

# Income Protector Plan Initial Claim Form

(Please also have your Medical Practitioner complete the attached Initial Medical Report form)

Please ensure that:

- All questions are answered fully to avoid any undue delays to this claim.
- You complete this form in black/blue ink and ensure that answers are clear and legible.
- The claimant is aware that any fee for the completion of these forms is the responsibility of the Claimant.

## A Part A - Personal Details

Policy Number:           Date of Birth:

Surname:  First name:

Current Residential Address (not a post office box):

Postal Address (if different from above):

Email Address:

Phone Numbers: (H)  (W)  (Mob)

## B Part B - Medical Details

1. What diagnosis have you been given for your condition?

2. Are you symptoms related to an Accident or illness? Accident  Illness

This section is to be completed for ILLNESS claims only

3. On what date did your symptoms first commence?

4. What are your current symptoms of this illness?

5. What were the circumstances that led you to seek medical treatment for this condition?

6. Have you previously had the same or similar condition or symptoms? Yes  No

If "yes", please provide full details:

This section is to be completed for ACCIDENT claims only

7. On what date did the accident occur?

8. Where did the accident happen and how did it occur?

9. What injuries did you sustain as a result of the accident?

This section is to be completed for ALL claims

10. On what date did you completely stop all work?

11. On what date did you seek medical attention for your symptoms or injuries?

12. Please provide contact details for the following:

The medical practitioner you first saw for this condition:

Address:

Phone Number:  Date last seen:  How long have you known this doctor?

The doctor from whom you are currently receiving medical treatment:

Address:

Phone Number:  Date last seen:

13. What treatment are you currently receiving (i.e. physiotherapy) and how frequently?

  

14. What medicines, if any, are you taking at present? Please provide the names and dosages of this medication?

  

15. How are you responding to the treatment and medication that you are receiving?

  

15. If you have Private Medical Insurance, please provide the following details:

Fund Name:

Membership Number:

**C Part C - Occupational Details**

1. What occupation were you performing immediately prior to your disability? Please include your specific job title.

2. Please advise the time spent performing the following tasks in your position prior to disability:

Manual duties  %

Sedentary duties (i.e. sitting)  %

3. Please provide details of ALL the duties that you performed in this occupation during an average day and the approximate time spent performing these duties:

Duties Performed	% of working day
<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"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Total = 100%

4. How long had you been in this occupation and performing these duties?

5. What is the average number of hours you worked per week over the last 12 months in the occupation?

6. Do you do any unpaid work? Yes  No

7. Have you returned to work yet? Yes  No

8. If "yes" on what date did you return to work?

9. If "no" what currently prevents you from returning to work?

10. If you have not returned to work, when do you expect to be able to do so?

Full-time  Part-time

11. If you are an employee, is your job currently being held open? Yes  No

12. Is it your intention to return to work with the same employer? Yes  No

If not please explain why?

**D Part D - Income Details**

1. What was your annual income in the last financial year? \$

2. What was your average monthly income in the 12 months before you became unable to work? \$

3. What income have you received since you became unable to work? \$

4. Do you have any other source of income? Yes  No

If "yes" please provide the details of the amount you are receiving and when these payments commenced:

**5. IMPORTANT!**

If you are **employed** please ATTACH

- a. Your Group Certificate and
- b. notice of assessment from the Tax Office for the last financial year
- c. a copy of your pay-slips for the month prior to your accident or illness

If you are **self-employed** please ATTACH

- a. your personal Tax Return and Business Tax return (if applicable)
- b. notice of Assessment from the Tax Office and
- c. a Profit and Loss Statement and a Balance Sheet for the 12 months prior to your accident or illness

(if you are unable to provide documentation for the 12 months prior to your accident or illness, please provide documentation for the last financial year)

This section is to be completed if you are EMPLOYED

6. Company name of Employer

7. Employer's Address

8. Employer's Phone Number

9. Employer's Name

10. How long have you been employed there?

This section is to be completed if you are SELF-EMPLOYED. Please complete the appropriate questions

11. What is the name of your business entity?

12. What is your trading name?

13. What is your business structure (please tick appropriate boxes)?

Sole Trader  Partnership  Trust  Or Complete below company details

Company  ACN  ABN

14. What is your % of ownership of the business?

15. Is your business continuing in your absence? Yes  No

16. If yes, who is running the business and in what capacity?

**E Part E - Other Claims Income**

17. Have you made, or do you intend to make, a disability claim with any of the following? If so, please tick the appropriate answer and provide details.

- a. Any insurers                      Yes       No       Name of Company:
- b. Centrelink / Social Security    Yes       No       Branch:
- c. Workers' Compensation        Yes       No       Organisation:
- d. Common Law Claim            Yes       No       Details:
- e. DVA                                Yes       No       Details:
- f. Any other organisation        Yes       No       Details:
- g. CTP Insurer                    Yes       No       Details:

18. What is the total benefit you have received, or are entitled to, from the above?      \$

19. Please provide the date you first started receiving this benefit     

20. Please provide bank account details for the claim benefit payments to be paid

BSB       Account Number

Name of account

**F Part F - Authorities**

**Medical Authority**

I,  (full name) hereby authorise any doctor, hospital, therapist or other medical professional who has attended me, to release to TAL Life Limited, or its representatives, information relevant to my policy and/or claim, with respect to any sickness or injury, medical history, consultations, medications or treatment, received by me, together with copies of any and all medical records.

I consent to TAL Life Limited collecting this sensitive information. A copy of this authority is to be regarded as if it were the original signed authority. This medical authority will only be used for the purpose of assessing initial and ongoing entitlements to a claim.

Signature:       Date:  /  /

**Information Authority**

I,  hereby authorise any insurer, employer, accountant or other relevant holder of information, to release to TAL Life Limited, or its representatives, information which TAL Life Limited requires for the purpose of assessing my claim for benefits. A copy of this authority is to be regarded as if it were the original signed authority.

Signature:       Date:  /  /

**G Part G - Declaration**

I hereby declare that the information provided 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 TAL Life Limited of any material information regarding my claim, TAL Life Limited may refuse to pay and cancel my claim.

Signature:       Date:  /  /

Personal and sensitive information is collected from you to enable TAL to provide the product or service you request. Without this information, TAL cannot provide this product or service. Your personal information may be disclosed to TAL and any relevant bodies corporate including the following 3rd parties, where necessary; health professionals; your (or your employer's, if relevant) Adviser or Financial Planner, other companies within TAL group; organisations to whom we outsource our mailing; administration and information technologies; the insurance Reference Service; Investigators; the Trustee (if relevant); the administration of the product or fund; reinsurers; government regulatory bodies; lawyers; accountants. By signing this form you consent to TAL and these organisations collecting your personal and sensitive information. In accordance with Privacy legislation, you can also obtain access to your information. A photocopy of this declaration is as valid as the original.

Signature:       Date:  /  /



Please return your documents: e-mail: [claims@insuranceline.com.au](mailto:claims@insuranceline.com.au) | Fax: 03 8686 9404  
Mail: Reply Paid 62, Carlton South VIC 3053 | Need Help: Call **13 88 98**