Bill Relief Plan

Sickness or injury initial claim form

Insuranceline

Need any help completing this form? Call us on 1300 880 750 8am-8pm AEST

Where required under Part B, please complete the 'Authority to release personal Medicare claims information to a third party' form and also have your Medical Practitioner complete the attached 'Bill Relief Initial Medical Report' form.

Please ensure that:

1. All questions are answered fully to avoid undue delays to your claim.
2. You complete this form in black/blue ink and that answers are clear and legible.
3. You're aware that any fee for the completion of the Initial Medical Report is your responsibility.

Part A – Personal details

Policy Number:

Date of Birth: dd: mm: yyyy:

Surname:

First Name:

Current Residential Address:
(Not Post Office Box)

suburb: state: postcode:

Postal Address:
(if different from above)

Email Address:

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

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

BSB: -

Account Number:

Account Name:

Part B – Claim type

Please only complete the sections and forms relevant to your type of claim:

- ☐ Sickness (complete parts C, D, G, H, Medicare Authority form, Bill Relief Initial Medical Certificate)
- ☐ Injury (complete parts C, E, G, H, Medicare Authority form, Bill Relief Initial Medical Certificate)
- ☐ Kids Injury Cover (complete parts F, G, H, Medicare Authority Form, Bill Relief Initial Medical Certificate)

Part C – Occupational/daily activity details

1. What occupation/daily activity were you performing immediately prior to your disability?

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/daily activity during an average day and the approximate time spent performing these duties:

Duties Performed	% of working day
	Total = 100%

Claims are administered and settled by TAL Life Limited ABN 70 050 109 450 AFSL 237848.

Part C – Occupational/daily activity details continued

4. How long had you been in this occupation/daily activity and performing these duties?
5. What is the average number of hours you spent per week over the last 12 months in the occupation/daily activity?
6. Do you do any unpaid work? Yes ☐ No ☐
7. Have you returned to work/your daily activity yet? Yes ☐ No ☐
8. If "yes" on what date did you return to work/your daily activity? dd: mm: yyyy:
9. If "no" what currently prevents you from returning to work/your daily activity?
10. If you have not returned to work/your daily activity, 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?

Part D – Sickness claim

Nature of sickness:

Date the symptoms began: dd: mm: yyyy:

Date Doctor first consulted: dd: mm: yyyy:

Date ceased work/regular activity:

What are your current symptoms?

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

If 'yes', please provide full details:

Details of all the Doctors/Medical Practitioners you have seen about your condition:

Name:

Address:

Phone Number:

Name:

Address:

Phone Number:

Name:

Address:

Phone Number:

Part D – Sickness claim continued

What treatments are you currently receiving (e.g. physiotherapy) and how frequently?

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

Medication	Dosage / Frequency per day	Recent changes / side effects

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

IMPORTANT!

Please attach copies of reports received from Specialists, other Treating Doctors and Health Professionals

Part E – Injury claim

Nature of Injury:

How did the injury occur?

Date of injury: dd: mm: yyyy:

Date Doctor first consulted: dd: mm: yyyy:

Date ceased work/regular activity: dd: mm: yyyy:

Details of all the Doctors/Medical Practitioners you have seen about your injury:

Name:

Address:

Phone Number:

Name:

Address:

Phone Number:

Name:

Address:

Phone Number:

Location where the Incident/Accident occurred:

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

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

Medication	Dosage / Frequency per day	Recent changes / side effects

Part E – Injury claim continued

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

IMPORTANT!

Please attach copies of reports received from Specialists, other Treating Doctors and Health Professionals

Part F – Kids Injury claim

Name of the child:

Nature of injury:

How did the injury occur?

Date of injury: dd: mm: yyyy:

Date Doctor first consulted: dd: mm: yyyy:

Doctor/Medical Practitioner details:

Name:

Address:

Phone Number:

Name:

Address:

Phone Number:

Name:

Address:

Phone Number:

Did the child stay in hospital as a result of the injury? ☐ Yes ☐ No If yes, length of hospital stay: days

What treatments is the child currently receiving (i.e. physiotherapy) and how frequently?

What medications, if any, is the child taking at present? Please provide the names and dosages of this medication?

Medication	Dosage / Frequency per day	Recent changes / side effects

IMPORTANT!

Please attach copies of reports received from Specialists, other treating Doctors and Health Professionals as well as copies of the discharge summary.

Declaration

I hereby declare that the information in this form is complete and correct. I understand and agree that if I make any false or fraudulent statements or fail to advise TAL Life Limited of any relevant information regarding my claim, TAL Life Limited may refuse to pay this claim.

Name:

Sign here: Date: dd / mm / yy

Medical authority

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, the insurer, TAL Life Limited (TAL), 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.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Medical consent authority 1

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 TAL Life Limited (TAL), or to third parties they engage.

I agree to all the following:

- My health information can be released in the form TAL 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.
- TAL 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 TAL 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:

Sign here: Date: dd / mm / yy

Medical authority continued

Medical consent authority 2

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 TAL Life Limited (TAL), or to third parties they engage, only if TAL 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:

- TAL 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 TAL 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:

Sign here: Date: dd / mm / yy

Information authority

Where we require information from other sources, such as your accountant or employer, we require your authority to obtain information about you from them. We will only use your authority to obtain information that we reasonably believe is relevant to your policy or claim.

I authorise any insurer (including workers compensation/CTP insurer), government agency or body (including Centrelink/Department of Veteran's Affairs), employer, accountant or other relevant holder of information, to release to TAL Life Limited, its related bodies, corporate, its agents or its representatives and my superannuation fund or its administrator, information which they require for the purpose of assessing or investigating my claim or application for cover, or verifying disclosures I made in connection with the cover.

A copy of this authority is to be regarded as if it were the original signed authority.

Name:

Sign here: Date: dd / mm / yy

Privacy

The ways in which Insuranceline & St Andrew's collect, use, disclose and secure your personal information is set out in their respective Privacy Policies available at www.insuranceline.com.au and www.standrews.com.au.

HOW TO RETURN YOUR DOCUMENTS