Bill Relief Plan

Sickness or Injury Initial Claim Form

Need any help completing this form? **1300 880 750** 8am-8pm

INSURANCELINE

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 Certificate'.

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%

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:

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

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.

PART G – AUTHORITIES

Medical Authority

I, _____ hereby authorise any Doctor, hospital, Therapist or other Medical Professional who has attended me, to release to TAL Direct Pty 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 Direct Pty 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.

Sign here: Date: dd / mm / yy

Information Authority

I, _____ hereby authorise any insurer, employer, accountant or other relevant holder of information, to release to TAL Direct Pty Limited, or its representatives, information which TAL Direct Pty 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.

Sign here: Date: dd / mm / yy

PART H – DECLARATIONS

Claim 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 Direct Pty limited of any material information regarding my claim, the insurer may refuse to pay and cancel my claim and in some cases, could cancel my policy.

Sign here: Date: dd / mm / yy

YOUR PRIVACY

The Privacy of InsuranceLine customers is important and InsuranceLine is bound by obligations imposed by current privacy laws including the Australian Privacy Principles.

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 by contacting 1300 880 750 or questions@insuranceline.com.au

Collection and use of personal information

We collect personal information, including your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay the claim.

We may take steps to verify the information we collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Disclosure of personal information

We disclose relevant personal information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you, such as the following:

- Claims assessors and investigators, claims managers and reinsurers;
- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Other insurers;
- For members of superannuation funds where InsuranceLine is the insurer, to the trustee, or administrator of the superannuation fund; and
- Other organisations to whom we outsource certain functions during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices)

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