Initial claim form

AC&L

Instructions

Policy number

1 Please ensure that you read each question carefully and answer each question fully. If this form is not fully completed the assessment of your claim will be delayed.

2 Your attending doctor must complete the Attending Doctor's statement. Any fee for the completion of this form is the responsibility of the claimant.

3 If you have any queries regarding completion of the form, please contact our Customer Service Centre on 132 987.

4 Return completed form to our Customer Service Centre at PO Box 14330, MELBOURNE VIC MC 8001.

Request for information – notice

Please note that upon lodgement of your claim or throughout the duration of your claim we may have cause to request the following:

- Medical reports/clinical notes from your treating doctors and **specialists**
- Authority to obtain a report from the Health Insurance Commission
- Periodical independent medical examinations
- Financial documentation
- Factual assessments/investigations/interviews
- Statements or separate questionnaires or other relevant information from you

Privacy – use and disclosure of personal information

The privacy of your personal information is important to you and also to AXA/AC&L. The purpose of collecting your information is to assess your claim. This includes information about your health, financial situation, occupation and lifestyle. If the information you give us is not complete or accurate, we may not be able to provide the products and services you have applied for.

We may need to disclose your personal information to other parties, such as reinsurers, medical and financial professionals, claims and factual assessors, judicial or dispute resolution bodies and AXA Australia Group companies. The Group includes companies such as Australian Casualty & Life and AXA Australia Health Insurance.

You are entitled to request reasonable access to information we have about you. We reserve the right to charge an administration fee for collating the information you request.

For our policy on Privacy, refer to www.axa.com.au or contact our Customer Service Centre on 132 987.

Consent

I have read and understood the Privacy Disclosure Statement above. I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement above. I acknowledge that I can opt out from the use of that information for the purposes of direct marketing by telephoning 132 987.

Signed | Dated

X | / /

Witness | Dated

X | / /

Final checklist

☐ Have all questions been fully answered?

☐ Privacy consent signed

☐ Medical Authority signed

☐ Health Insurance Commission Authority signed

☐ Information Authority signed

☐ Declaration signed

☐ Attending doctor's statement fully completed

Note: If you have an Indemnity Plan please provide a copy of the last two years' Tax Returns (immediately prior to your disability commencing), to enable us to calculate your benefit entitlements.

Section A – Personal details

1 Full name | Date of birth

Current residential address (we do not accept PO Box nos)

Street number and name | Town/Suburb | State | Postcode | Country

Home phone ( ) | Business phone ( ) | Mobile phone

Height cm Weight kg ☐ Male ☐ Female

Section B – Claim details

2 Name the injury or sickness that is causing your disability:

3 Please provide your account of the injury or sickness:

Date / / Time

Place

How it occurred

4 Please list all the duties you are unable to perform in your occupation:

5 If an accident, please provide name, address and telephone number of any witnesses to your injury/illness:

Name/how related	Address	Telephone
		( )
		( )

6 List name and address of attending doctor(s) for this injury/illness/disability

Name/specialty	Address	Telephone
		( )
		( )
		( )

7 (a) When did you cease ALL work?

Date / / Time

(b) Have you returned to work in your own or any occupation, either paid or unpaid?

Date Full-time / / Date Part-time / /

(c) If you have returned to work part-time, what duties are you able to perform?

(d) When do you expect to return to work in your own or any occupation, either paid or unpaid?

Date Full-time / / Date Part-time / /

(e) If you will be returning to work part-time, what duties will you be able to perform?

Section C – Employment

8 Occupation at the time you stopped work:

How long have you been in this occupation? yrs

9 On average how many hours per week did you work prior to your disablement?

10 Occupational Duties: Please also indicate the (%) performed in each of the duties performed.

Duties	Percentage (%)
	%
	%
	%

11 Do you usually work from home? ☐ Yes ☐ No

If yes, please advise how many hours/days per week are worked at home; specific duties; and frequency and nature of contact with clients:

12 Do you have any trade/tertiary/professional qualification? ☐ Yes ☐ No

If yes, please describe:

13 Please tick off the following physical requirements of your occupation where applicable.

	Never/rare	Occasional	Frequent	Continuous
Lifting, 20 kgs & over	☐	☐	☐	☐
Lifting, 7 – 19 kgs	☐	☐	☐	☐
Lifting, under 7 kgs	☐	☐	☐	☐
Carrying, 20 kgs & over	☐	☐	☐	☐
Carrying, 7 kgs	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Climbing – ladders, scaffolding etc	☐	☐	☐	☐
Climbing – ramps, steps, etc	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Key boarding	☐	☐	☐	☐
Office duties (admin, phone, clerical, photocopying)	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐

Never/rare (0% – 10%)
Occasional (11% – 40%)
Frequent (41% – 70%)
Continuous (71% +)

14 In your occupation, what percentage of time do you spend performing the following types of duties:

Sedentary/administrative	%
Supervising work	%
Light manual	%
Heavy manual	%
Total duties	**100%**

15 Have you changed your occupation in the last six months prior to your illness/injury? ☐ Yes ☐ No If yes, why?

16 If you are not self-employed, is your job still available for you to return to?

17 Business name/employer's full name and address: Telephone ( )

18 If self-employed (Please tick the appropriate box):

Are you a: ☐ Sole trader ☐ Partnership ☐ Company ☐ Trust

Please state your registered business name and address:

Please state your business phone number ( )

(a) If Partnership – What is your share of partnership (Income and Expense Distribution) %

Who is/are the other active partners? (Please list all names)

1	
2	
3	

(Please attach a separate sheet if there are more than three active partners)

(b) If a company – who are the directors and shareholders? (Please list all names)

1	
2	
3	

(Please attach a separate sheet if there are more than three director/shareholders)

(c) Have you hired a locum or replacement for your specific role? ☐ Yes ☐ No

What is the remuneration paid to the locum(s) or your replacement $

19 Total number of employees (excluding yourself): Full time Part time

20 Has your business ceased trading since you became disabled? ☐ Yes ☐ No

If yes what date did the business cease trading? / /

If the business was sold, what was the date of sale? / /

21 If your business is still trading please advise the names of the person(s), including family members involved?

22 Were the above people involved in the business prior to your disability? If yes what were their duties and hours?

23 Has there been a loss of income from the business due to your disability? ☐ Yes ☐ No Details of loss:

24 Have you bought or sold any/your business during the six months prior to the date you stopped work? ☐ Yes ☐ No
If yes, please provide details:

Section D – Financial

25 (a) Gross annual income in the 12 months prior to your disability $

(b) Annual business expenses for the 12 months prior to your disability $

26 Do you have any other source of income? ☐ Yes ☐ No If yes, please provide details:

Section E – Nature of injury or illness

27 Details of first treatment/consultation for this injury or sickness:

Date / / Name of doctor

28 What is your current treatment?

List treatment/ medication	Name of physician/specialist or other treating provider	Frequency of treatment/dosage	Address of provider

29 Were you admitted to hospital for your injury/sickness? ☐ Yes ☐ No (Please include a copy of your hospital discharge summary)

From To

Name and address of hospital:

30 Was an operation performed? ☐ Yes ☐ No If yes:

(a) Nature of operation:

(b) Date performed:

(c) Name of the doctor:

31 Have you had this or similar injury/sickness before? ☐ Yes ☐ No If yes, when?

Name and address of doctor on the previous occasion(s):

Section F – Occupational rehabilitation

32 If not self employed, has alternative employment been offered? ☐ Yes ☐ No
If yes, please list in the following table what duties you are still able/unable to perform, in respect of that alternative employment?

Duties	Able to perform	Unable to perform

33 Did you work at all between the onset of the sickness or the date of the accident and the first time you saw a doctor?

34 Has occupational rehabilitation or a 'return to work' plan been attempted? ☐ Yes ☐ No
If yes, please provide contact details of Rehabilitation provider:

35 Has a return to work date in your own occupation, either paid or unpaid, been discussed with your doctor? ☐ Yes ☐ No Details:

36 Please provide details of your current daily activities:

Section G – Other claims or insurance

37 Is a claim being made for disability against any of the following?

☐ Other income protection/life insurance	☐ Yes	☐ No
☐ Workers compensation	☐ Yes	☐ No
☐ Social security	☐ Yes	☐ No
☐ Third party motor vehicle accident	☐ Yes	☐ No
☐ Superannuation	☐ Yes	☐ No
☐ Other	☐ Yes	☐ No

(If you answered yes to any of the above, please complete the following table)

Name/Insurer	Type of claim	Policy No. Claim No.	Address/Phone No.	Liability accepted/ denied. If accepted state payment and frequency
				$
				$
				$
				$

Note: all details must be completed. Failure to fully complete the claim form will result in delayed assessment of your claim.

Medical Authority

I hereby authorise any doctor, dentist, hospital, or other person who has attended me, to release to the Insurer and its group of companies, its medical officer, 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 photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Print name	Signed	Dated
	X	/ /

Information Authority

I hereby authorise any insurer, accountant or institution to release to the Insurer, its group of companies, or its representatives all information which the Insurer may request for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be effective and valid as the original.

I hereby authorise AXA/AC&L to supply information relating to my claim to data matching services subscribed to by AXA/AC&L.

I hereby authorise to provide refresher authorities or extra authorities for the request of information throughout the duration of the claim.

Print name	Signed	Dated
	X	/ /

Declaration

I hereby declare that the information in the Claim Form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to inform AXA/AC&L of any relevant information regarding my claim, AXA/AC&L may refuse to pay and cancel my claim. I understand that I can be prosecuted if I make any fraudulent statement.

Print name	Signed	Dated
	X	/ /

Attending doctor's statement
Initial claim form

AC&L

This form is to be completed by your attending doctor

Doctor – please complete this form and return it to the claimant

NB If there is a charge for completion of this form, it is the responsibility of the claimant

Claimant's name | Date of birth

1 | / /

2 Are you the claimant's usual doctor? ☐ Yes ☐ No

3 Are you the claimant's treating GP/specialist? ☐ Yes ☐ No If specialist, what is your specialty?

(If specialist please enclose a copy of the referring doctor's referral form.)

4 Is the condition: ☐ Injury ☐ Sickness

5 If sickness, when did symptoms first appear? / /

What are the current symptoms?

6 If injury, when did this incident occur? / /

7 Date the claimant was first ever seen by you? / /

8 Date the claimant was first seen for the current condition? / /

9 Date insured claimant advised to first cease work as a result of their current condition? / /

10 What is your current diagnosis and the date of diagnosis? / /

11 Has the claimant ever had the same or similar condition? (If yes, state when and describe)

12 Are there any other sicknesses or conditions affecting present condition:

13 Have you referred the claimant to any other doctor? ☐ Yes ☐ No If yes, please provide the name and address of that doctor:

14 If referred to you, give name and address of referring doctor:

15 If hospitalised:

(a) Give name and address of hospital

(b) Dates of admission and discharge Admission / / Discharge / /

Admission / / Discharge / /

(c) If surgery performed, state the procedure

(d) Surgeon's name

16 Results of any medical investigations (Please attach copy of test results, if possible):

17 What is the current treatment plan that is being prescribed? (Including medication)

18 To the best of your knowledge, is the claimant complying with the treatment?

19 Is a change in treatment contemplated? ☐ Yes ☐ No If yes, please provide details:

20 Please advise your understanding of the claimant's occupation:

21 Please describe the duties performed prior to the onset of the condition:

22 What occupational duties can the claimant currently perform and to what extent? (eg full-time/part-time)

23 What occupational duties can the claimant **not** perform and to what extent?

24 If still unable to return to work, when do you expect that the claimant may be able to return to work?

☐ Full-time / / ☐ Part-time / /

(a) If part-time what duties will the claimant be able to perform?

25 Has occupational rehabilitation been considered or attempted?

26 Do you have any comments on the future management of the claimant's condition?

27 Is this a worker's compensation case, or are you completing forms for this claimant for anyone else, including other insurance companies?
☐ Yes ☐ No If yes, please give details:

(If you have reports from specialists, we would be pleased to receive copies)

28 Remarks and/or additional information:

Name | Telephone ( )

Street number and name | Town/Suburb | State | Postcode

Qualifications

Specialist ☐ Yes ☐ No

Signed **X** | Dated / /