionally _____ Personally _____

2. (a) Are you the patient's usual doctor? ☐ Yes ☐ No
If '**No**', please provide the name, address and telephone contact details of his/her usual doctor.

(b) If the patient was referred to you, please advise name, address and telephone contact details of referring doctor.

3. (a) What is your patient's height and weight? Height _____ cm Weight _____ kg

(b) Is your patient left or right handed? ☐ Left handed ☐ Right handed

4. Does your patient smoke? If '**Yes**', please state substance, quantity and how long he/she has smoked. ☐ Yes ☐ No

5. Please describe the nature and extent of the patient's condition, its probable cause (if known) and the level of disability.
Please confirm whether the condition is an injury or sickness.

6. (a) (i) On what date did the condition first occur? / /

(ii) Is the patient still receiving treatment? ☐ Yes ☐ No

(b) When were you first consulted for this condition? / /

(c) Please provide dates of all subsequent consultations.

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PO Box 6111, Melbourne VIC 3004 Phone: 1800 333 613 Fax: 1800 832 266

7. (a) Please advise the date that total disablement commenced. / /

(b) **Please attach a copy of your patient's clinical notes relevant to their condition, including medical evidence that supports your assessment date of total disablement.**

(c) Are there any factors affecting or prolonging the condition? For example, does the patient have any contributing, concurrent or pre existing conditions. If '**Yes**', please provide details. ☐ Yes ☐ No

8. If any tests or investigations have been performed (i.e. x-ray etc.) please provide results (or attach a copy of applicable reports if available).

9. (a) (i) What is the diagnosis and what are the objective clinical signs of the condition?

(ii) Date of diagnosis. / /

(b) What is the short term and long term prognosis?

(c) Has the patient suffered from this or a similar injury/sickness previously? ☐ Yes ☐ No
If '**Yes**', please provide date of previous injury/sickness, period of disability, date of diagnosis and prognosis.

(d) Has the patient been referred to any other doctor(s) or medical provider(s), or rehabilitation provider(s) or other health professionals for treatment or consultation? If '**Yes**', please state: ☐ Yes ☐ No

Date of referral / / Field of Practice (cardiologist, ortho surgeon, etc.)

Name, address and telephone contact details

Date of referral / / Field of Practice (cardiologist, ortho surgeon, etc.)

Name, address and telephone contact details

Date of referral / / Field of Practice (cardiologist, ortho surgeon, etc.)

Name, address and telephone contact details

10. What is the current treatment plan (including the names and dosages of any medication)?

11. (a) To the best of your knowledge is the patient following the treatment plan prescribed? If '**No**', please comment. ☐ Yes ☐ No

(b) Do you consider any other treatment plan necessary and/or beneficial for recovery and return to work in their usual capacity? If '**Yes**', please comment. ☐ Yes ☐ No

(c) What medical, surgical, rehabilitation or other treatment have you scheduled?

(d) Has the patient been involved in a rehabilitation program? ☐ Yes ☐ No
If '**Yes**', please provide full details.
If '**No**', would the patient benefit from such a program, including Occupational Rehabilitation?
e.g. Return to work program, studying, re-training, up-skilling etc.

12. Was the patient hospitalised? If '**Yes**', please provide details below (attach a separate sheet if required). ☐ Yes ☐ No

Date admitted	Date discharged	Hospital name/Address and telephone contact details	Condition/Procedure
/ /	/ /		
/ /	/ /		
/ /	/ /		

13. Have you given any other certificates concerning the patient's disability? If '**Yes**', please provide details. ☐ Yes ☐ No

14. (a) To the best of your knowledge, what are the duties of the patient's usual occupation?

(b) Does your patient work ☐ Full-time? ☐ Part-time? ☐ Casual? ☐ Contract?

(c) Please list the duties and or responsibilities the patient is **unable** to perform of their usual occupation, including the reasons why they are **unable** to perform them.

Work duty **unable** to perform	Reason he/she is **unable** to perform this duty

(d) How long do you expect the patient to be unable to perform these duties? From / / to / /

(e) Is the patient **able** to perform any of their usual occupation duties? ☐ Yes ☐ No

If '**No**', please continue to question 14(g).

If '**Yes**', from / / to / / please continue to question 14(f).

(f) Please provide full details including which duties the patient can perform and the number of hours per week these duties can be performed.

Duties	No. of hours duties can be performed

(g) Is the patient **currently performing** any **alternative** duties? ☐ Yes ☐ No

If '**No**', please continue to question 14(i).

If '**Yes**', from / / to / /

(h) Please provide full details including which duties the patient is **currently performing** and the number of hours per week these duties are being performed.

Duties	No. of hours duties can be performed

(i) If still **unable** to work, when do you expect that your patient will be:

(i) **able** to perform some of the duties of their usual occupation? / /

(ii) **able** to perform all of the duties of their usual occupation? / /

Additional Information

15. Please provide any additional information or comments you feel are relevant to this claim.

Declaration

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true, correct and complete.

I confirm that I have handled, collected, used and disclosed the patient's personal and sensitive information provided with this form in accordance with privacy law.

I understand that AIA Australia may be entitled or required to provide access or a copy of my report to the patient, the patient's representatives, a conciliator, mediator, tribunal or court, or to medical specialists and other third parties, under privacy law and the AIA Australia Privacy Policy, and authorise AIA Australia to do so.

Name (please print)		Qualification(s)	
Signature		Date	/ /
Address		Postcode	
E-mail			
Telephone		Facsimile	