Income Protector Plan
Initial medical report

Insuranceline

Any questions?
Please call us
1300 880 750

To be completed by your Medical Practitioner.

Please ensure that:

1. All questions are answered fully to avoid any undue delays to this claim.
2. You complete this form in black/blue ink and ensure that answers are clear and legible.
3. The Insured is aware that any fee for the completion of this certificate is their responsibility.

Part A – Personal details (Medical Practitioner)

Full Name | First name | Surname

GP ☐ Specialist ☐

Qualifications

Address

Suburb | State | Postcode

Email Address

Contact Number

Are you the Insured's treating doctor? Yes ☐ No ☐

How long has the Insured been consulting with you?

If the Insured was referred to you, please advise by whom and the date of referral

Part B – Insured's details

Policy Number

Date of Birth dd / mm / yyyy | Height | Weight

Full Name | First name | Surname

Occupation or Job Title

Hours worked per week

Employment status prior to the Sickness or injury Full-time ☐ Part-time ☐ Casual ☐ Other ☐

Part C – Medical details: diagnosis

1. What is the Insured's diagnosis?

2. Please provide details of the objective tests on which the diagnosis was based (Please attach copies of test results wherever possible).

Part C – Medical details: diagnosis cont.

3. What are the Insured's current signs and symptoms and the cause of these?

4. What specific effect do these symptoms have in the Insured's current functional ability?

5. On what date did you

First consult with the Insured in regard to this condition? dd / mm / yyyy

Last consult and treat the Insured for this condition? dd / mm / yyyy

6. When are you next scheduled to consult and treat the Insured? dd / mm / yyyy

7. Has the Insured seen any other Doctors in relation to this disability, prior to seeing you? Yes ☐ No ☐

If yes, please provide details.

Full Name

Address

Suburb State Postcode

8. Has the Insured been referred to a Specialist? Yes ☐ No ☐

If yes, please provide details (attach an additional list if necessary).

Full Name

Address

Suburb State Postcode

Date(s) seen dd / mm / yyyy Speciality

Full Name First name Surname

Address

Suburb State Postcode

Date(s) seen dd / mm / yyyy Speciality

Full Name

Address

Suburb State Postcode

Date(s) seen dd / mm / yyyy Speciality

9. Is the Insured scheduled to see the Specialists again for a follow up? If so, when, and with which Specialist?

Full Name

Date(s) seen dd / mm / yyyy

10. What is your prognosis for the Insured's ability to improve their current symptoms and level of function?

Part D – Medical details: Treatment

1. Please describe the Insured's treatment plan, including surgery (either performed or being consulted) and details of all medication prescribed.

2. Is the Insured taking prescribed medication? Yes ☐ No ☐

   If so, how often are you renewing the prescriptions?

3. Has the Insured been compliant with the treatment prescribed? Yes ☐ No ☐

4. What improvement to symptoms has the Insured experienced as a result of the treatment received so far?

5. If no improvements have been made, please advise why, and what further treatment is being considered at this time.

6. What future/further treatment plans have you recommended to aid the Insured's recovery?

Part E – Medical details: Occupation related

1. What specific symptoms affect the Insured's ability to perform their full pre-injury duties?

Occupation Duties	Specific symptoms affecting ability to perform these duties

2. Please advise from what date the Insured has been

   Totally unable to perform the duties of their usual occupation dd / mm / yyyy

   Able to return to work full-time dd / mm / yyyy

   Able to return to partial duties dd / mm / yyyy

3. If the Insured has not yet returned to work, when do you anticipate they will be able to?

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

4. Have you considered, or are considering, implementing a return to work program or rehabilitation? Yes ☐ No ☐

   If yes, please provide details or attach a copy of the program.

   If no, please explain why you don't consider this advisable.

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Part F – Medical details: Insured's history

1. Please detail any ongoing medical problems, past history or circumstances of which you are aware that are affecting the Insured's current condition.

2. Has the Insured ever consulted you, or any other Medical Practitioner previously for a similar condition or symptoms? Yes ☐ No ☐

   If yes, please provide dates and doctors consulted.

Part G – Other

1. In respect of the Insured's present disability, have you given any certificate or report to.

Another Insurance Company	Yes ☐	No ☐
Solicitor	Yes ☐	No ☐
Third Party Insurer	Yes ☐	No ☐
Centrelink Office	Yes ☐	No ☐
Workers Compensation Insurer	Yes ☐	No ☐

   Other

   If yes, please provide details of who reports have been sent to.

2. If you have any other comments or suggestions as to how TAL Life Limited can assist in returning the Insured to good health and to return to work, or with respect to this claim, we welcome your comments here.

Part H – Declaration

By providing you with this Initial Medical Report to complete the Insured consents to the release of their personal and sensitive information and its collection by TAL. I hereby declare that the above statements are true and correct.

Sign here

Date dd / mm / yyyy

Qualification

Address

Suburb State Postcode

Privacy

The way in which Insuranceline collects, uses, secures and discloses your personal information is set out in the Insuranceline Privacy Policy available at www.insuranceline.com.au/Privacy-Policy or free of charge on request to Insuranceline.

How to return your documents

Reply Paid 5380, Sydney NSW 2001

claims@insuranceline.com.au

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