Income Protection Plus

Sickness or injury initital claim form

Insuranceline

Any questions?
Please call us

1300 880 750

Please answer ALL questions. Use black/blue ink and ensure answers are clear and legible.

Any fee for the completion of the Initial Medical Report by your Medical Practitioner is your responsibility.

In addition to this form, please provide:

1. An 'Authority to release personal Medicare claims information to a third party' form.
2. Initial Medical Report (to be completed by your Medical Practitioner).

Part A – Self assessment

1.	Have you been off work or unable to perform Regular Daily Activities for longer than the waiting period?	Yes ☐	Complete and Submit this form	No ☐	Answer Q2
2.	Has a Medical Practitioner confirmed that you are likely to be off work for longer than the waiting period?	Yes ☐	Complete and Submit this form	No ☐	Please wait before claiming
3.	Have you experienced this condition, or a related condition, in the past?	Yes ☐	Please check your policy exclusions	No ☐	

Part B – Personal details Insured

Policy Number

Date of Birth dd / mm / yyyy

Full Name First name Surname

Current Residential Address
(Not Post Office Box)

Suburb State Postcode

Postal Address
(if different from above)

Suburb State Postcode

Email Address

Contact Numbers Home Work Mobile

Part C – Banking details

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

BSB Number ☐☐☐ - ☐☐☐

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Name

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

TALD0031 0724 ISS12

Part D – Occupational/daily activity details

1. What occupation or daily activities were you performing prior to your sickness or injury?

2. 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	Please explain if/how/why you are currently restricted from performing these duties?
e.g Driving	e.g 25%	e.g Broken leg prevents ability to use brakes

3. If employed, how long had you been in this occupation and performing these duties?

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

5. Do you do any unpaid work? Yes ☐ No ☐

6. Have you returned to work yet? Yes ☐ No ☐

7. If yes, on what date did you return to work? dd / mm / yyyy

8. If no,
   a. what currently prevents you from returning to work?

   b. when do you expect to be able to do so?

   Full-time dd / mm / yyyy Part-time dd / mm / yyyy

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

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

    If not please explain why?

Part E – 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.

Part E – Income details cont.

THIS SECTION IS TO BE COMPLETED IF YOU ARE EMPLOYED

IMPORTANT

If you are **employed** please ATTACH all of the following

a. Your income tax return for the last financial year.

b. Your Notice of Assessment from the Tax Office for the last financial year.

c. A copy of your pay-slips for the 12 months prior to your sickness or injury.
(If you are unable to supply any of these, please call us on **1300 880 750** to discuss.)

5. Company Name of Employer

6. Employer's Address

7. Employer's Contact Number

8. Manager/HR Representative's Name

THIS SECTION IS TO BE COMPLETED IF YOU ARE SELF-EMPLOYED. PLEASE COMPLETE THE APPROPRIATE QUESTIONS

IMPORTANT

If you are **self-employed** please ATTACH all of the following

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 sickness or injury.
(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).

9. What is the name of your business entity?

10. What is your trading name?

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

Sole Trader ☐ Partnership ☐ Trust ☐ Or Complete below company details

Company ☐ ACN ABN

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

13. Is your business continuing in your absence? Yes ☐ No ☐

14. If yes, who is completing your role/duties?

Part F – Other claims income

1. Have you made, or do you intend to make, a sickness or injury claim with any of the following?

If so, please tick the appropriate answer and provide details.

a.	Any other 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		

Part F – Other claims income cont.

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

3. Please provide the date you first started receiving this benefit. dd / mm / yyyy

Part G – Sickness claim (please complete either G: Sickness claim or H: Injury claim)

1. Nature of sickness

2. Date the symptoms began dd / mm / yyyy

   Date Doctor first consulted dd / mm / yyyy

3. Date ceased work/regular activity dd / mm / yyyy

4. What are your current symptoms?

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

   If yes, please provide full details

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

   Full Name

   Address

   Suburb State Postcode

   Contact Number

   Full Name

   Address

   Suburb State Postcode

   Contact Number

   Full Name

   Address

   Suburb State Postcode

   Contact Number

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

Part G – Sickness claim cont.

8. 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

9. 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 H – Injury claim

1. Nature of Injury

2. How did the Injury occur?

3. Location where the Incident/Accident occured

4. Date of Injury — dd / mm / yyyy

5. Date Doctor first consulted for this condition — dd / mm / yyyy

6. Date ceased work/regular activity — dd / mm / yyyy

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

Full Name

Address

Suburb | State | Postcode

Contact Number

Full Name

Address

Suburb | State | Postcode

Contact Number

Full Name

Address

Suburb | State | Postcode

Contact Number

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

Part H – Injury claim cont.

9. 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

10. 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.

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.

Full Name of Life Insured

Sign here

Date dd / mm / yyyy

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 authority

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.

Full Name

Sign here | Date dd / mm / yyyy

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 4 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.

Full Name

Sign here | Date dd / mm / yyyy

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.

Full Name

Sign here | Date dd / mm / yyyy

Privacy

The ways in which Insuranceline and Hallmark General Insurance collect, use, disclose and secure your personal information are set out in their respective Privacy Policies at www.insuranceline.com.au/Privacy-Policy and www.hallmarkinsurance.com.au, which are available free of charge on request.

How to return your documents

Reply Paid 5380, Sydney NSW 2001

claims@insuranceline.com.au

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