Retail Supplementary Report Form Partial Disablement

Statement by LIFE INSURED. All relevant questions MUST be answered fully.

SECTION A – Personal Details

Name of Life Insured

Policy Number

Residential Address

Postcode

Postal Address

Postcode

Telephone (home) (business) (mobile)

E-mail
(for correspondence)

This form covers the claim period / / **to** / / **inclusive.**

AIA Australia Claim Number

SECTION B – Details of this Condition

1. Has your condition and/or diagnosis changed since you last completed a claim form? If '**Yes**', please provide details. ☐ Yes ☐ No

2. (a) When did you last consult a doctor or medical provider? / /

(b) Please list the name (including address and telephone contact details) and the date of all doctors or medical providers you consulted during this claim period.

3. When is your next scheduled consultation? / /
Please provide details.

4. Please list all your current medication/s, including dosages.

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SECTION C – Details of Work Capacity

1. When did you start part time duties? / /

2. Who has been your Employer during this period of partial disability?

3. What occupation have you been working in?

4. (a) How many hours per week did you work prior to your disability?

(b) How many hours per week are you working now?

SECTION D – Details of Work Done

1. Please list all the work duties you have been **ABLE** to perform whilst partially disabled and the percentage of time performed on each duty (to a total of 100%).

Work duty	% of time

2. Please list all the work duties you are **UNABLE** to perform whilst partially disabled.

3. When do you expect to return to full time work? / /

4. If you have not returned to full time work, do you have a return to work plan or have you discussed one with your treating doctor?

☐ Yes – If '**Yes**', please provide details.

☐ No – If '**No**', please advise the reason.

SECTION D – Details of Work Done (continued)

5. Details of work done, paid or unpaid, during this claim period.
(This is a diary to record all work you have done during this current claim period. To ensure accuracy, we suggest that you fill in the details daily.)

Date	Hours worked	Duties performed
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6. If you are **SELF-EMPLOYED**, have you employed or engaged any staff to perform some of your usual duties?..... ☐ Yes ☐ No
If '**Yes**', please provide details below.

Name of staff member	Full time or part time	Duties performed	Payment	Income generated

SECTION E – Details of Earnings

Employed Persons:

What is your **TOTAL GROSS MONTHLY INCOME** for this claim period?*
(Please provide a copy of your payslip(s) for the claim period.)

$

Self-employed Persons:

What is your **TOTAL NET EARNED INCOME** (before tax) for this claim period?*
(Please provide a copy of a Profit and Loss Statement for the claim period.)

$

**When advising details of your earnings, please note that if there was a delay between the time you generated the income and when you actually received it, the income generated in the period of work should be advised.*
If required, please refer to the Product Disclosure Statement/Policy Document for the definition of income.

SECTION F – Other Insurances

1. As a result of your disability are you entitled to receive, or are you receiving any other benefit or are you entitled to claim any other benefits? (e.g. Centrelink, Workers Compensation, Transport Accident Commission, Third Party Insurance, Income Protection, Superannuation, Salary Continuance, common law, any other insurer or any other source.) ..... ☐ Yes ☐ No

If '**Yes**', please provide the following:

Type of claim

Insurer (if applicable)

Reference number

Gross amount received/expected $ per week

Period the payment refers to: From / / to / /

Contact person

Contact number

Declaration

I hereby declare that the information 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 AIA Australia of any relevant information regarding my claim, AIA Australia may refuse to pay benefits and proceed to cancel my claim and/or my insurance cover.

I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the AIA Australia Privacy Policy available on the AIA Australia website at www.aia.com.au as updated from time to time or by calling AIA Australia on 1800 333 613, including the exchange with third parties located in Australia and overseas.

Name of Life Insured *(please print)*	Signature of Life Insured	Date
	✗	

Authority to Release Health Information

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, (**AIA Australia**), 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

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 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 **AIA Australia**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **AIA Australia** 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.
- **AIA Australia** 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 **AIA Australia** 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:

Signature:

✗

Date:

Authority 2

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.

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 **AIA Australia**, or to third parties they engage, only if **AIA Australia** 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:

- **AIA Australia** 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 **AIA Australia** 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:

Signature:

✗

Date:

☐ I/We authorise and consent to any life insurance company disclosing to AIA Australia personal and sensitive information about me/us with regard to previous or current applications for insurance cover or claims made under other insurance cover which may include details of my/our health and medical history.

Retail Medical Attendant's Statement

Partial Disablement

Forming part of the Supplementary Report Form

This Medical Attendant's Statement is to be completed by your usual doctor.
If there is a charge for completing this form, its payment is the responsibility of the patient.

Privacy
In completing this form you may be providing AIA Australia Limited with personal and sensitive information. This information must be handled, collected, used and disclosed in accordance with the Privacy Act 1988 (Cth) and the AIA Australia Group Privacy Policy as updated from time to time (AIA Australia Privacy Policy). For more information about the AIA Australia Privacy Policy (including notification) please refer to www.aia.com.au or contact 1800 333 613 to request a copy. AIA Australia may, if requested by the patient, require that you consider a request for personal and sensitive information and act accordingly.

Patient's Name | Occupation

AIA Australia Claim Number

1. (a) How long have you known this patient? Professionally | Personally

(b) If the patient was referred to you please provide:

Name of referring doctor

Address and telephone contact details

Date of referral / /

2. (a) What is your current diagnosis and the patient's level of disability?

(b) What is the objective clinical evidence to support your diagnosis?

3. (a) Are you still attending the patient? ☐ Yes ☐ No

If '**Yes**', how frequently?

(b) Please provide the date of the last consultation. / /

(c) What was the reason for the consultation?

(d) When is the next scheduled consultation for the patient to attend you? / /
If no further consultation has been arranged, please provide reason.

4. Please provide details of the treatment plan currently prescribed (including the names and dosages of any medication).

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5. To the best of your knowledge is the patient following the treatment plan prescribed? ☐ Yes ☐ No
If '**No**', please comment.

6. Do you consider any other treatment plan necessary and/or beneficial for recovery and return to usual occupation? ☐ Yes ☐ No
If '**Yes**', please comment.

7. What is the short term and long term prognosis?

8. Has the patient been referred to any other doctor(s), medical provider(s) or rehabilitation provider(s) or other health professional(s) for treatment or consultation? If '**Yes**', please state: ☐ Yes ☐ No

Date of referral / / Field of Practice (cardiologist, ortho surgeon, etc.)

Name, address and telephone contact details

Date of referral / / Field of Practice (cardiologist, ortho surgeon, etc.)

Name, address and telephone contact details

9. From your knowledge and understanding of the patient's usual occupation should he/she be **able** to perform any of the duties and/or responsibilities of their usual occupation?

☐ Yes – **Please continue to question 10**

☐ No – **Please continue to question 11**

10. (a) If the patient is **able** to perform some duties of their usual occupation, please list the date from which the patient became capable of resuming at least some duties they can perform and to what capacity (i.e. 50%, etc.)?

Work duty **able** to be performed	Date able to perform work duty	% capacity
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(b) How many hours per week can the patient perform these duties?

(c) When do you consider the patient will be **able** to perform all of his/her usual occupational duties? / /

(d) Please continue to question 12.

11. (a) Please state the duties and/or responsibilities the patient is **unable** to perform of his/her usual occupation, including the reasons why he/she is **unable** to perform them.

Work duty **unable** to perform	Reason he/she is unable to perform this duty

(b) While under your care, how long was, or will the patient be:

(i) **unable** to perform **all** the duties of their usual occupation? / / to / /

(ii) **able** to perform **some** of the duties of their usual occupation? / / to / /

(c) When do you consider the patient will be:

(i) **able** to perform **some** the duties of their usual occupation? / /

(ii) **able** to perform **all** of the duties of their usual occupation? / /

12. (a) Is the patient **currently performing** any **alternative** duties? ☐ Yes ☐ No

If '**Yes**', please state from / / to / /

(b) Please provide full details including the duties the patient is currently performing and the number of hours per week these duties are being performed.

Duties	No. of hours duties can be performed

Additional Information

13. Please provide any additional information or comments you feel are relevant to this claim.

Declaration

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true, correct and complete.

I confirm that I have handled, collected, used and disclosed the patient's personal and sensitive information provided with this form in accordance with privacy law.

I understand that AIA Australia may be entitled or required to provide access or a copy of my report to the patient, the patient's representatives, a conciliator, mediator, tribunal or court, or to medical specialists and other third parties, under privacy law and the AIA Australia Group Privacy Policy, and authorise AIA Australia to do so.

Name *(please print)* Qualification(s)

Signature Date

Address Postcode

E-mail

Telephone Facsimile