Income Protection Plus

Sickness or Injury Initial Claim Form

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

INSURANCELINE

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

Any fee for the completion of the Initial Medical Certificate 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.
   (We also recommend that you obtain the last 3 years of your Medicare records from the Medicare website to speed up the claims process).
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 CLAIMANT

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)

PART C – BANKING DETAILS

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

BSB: ☐☐☐-☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Name:

PART D – OCCUPATIONAL/DAILY ACTIVITY DETAILS

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

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 ◯

7. Have you returned to work/your daily activity yet? Yes ◯ No ◯

6. If "yes" on what date did you return to work/your daily activity? dd: mm: yyyy:

7. If "no":

a. what currently prevents you from returning to work/your daily activity?

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

Full-time Part-time

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

9. 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 CONTINUED

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 880 570 to discuss.)

5. Company name of Employer
6. Employer's Address
7. Employer's Phone 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

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 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:	

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:

   Name:
   Address:
   Phone Number:

   Name:
   Address:
   Phone Number:

   Name:
   Address:
   Phone Number:

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

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

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 conditions:

Name:
Address:
Phone Number:

Name:
Address:
Phone Number:

Name:
Address:
Phone Number:

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

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

PART I – AUTHORITIES

Medical Authority

I, (full name) 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, (full name) 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 J – 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.

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)

INSURED BY:

TAL

How to return your documents

Mail FREE Post
Reply Paid 62
Carlton South VIC 3053

FREE Fax
1800 245 622

Local Phone
1300 880 750

Email
claims@insuranceline.com.au