

# Helpful tips when lodging a claim

## Claimant – superannuation fund



Life's better with the right partner®

Making a claim can be difficult, particularly when you also have to deal with stressful life events. That's why we try to make the process as easy as possible. AIA Australia is the insurer for your life insurance policy and will be processing your claim. To help you, we have provided some tips below.

### What happens when you make a claim?

When you make a claim your fund will check your details and write to you. If your claim form is completed correctly, your fund will send it to us and we will start processing your claim. If your form is incomplete, or does not include all necessary information, your fund will contact you and wait until it has received the information before sending it to us.

Once we have your claim form we will go through it and make a decision about your claim. Sometimes we will need to request information from third party providers (e.g. your doctor, employer, workers' compensation) and this may slow the process down. We will not be able to process your claim until we have this information, but once we have it, we'll do so as quickly as possible.

### How can you speed up your claim?

#### 1. Give as much information as possible upfront

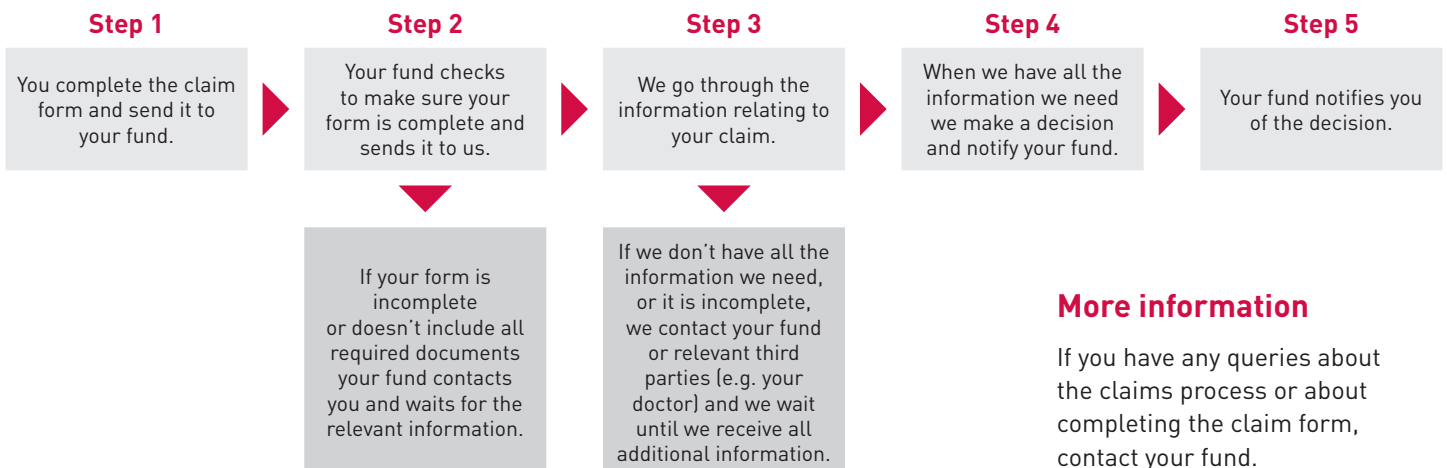
As we don't know about your circumstances, we need to ask for a lot of information to be able to make a decision about your claim. So it's important to provide as much information as possible upfront. Most delays happen when we don't get all the information we need. You can help speed up the process by providing all relevant information when you first complete your form.

#### 2. Check the information you provide is correct and complete

Before sending in your form and any other documents, read through the form and check that all information is correct and that you haven't missed anything.

#### 3. Follow-up promptly

If for any reason you are asked to provide further information, please respond quickly so we can process your claim.



## Frequently asked questions about lodging a claim

### Why do I have to provide information to support my claim?

We need this information to understand your circumstances and decide whether your claim is covered by the insurance policy.

### How long will it take to assess my claim?

The time it takes to assess your claim varies as we assess each claim on its merits. It will depend on whether we have all the information we need upfront and whether we need to request additional information.

### How can I speed up the process of assessing my claim?

You can speed up the process by providing as much information as you can upfront, ensuring that your form is fully complete, and following up with third parties (e.g. doctor and employer) to ensure they provide any information requested from them.

### Why does the insurer need a Medical Attendant's Statement?

The Medical Attendant's Statement gives information about the diagnosis, treatment and current status of your condition. We use this information to assist us in assessing your claim.

### Why does the insurer need an Employer Statement?

The Employer Statement helps us understand your work environment and the impact your condition has on your ability to perform your work.

### What is a certified copy?

A 'certified copy' of a document such as your Driver's Licence or Passport means the document must be certified 'as a true copy of the original document'. The person who certifies must be either a:

- magistrate, or a CEO of a Commonwealth Court
- registrar or deputy registrar of a court
- JP or notary public
- police officer
- person in charge of a post office agency or an Australia Post employee of two or more years service
- Australian Consular or diplomatic officer
- officer of a financial institution or finance company of at least two years service
- officer of an AFSL holder, or an authorised representative of an AFSL holder, of at least two years continuous service
- CPA or chartered accountant of at least two years standing.

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The information contained in this document is for general reference and guidance purposes only. While AIA Australia has made all reasonable efforts to ensure the information is up-to-date and accurate, the information may be subject to change from time to time. The information should not be construed as advice of any type. AIA Australia treats and assesses all claims it receives on a case by case basis taking into account the individual circumstances applying to each particular claim. As such, AIA Australia reserves the right at all times to deviate from the standard processes and procedures described in this document if required.



# Member Initial Claim Form Salary Continuance Insurance/ Income Protection

STATEMENT BY MEMBER. Please answer ALL relevant questions fully, not doing so could result in delays in processing your claim.

Fund Name	Fund Member No.	Policy No.
<input type="text"/>	<input type="text"/>	MP

## SECTION A – Personal Details

Member Name	<input type="text"/>	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Residential Address	<input type="text"/>		Postcode <input type="text"/>
Postal Address <i>(if different to above)</i>	<input type="text"/>		Postcode <input type="text"/>
Telephone	(home) <input type="text"/>	(work) <input type="text"/>	(mobile) <input type="text"/>
Your last physical day at work?	<input type="text"/> / <input type="text"/> / <input type="text"/>	E-mail <i>(for correspondence)</i>	<input type="text"/>

## SECTION B – Claim Details

1. What is the nature of your injury/sickness?  
(If an injury, please provide full details of the extent of your injuries. If to a limb, specify whether left or right.)

2. When did the injury or symptoms of your sickness first occur?    Date  /  /     Time  am/pm

**If your claim is for an injury – please answer question 3**  
**If your claim is for sickness – please answer question 4**

3. If your claim is for an injury, please advise:

(a) How did the injury occur (including what caused it and the events leading up to the injury)?

(b) Where did the injury occur? (Please provide the full address details of the place where the injury occurred.)

(c) Were there any witnesses to the injury?     Yes     No    If 'Yes', please provide their names and telephone contact details (if known).

4. (a) If your claim is for sickness, on what date was the diagnosis made?    Date  /  /

(b) Please describe your current symptoms and their severity.

**SECTION C – Treatment for this Condition**

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

Name of doctor/medical provider who made the diagnosis

Field of Practice (i.e. GP, cardiologist, etc.)  Telephone

Address

(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 number of your usual doctor or medical provider.

Name  Telephone

Address

(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	Name of medical provider and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>

2. Were you hospitalised for this condition?  Yes  No

If 'Yes', please provide details below and copies of your discharge summaries (attach a separate sheet if required).

Date admitted	Date discharged	Hospital name	Address and telephone contact details
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>

3. Have you ever had the same or similar injury or sickness before?  Yes  No If 'Yes', please advise the following:

(a) the date the injury or sickness occurred.

(b) what was the nature of the injury or sickness?

(c) please provide the names and contact details of any doctors or medical providers you consulted (attach a separate sheet if required).

Name	Address and telephone contact details
<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text"/>	<input type="text"/> Tel: <input type="text"/>

## SECTION C – Treatment for this Condition (continued)

4. Do you have a Return to Work Plan or have you discussed one with your doctor or employer?  Yes  No  
 If 'Yes', please provide details (including the name of the rehabilitation provider and their contact details).  
 If 'No', please provide the reason and whether you believe occupational rehabilitation (eg. Return to Work Plan, studying, re-training, up-skilling etc.) could assist you.


## SECTION D – Medical History

1. Give the dates and reasons for all other consultations with your usual doctor or medical provider and medications taken during the last 3 years.

Date	Reason	Medications taken (other than for cold or influenza)

2. Have you attended any other doctor or medical provider (other than detailed in Section C question 1) during the last 3 years?  Yes  No  
 If 'Yes', please give details below.

Date	Reason	Name, address and telephone contact number of doctor	Medications taken (other than for cold or influenza)
		Tel:	
		Tel:	
		Tel:	
		Tel:	

3. 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 of sick leave you required.


## SECTION E – Occupation Details

1. Name of Current or Last Employer

Street Address  Postcode

Contact Numbers (phone)  (facsimile)

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

3. Please provide details of your usual work duties and % of time spent on those duties.

Work duties	% of time spent
1	
2	
3	
4	
5	
6	
	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 (eg. office, factory, building site)?

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

7. How many hours per week, on average, did you work in the last 3 months prior to ceasing work?

8. Did you supervise other employees?  Yes  No

9. Please indicate (✓) the following requirements of your usual job, where applicable.

	Never	Occasional (i.e. less than 33% of the time)	Frequent (i.e. approximately 50% of the time)	Continuous (i.e. more than 66% of the time)
Lift/Carry 20 kg and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift/Carry, 5 to 19 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift/Carry, under 5 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

% Sitting  % Standing  % Walking  % Bending  % Lifting

% Driving  % Climbing  % Crawling  % Kneeling

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

If 'Yes', please state the following:

(a) how many kilometres per week did you travel?  km

(b) please provide details (nature of travel and type of vehicle, eg. car, bus, train, plane, truck, ferry etc.)?

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

### Only complete questions 13 to 21 if you are SELF EMPLOYED

13. Are you a  Sole trader  Partnership  Company  Trust

14. What is the name of your business?

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

(b) How many partners are there?

16. How many employees does your business have?

**SECTION E – Occupation Details (continued)**

17. What are their work responsibilities?


18. Since you ceased all work, has your business continued to operate in any way?  Yes  No  
 If 'Yes', please detail what activities have continued.


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


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

21. 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. Have you returned to work?  Yes – If 'Yes', please continue to question 3.  
 No – If 'No', please continue to question 4.

3. (a) If you are working, when did you return to work and in what capacity (full-time, part-time or casual and paid or unpaid)?  
 Full-time  /  /  Part-time  /  /  Casual  /  /   Paid  Unpaid

(b) How many hours a week are you working?

(c) If you have returned to work with a different employer, please provide the following information:

Other employer name/s and contact details (if different to Section E, question 1)	Job title	Duties	Gross monthly income
			\$
			\$

4. If you have not returned to work, when do you think you will be able to return to work?  
 Full-time  /  /  Part-time  /  /  Casual  /  /

5. (a) If you are currently not working, 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, job title and your expected start date.


## SECTION F – Level of Disability (continued)

6. What jobs do you think you may be able to do in the future?


## SECTION G – Vocational History

1. What is your level of education?  Primary  Secondary  TAFE  Tertiary

2. Please provide a detailed education history of all secondary, tertiary, TAFE courses and any other job related training undertaken (attach a separate sheet if required or your resume). If not in Australia, please advise which country the qualification was provided.

Course description/Qualification	Country	Date started	Date qualified
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Please provide a detailed work history for the last 10 years (please attach a separate sheet if required or your resume). If not in Australia, please advise which country the work was performed.

Period of employment	Employer	Job title	Position description/Duties
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

## SECTION H – Activities and Restrictions

1. (a) Please describe your hobbies, interests and social activities.


(b) Are you still able to pursue these?  Yes  No If 'No', please describe how long your condition has affected your hobbies, interests and social activities (eg. which activities can you no longer perform).


(c) What are your current daily activities?




## SECTION I – Financial Information

1. What was your total gross income for the last 12 months prior to disablement? \$

If you are an **Employee**, provide a breakdown of regular bonuses, overtime earnings etc.

If you are **Self Employed**, income is the gross income derived from your personal exertion after deducting your share of the business expenses.

**During your period of disability, we may ask you to provide other documentation to support your claim including future Tax Returns and other financial evidence to confirm these figures.**

2. If you are **Self Employed**, please provide a copy of your most recent Tax Return submitted to the Australian Taxation Office for the financial year **prior** to you becoming Totally Disabled.

**Should your claim be admitted by AIA Australia, we will pay your benefits directly into your nominated bank account. AIA Australia will keep your account details confidential.**

Bank Name	<input type="text"/>	Branch Name	<input type="text"/>
BSB Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>	Account Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Account Name	<input type="text"/>		

## SECTION J – Other Benefits

1. Have you previously made a claim against this policy?  Yes  No If 'Yes', please provide details.

2. (a) As a result of your injury/sickness, have you received, or are you entitled to receive/claim any benefits from:

<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Centrelink (Please ask Centrelink to provide you with an income statement/break-down of payment.)
<input type="checkbox"/> Common Law	<input type="checkbox"/> Another Insurer (eg. for another Income Protection policy)
<input type="checkbox"/> TAC	<input type="checkbox"/> Any other source. Please state: <input type="text"/>

(b) If you are receiving or have received any benefits, please provide full details of each benefit including:

Type of claim	<input type="text"/>	Claim/Ref No.	<input type="text"/>
Insurer (if applicable)	<input type="text"/>	Gross amount of claim	\$ <input type="text"/> per week
Contact person	<input type="text"/>	Contact number	<input type="text"/>
Type of claim	<input type="text"/>	Claim/Ref No.	<input type="text"/>
Insurer (if applicable)	<input type="text"/>	Gross amount of claim	\$ <input type="text"/> per week
Contact person	<input type="text"/>	Contact number	<input type="text"/>

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

## SECTION K – Checklist

- I have attached a certified copy of my:  Driver's Licence or  Passport or  Birth Certificate
- I have provided any other information that was requested or that may assist my claim.
- I have provided my Doctor with my Fund Name and Fund Member Number so he/she can complete the Medical Attendant's Statement.
- I have fully completed this form, to ensure my claim is assessed promptly.

**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 the insurer, 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 this form and the Privacy Policy on the AIA Australia website [www.aia.com.au](http://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 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 also authorise AIA Australia to contact me directly to obtain personal and sensitive information in the course of investigating, assessing and managing my claim.

**AUTHORITY TO OBTAIN INFORMATION**

I hereby authorise any individual, organisation or entity within any of the above categories (a to h) that holds my personal and sensitive information to release that information to AIA Australia Limited on request, for the purpose of investigating, assessing and managing my claim.

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

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

Name <i>(please print)</i>	Member's signature	Date
	X	

# Authority to Release 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

**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 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

**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 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:

I/We authorise and consent to any life insurance company disclosing to AIA Australia personal and sensitive information about me/us with regard to previous or current applications for insurance cover or claims made under other insurance cover which may include details of my/our health and medical history.



# Privacy

This section summarises key information about how AIA Australia handles personal information including sensitive information. For further information, please review the most up to date full version of the AIA Australia Group Privacy Policy on AIA Australia's website at [www.aia.com.au](http://www.aia.com.au), as updated from time to time (AIA Australia Privacy Policy).

Your privacy is important to us and AIA Australia and we are both bound by the Privacy Act, and other laws which protect your privacy. AIA Australia Group consists of AIA Australia Limited, AIA Financial Services Limited, The Colonial Mutual Life Assurance Society Limited, CMLA Services, Jacques Martin Pty Ltd, Jacques Martin Administration and Consulting Pty Ltd, AIA Group and their related bodies corporate and joint venture partners (together referred to as "AIA Australia", "we", "us" and "our"). Together, we provide you the following notification and information about AIA Australia's Privacy Policy and your rights.

## Why AIA Australia collects Personal Information

AIA Australia collects, uses and discloses personal and sensitive information ("Personal Information") for purposes set out in the AIA Australia Privacy Policy, including to process applications for AIA Australia's products and services (including products AIA Australia distribute), to assist with enquiries and requests in relation to AIA Australia's products and services (including products AIA Australia distributes), for underwriting and reinsurance purposes, to administer, assess and manage your products and services, including claims, to understand your needs, interests and behaviour and to personalise dealings with you, to provide, manage and improve AIA Australia's products and services, to maintain and update AIA Australia's records, to verify your identity and/or authority to act on behalf of a customer, to detect, detect, manage and deal with improper conduct and commercial risks, for reporting, research and marketing purposes, to otherwise comply with local and foreign laws and regulatory obligations, and for any other purposes outlined in AIA Australia's Privacy Policy. The reasons why AIA Australia collect, use and disclose Personal Information may vary depending on the product, services or other circumstances in which you have engaged with AIA Australia. Where you agree or AIA Australia is otherwise permitted by law, AIA Australia may contact you on an ongoing basis by email, phone and otherwise, with offers and other promotional information about products or services AIA Australia think may interest you. If you do not wish to receive these direct marketing communications you may indicate this where prompted or by contacting AIA Australia as set out in AIA Australia's Privacy Policy.

## How AIA Australia collects, uses and discloses Personal Information

AIA Australia may collect your Personal Information from various sources including forms you submit and AIA Australia's records about your use of AIA Australia's products and services and dealings with AIA Australia, including any telephone, email and online interactions. AIA Australia may also collect your information from public sources, social media and from the parties described in AIA Australia's Privacy Policy. AIA Australia is 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 AIA Australia's Privacy Policy. Where you provide AIA Australia with Personal Information about someone else, you must have their consent to provide their Personal Information to AIA Australia in the manner described in AIA Australia's Privacy Policy.

AIA Australia may collect your Personal Information from, and exchange your Personal Information with, AIA Australia's related bodies corporate including without limitation, joint venture partners and third parties, including the life insured, policy owner or beneficiaries of your insurance policy, AIA Australia service providers or contractors, your intermediaries (including without limitation, your financial adviser and the Australian Financial Service Licensee they represent, the distributor of your insurance policy, the trustee or administrator of your superannuation fund, your employer, unions of current and former staff members of AIA Australia (including contactors) medical professionals or anyone acting on your behalf including any other representative or intermediary) ("Representatives"), your employer, bank, medical professional or health providers, partners used in AIA Australia's activities or business initiatives (including if relevant to your policy, the Commonwealth Bank of Australia), AIA Australia's distributors, clients, and reinsurers, private health insurers (including MO Health Pty Ltd) and their contractors and agents, other insurers including worker's compensation insurers, authorities and their agents, other super funds, trustees of those super funds and their agents, regulatory and law

enforcement agencies, other bodies that administer applicable industry codes, and other parties as described in AIA Australia's Privacy Policy.

Where AIA Australia provides 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.

Parties to whom AIA Australia discloses Personal Information may be located in Australia, South Africa, the United States, the United Kingdom, Europe, Asia and other countries including those set out in AIA Australia's Privacy Policy. If the Financial Services Council Life Code of Practice ("Code") applies to the insurance cover AIA Australia provides to you, AIA Australia will comply with the Code when AIA Australia collects, uses and discloses your Personal Information.

## Other important information

By providing information to AIA Australia or your Representatives, the trustee or administrator of a superannuation fund, submitting or continuing with a form or claim, or otherwise interacting or continuing your relationship with AIA Australia directly or via an intermediary, you confirm that you agree and consent to the collection, use (including holding and storage), disclosure and handling of Personal Information in the manner described in AIA Australia's Privacy Policy on AIA Australia's website as updated from time to time, and that you have been notified of the matters set out in the AIA Australia Privacy Policy before providing Personal Information to AIA Australia. You agree that AIA Australia 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 AIA Australia's website at [www.aia.com.au](http://www.aia.com.au) or by contacting AIA Australia on 1800 333 613 to obtain a copy. You have the right to access the Personal Information AIA Australia holds about you, and can request the correction of your Personal Information if it is inaccurate, incomplete or out of date. Requests for access or correction can be directed to AIA Australia using the details in the 'Contact AIA Australia' section below. AIA Australia's Privacy Policy provides more detail about AIA Australia's 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 AIA Australia will deal with that complaint, and your opt-out rights. Always ensure you are reviewing the most up-to-date version of AIA Australia's Privacy Policy as published on AIA Australia's website.

For the avoidance of doubt, the AIA Australia Privacy Policy applicable to the management and handling of Personal Information will be the most current version published at [www.aia.com.au](http://www.aia.com.au), which shall supersede and replace all previous AIA Australia 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, websites and applications, underwriting and claim forms, Product Disclosure Statements and other insurance and disclosure statements and documentation.

## Contact AIA Australia

If you have any questions or concerns about your Personal Information, please contact AIA Australia as set out below:

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



# Medical Attendant's Statement

Forming part of the Salary Continuance Insurance/  
Income Protection Member Initial Claim Form

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, the payment is the responsibility of the patient.

## Privacy

In completing this form you may be providing AIA Australia Limited with personal and sensitive information. This information must be handled, collected, used and disclosed in accordance with the Privacy Act 1988 (Cth) and the AIA Australia Group Privacy Policy as updated from time to time (AIA Australia Privacy Policy). For more information about the AIA Australia Privacy Policy (including notification) please refer to [www.aia.com.au](http://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.

Fund Name  Fund Member No.

Patient's Name  Date of Birth  /  /

Patient's Address  Postcode

Occupation

Patient's height  cm weight  kg Is your patient left or right handed?  Left handed  Right handed

Does your patient smoke?  Yes  No If 'Yes', please state substance, quantity and how long they have smoked.

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

2. (a) Are you the patient's usual doctor?  Yes  No

If 'No', please advise the name, address and telephone contact details of their usual doctor.

Name of usual doctor  Telephone

Address

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

Name of referring doctor  Telephone

Address

3. (a) Please confirm whether the condition is an injury or sickness.  Injury  Sickness

(b) Please describe the nature and extent of the patient's condition, its probable cause (if known) and the level of disability.

(c) Is the injury/sickness consistent with the patient's description of cause?  Yes  No If 'No', please provide details.

4. (a) (i) On what date did the condition first occur? Date  /  /  Time  am/pm

(ii) Please advise the date that total disablement commenced and caused the patient to become unfit for work.  /  /

(iii) Is the patient still receiving treatment?  Yes  No

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

(c) Please provide details of all subsequent consultations.

Form area for subsequent consultations with horizontal dotted lines.

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

Form area for factors affecting or prolonging the condition with horizontal dotted lines.

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

Form area for test results with horizontal dotted lines.

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

Form area for diagnosis and clinical signs with horizontal dotted lines.

(ii) Date of diagnosis.

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

Form area for short and long term prognosis with horizontal dotted lines.

(c) Please describe your patient's current symptoms.

Form area for current symptoms with horizontal dotted lines.

(d) (i) Is your patient's illness considered terminal?  Yes  No

(ii) If 'Yes', what is the patient's life expectancy?

(e) Has the patient suffered from this or a similar condition previously?  Yes  No If 'Yes', please provide the following:

(i) date of previous injury/sickness

(ii) period of disability

(iii) date of diagnosis

(iv) prognosis

(f) 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?  Yes  No If 'Yes', please state:

Date of referral	Name and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>

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

.....
.....
.....

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

.....
.....
.....

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

.....
.....
.....

(c) Has the patient been involved in any other medical, surgical, rehabilitation or other treatment you have scheduled?  Yes  No  
 If 'Yes', please provide full details.  
 If 'No', would the patient benefit from such a program, including Occupational Rehabilitation, eg. graduated RTW program, studying, re-training, etc.?

.....
.....
.....

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

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

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

.....
.....
.....

12. (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  Contractor

(c) Please state 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 <b>unable</b> to perform	Reason they are <b>unable</b> 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** occupational duties?  Yes  No  
 If 'No', please go to question 12(f)  
 If 'Yes', please enter the date the patient returned to work (or will be able to return to work):

Please provide full details including which duties the patient **can perform** and the number of hours per week these duties can be performed. (After detailing the duties below please go to question 13.)

Duties	No. of hours duties can be performed

(f) Is the patient **currently performing** any **alternative** duties?  Yes  No If 'No', please go to question 12(g)  
 If 'Yes', please state: From  to

Please provide full details including which duties the patient is **currently performing** and the number of hours per week these duties can be performed.

Duties	No. of hours duties can be performed

(g) 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?

(h) Will the patient be able to perform any work/duties within their education/training or experience in the future?  Yes  No  
 Please give details.

## ADDITIONAL INFORMATION

13. 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 Group Privacy Policy, and authorise AIA Australia to do so.

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