Retail Waiver of Premium Claim Form

Statement by LIFE INSURED. All 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) | Date of Birth / /

Do you hold citizenship(s) other than an Australian citizenship? ☐ Yes ☐ No | Age

If 'Yes', please advise your other country of citizenship(s)

When did you cease work? / / | When did you first consult a doctor or medical provider after you ceased work? / /

Please provide the name, address and telephone contact details of this doctor or medical provider you consulted.

SECTION B – Claim Details (complete part A in case of injury or part B in case of sickness)

A: Injury Claim – Answer all of Section A (questions 1 to 5 below), if your claim is in respect of an injury.

1. What is your injury? (Please provide full details of the nature and extent of your injuries. E.g. If to a limb, specify whether left or right.)
2. When did the injury occur? Date / / Time am/pm
3. Where did the injury occur? (Please provide the full address details of the place where the injury occurred.)
4. How did the injury happen and what caused it?
5. Were there any witnesses to the injury? ☐ Yes ☐ No If '**Yes**', please provide their names and contact details (if known).

B: Sickness Claim – Answer all of Section B (questions 1 to 5 below), if your claim is in respect of a sickness.

1. What is the nature of your sickness?
2. When did your symptoms first occur? Date / /
3. Please describe your current symptoms and their severity.
4. When was a diagnosis made? Date / /
5. Please provide the name, address and telephone contact details of the doctor or medical provider who made the diagnosis.

SECTION C – Treatment for this Condition

1. (a) When did you first consult a doctor or medical provider for your condition? / /

Name, address and telephone contact details of the doctor or medical provider consulted

Field of Practice (GP, cardiologist, etc.)

(b) When did you last consult this doctor or medical provider? / /

(c) Is this your usual doctor or medical provider? ☐ Yes ☐ No
If '**No**', please provide the name, address and telephone contact details of your usual doctor or medical provider.

(d) How long have you attended your usual doctor or medical provider?

(e) Have you consulted any other doctors and/or medical providers for your condition? ☐ Yes ☐ No
If '**Yes**', please provide details below (attach a separate sheet if required).

Date first consulted	Date last consulted	Doctor's name/Field of practice	Address and telephone contact details
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

(f) Do you have a Return to Work Plan or have you discussed one with your doctor? ☐ Yes ☐ No
If '**Yes**', please provide full details.
If '**No**', please provide the reason and whether you believe occupational rehabilitation (e.g. Return to work program, studying, re-training, up-skilling etc) could assist you.

2. Were you hospitalised? ☐ Yes ☐ No
If '**Yes**', please provide details below (attach a separate sheet if required).

Hospital name	Address and telephone contact details	Date admitted	Date discharged
		/ /	/ /
		/ /	/ /
		/ /	/ /

SECTION C – Treatment for this Condition (continued)

3. Are you entitled to receive sick leave from your employer for your present disablement? ☐ Yes ☐ No
If '**Yes**', what period(s) are you entitled to and how much sick leave have you, or are you entitled to receive?

4. Have you ever had the same or similar injury or sickness before? ☐ Yes ☐ No
If '**Yes**', please advise the dates of when the injury or sickness occurred, what the nature of the injury/sickness was and the names of all doctors or medical providers you consulted (attach a separate sheet if required).

SECTION D – Medical History

1. Please provide the dates and reasons of all consultations with your usual doctor or medical provider during the last 5 years.

Date	Reason

2. Have you attended any other doctor or medical provider (other than your usual doctor or medical provider) during the last 5 years? ☐ Yes ☐ No If '**Yes**', please provide reasons below.

Date	Reason	Name, address and telephone contact details of doctor

3. What medications have you taken during the last 5 years (other than for colds or influenza)?

4. Have you been disabled or incapacitated through any other injury or sickness in the last 12 months? ☐ Yes ☐ No
If '**Yes**', please advise the nature of the injury or sickness and how many days leave you required.

SECTION E – Occupational Details

A: Employees (Answer questions 1 to 13 if you are an employee.)

1. What is your Employer's name, address and telephone contact details?

2. What was your job title when you ceased work?

3. Please provide details of your work duties and responsibilities.

Duties and responsibilities	% (totalling 100%)

4. (a) Was your employment ☐ Full-time? ☐ Part-time? ☐ Casual? ☐ Contractor?

(b) If contractor, please provide the term of contract. From / / to / /

5. Where did you work (e.g. office, factory, building site)?

6. How long have you been in that job? Years Months

7. How many hours per week did you work?

8. Did you supervise other employees? ☐ Yes ☐ No If '**Yes**', how many?

9. Did you operate machines or any special equipment? ☐ Yes ☐ No If '**Yes**', please provide details.

10. Please indicate (✔) the following requirements of your usual occupation, where applicable.

	A	B	C	D		A	B	C	D
Lifting, 20 kg and over	☐	☐	☐	☐	Carrying, 20 kg and over	☐	☐	☐	☐
Lifting, 5 to 19 kg	☐	☐	☐	☐	Carrying, 5 to 19 kg	☐	☐	☐	☐
Lifting, under 5 kg	☐	☐	☐	☐	Carrying, under 5 kg	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐					

***A** = continuous (more than 2/3 of time), **B** = frequently (1/3 to 2/3 of time), **C** = occasional (1/3 of time or less), **D** = never*

11. What percentage of time, on average, did you spend in the following activities while performing your usual occupation?

%	Sitting	%	Standing	%	Walking	%	Bending	%	Lifting
%	Driving	%	Climbing	%	Crawling	%	Kneeling		

12. Were you required to travel as part of your usual occupation? ☐ Yes ☐ No

If '**Yes**', how may kilometres per week and type of vehicle.

13. How far from home was your place of employment and how did you get there?

14. What was your total gross income earned for the last 12 months prior to disablement? $

SECTION E – Occupational Details (continued)

B: Self-Employed (Answer questions 1 to 12 if you are self employed.)

1. Are you a ☐ Sole trader? ☐ Partnership? ☐ Company? ☐ Trust?

2. What is the name of your business?

3. (a) **If a partnership**, what is your share of partnership (income and expenses) distribution? %

(b) How many partners are there?

4. What duties did you normally perform in the business prior to your disability?

Duties	% (totalling 100%)

5. Please indicate (✔) the following requirements of your usual occupation, where applicable.

	A	B	C	D		A	B	C	D
Lifting, 20 kg and over	☐	☐	☐	☐	Carrying, 20 kg and over	☐	☐	☐	☐
Lifting, 5 to 19 kg	☐	☐	☐	☐	Carrying, 5 to 19 kg	☐	☐	☐	☐
Lifting, under 5 kg	☐	☐	☐	☐	Carrying, under 5 kg	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐					

***A** = continuous (more than 2/3 of time), **B** = frequently (1/3 to 2/3 of time), **C** = occasional (1/3 of time or less), **D** = never*

6. What percentage of time, on average, did you spend in the following activities while performing your usual occupation?

% Sitting % Standing % Walking % Bending % Lifting

% Driving % Climbing % Crawling % Kneeling

7. How many hours per week did you work?

8. (a) How many employees does your business have?

(b) What are their work responsibilities?

9. Since your disablement, has your business continued to operate in any way? ☐ Yes ☐ No
If '**Yes**', please detail what activities have continued.

10. If your business has continued, what impact has your disability had on the business?

11. Who has been operating your business in your absence?

12. How long will your business continue to operate during your absence?

13. What was your total gross income earned for the last 12 months prior to disablement? $

Income is the income generated by the business or practice due to your personal exertion or activities, less your share of the necessarily incurred business expenses.

SECTION F – Level of Disability

1. Please list which of your usual occupation duties you **can** and **cannot** do solely due to your injury or sickness.

Work duties you **can** do	Work duties you **cannot** do

2. Have you returned to any form of work? ☐ Yes ☐ No
If '**Yes**', please provide details of employer name, hours worked, duties performed and period worked

Employer name/s and contact details	Hours worked	Duties performed	Period worked

3. What jobs do you think you will be able to do in the future?
(Please ensure you provide full details, including whether you have applied for any of these jobs since ceasing work.)

4. Why do you think you are totally and permanently disabled and unable to perform any work/duties within your education/training or experience in the future?

SECTION G – Vocational History

1. What is your level of education? ☐ Primary ☐ Secondary ☐ TAFE ☐ Tertiary

2. Please provide a detailed education history of all secondary, tertiary, TAFE courses and any other job related training undertaken (attach a separate sheet if required or your resume).
If not in Australia, please advise which country the qualification was provided.

Course description/Qualification	Country	Date started	Date qualified
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Please provide a detailed work history for the last 10 years (please attach a separate sheet if required or your resume).
If not in Australia, please advise which country the work was performed.

Period of employment	Employer	Job title	Position description/Duties
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

SECTION H – Activities and Restrictions

1. (a) Please describe your hobbies, interests and social activities.

(b) Are you still able to pursue these? ☐ Yes ☐ No
If '**No**', please describe how long your condition has affected your hobbies, interests and social activities (eg. which activities can you no longer perform).

(c) What are your current daily activities?

SECTION I – Other Insurances

1. Have you previously made a claim against this policy? ☐ Yes ☐ No If '**Yes**', please provide details.

2. (a) As a result of your injury/sickness, have you received, or are you entitled to receive/claim any benefits from:

☐ Centrelink ☐ TAC ☐ Another Insurer (eg. for another policy providing disablement cover)
☐ Workers' Compensation ☐ Common Law ☐ Any other source. Please state:

(b) If you are receiving or have received any benefits, please provide full details of each benefit including:

Type of claim		Claim/Ref No.	
Insurer (if applicable)		Amount of claim	$
Contact person		Contact number	

Type of claim		Claim/Ref No.	
Insurer (if applicable)		Amount of claim	$
Contact person		Contact number	

3. Do you have any other sources of income? ☐ Yes ☐ No If '**Yes**', please provide details.

SECTION J – Declarations and Authorities

DECLARATION AND CONSENT

I 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 Limited of any relevant information regarding my claim, AIA Australia Limited 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 Privacy section of this form and the Privacy Policy on the AIA Australia website www.aia.com.au as updated from time to time, including (without limitation) for the purposes of investigation, assessment and management of my claim and related purposes, and the collection and exchange of my personal and sensitive information from and with the following (where relevant):

a. the life insured, policy owner or beneficiaries of my insurance policy;
b. my representatives (including my financial adviser), employer and financial institution;
c. other insurers (including workers' compensation insurers), insurance brokers and intermediaries and insurance and credit reference agencies;
d. medical and health providers, including the ambulance service;
e. AIA Australia's investigators, service providers, partners and reinsurers;
f. regulatory and law enforcement agencies;
g. the trustee and administrator of my superannuation fund; and
h. other third parties assisting with the investigation, assessment and management of my claim.

I authorise my previous and current employer to provide AIA Australia Limited details of my employment history.

I agree that a copy of this authorisation shall be considered as effective and valid as the original.

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

AUTHORITY TO OBTAIN INFORMATION

I hereby authorise any insurer or other institution to release to AIA Australia Limited or its representatives all information which AIA Australia Limited requests for the purpose of assessing or investigating my claim.

I agree that a copy of this authorisation shall be as effective and valid as the original.

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

ACCOUNTANT/FINANCIAL ADVISER AUTHORITY

I hereby authorise my previous and current accountant/financial adviser to release to AIA Australia Limited or its representatives all information which AIA Australia Limited requests for the purpose of assessing or investigating my claim.

I agree that a copy of this authorisation shall be as effective and valid as the original.

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.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

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.

Privacy

This section summarises key information about how AIA Australia handles personal information including sensitive information. For further information, please review the most up to date full version of the AIA Australia Group Privacy Policy on AIA Australia's website at www.aia.com.au, as updated from time to time (AIA Australia Privacy Policy).

Your privacy is important to us and AIA Australia and we are both bound by the Privacy Act, and other laws which protect your privacy. AIA Australia Group consists of AIA Australia Limited, AIA Financial Services Limited, The Colonial Mutual Life Assurance Society Limited, CMLA Services, Jacques Martin Pty Ltd, Jacques Martin Administration and Consulting Pty Ltd, AIA Group and their related bodies corporate and joint venture partners (together referred to as " AIA Australia ", "we", "us" and "our"). Together, we provide you the following notification and information about AIA Australia's Privacy Policy and your rights.

Why AIA Australia collects Personal Information

AIA Australia collects, uses and discloses personal and sensitive information ("Personal Information") for purposes set out in the AIA Australia Privacy Policy, including to process applications for AIA Australia's products and services (including products AIA Australia distribute), to assist with enquiries and requests in relation to AIA Australia's products and services (including products AIA Australia distributes), for underwriting and reinsurance purposes, to administer, assess and manage your products and services, including claims, to understand your needs, interests and behaviour and to personalise dealings with you, to provide, manage and improve AIA Australia's products and services, to maintain and update AIA Australia's records, to verify your identity and/or authority to act on behalf of a customer, to detect, detect, manage and deal with improper conduct and commercial risks, for reporting, research and marketing purposes, to otherwise comply with local and foreign laws and regulatory obligations, and for any other purposes outlines in AIA Australia's Privacy Policy. The reasons why AIA Australia collect, use and disclose Personal Information may vary depending on the product, services or other circumstances in which you have engaged with AIA Australia. Where you agree or AIA Australia is otherwise permitted by law, AIA Australia may contact you on an ongoing basis by email, phone and otherwise, with offers and other promotional information about products or services AIA Australia think may interest you. If you do not wish to receive these direct marketing communications you may indicate this where prompted or by contacting AIA Australia as set out in AIA Australia's Privacy Policy.

How AIA Australia collects, uses and discloses Personal Information

AIA Australia may collect your Personal Information from various sources including forms you submit and AIA Australia's records about your use of AIA Australia's products and services and dealings with AIA Australia, including any telephone, email and online interactions. AIA Australia may also collect your information from public sources, social media and from the parties described in AIA Australia's Privacy Policy. AIA Australia is required or authorised to collect Personal Information under various laws including the Life Insurance Act, Insurance Contracts Act, Corporations Act and other laws set out in AIA Australia's Privacy Policy. Where you provide AIA Australia with Personal Information about someone else, you must have their consent to provide their Personal Information to AIA Australia in the manner described in AIA Australia's Privacy Policy.

AIA Australia may collect your Personal Information from, and exchange your Personal Information with, AIA Australia's related bodies corporate including without limitation, joint venture partners and third parties, including the life insured, policy owner or beneficiaries of your insurance policy, AIA Australia service providers or contractors, your intermediaries (including without limitation, your financial adviser and the Australian Financial Service Licensee they represent, the distributor of your insurance policy, the trustee or administrator of your superannuation fund, your employer, unions of current and former staff members of AIA Australia (including contactors) medical professionals or anyone acting on your behalf including any other representative or intermediary) ("Representatives"), your employer, bank, medical professional or health providers, partners used in AIA Australia's activities or business initiatives (including if relevant to your policy, the Commonwealth Bank of Australia), AIA Australia's distributors, clients, and reinsurers, private health insurers (including MO Health Pty Ltd) and their contractors and agents, other insurers including worker's compensation insurers, authorities and their agents, other super funds, trustees of those super funds and their agents, regulatory and law enforcement agencies, other bodies that administer applicable industry codes, and other parties as described in AIA Australia's Privacy Policy.

Where AIA Australia provides your Personal Information to a third party, the third party may collect, use and disclose your Personal Information in accordance with their own privacy policy and procedures. These may be different to those of AIA Australia.

Parties to whom AIA Australia discloses Personal Information may be located in Australia, South Africa, the United States, the United Kingdom, Europe, Asia and other countries including those set out in AIA Australia's Privacy Policy. If the Financial Services Council Life Code of Practice ("Code") applies to the insurance cover AIA Australia provides to you, AIA Australia will comply with the Code when AIA Australia collects, uses and discloses your Personal Information.

Other important information

By providing information to AIA Australia or your Representatives, the trustee or administrator of a superannuation fund, submitting or continuing with a form or claim, or otherwise interacting or continuing your relationship with AIA Australia directly or via an intermediary, you confirm that you agree and consent to the collection, use (including holding and storage), disclosure and handling of Personal Information in the manner described in AIA Australia's Privacy Policy on AIA Australia's website as updated from time to time, and that you have been notified of the matters set out in the AIA Australia Privacy Policy before providing Personal Information to AIA Australia. You agree that AIA Australia may not issue a separate notice each time Personal Information is collected.

You must obtain and read the most up to date version of the AIA Australia Privacy Policy from AIA Australia's website at www.aia.com.au or by contacting AIA Australia on 1800 333 613 to obtain a copy. You have the right to access the Personal Information AIA Australia holds about you, and can request the correction of your Personal Information if it is inaccurate, incomplete or out of date. Requests for access or correction can be directed to AIA Australia using the details in the 'Contact AIA Australia' section below. AIA Australia's Privacy Policy provides more detail about AIA Australia's collection, use (including handling and storage), disclosure of Personal Information and how you can access and correct your Personal Information, make a privacy related complaint and how AIA Australia will deal with that complaint, and your opt-out rights. Always ensure you are reviewing the most up-to-date version of AIA Australia's Privacy Policy as published on AIA Australia's website.

For the avoidance of doubt, the AIA Australia Privacy Policy applicable to the management and handling of Personal Information will be the most current version published at www.aia.com.au, which shall supersede and replace all previous AIA Australia Privacy Policies and/or Privacy Statements and privacy summaries that you may receive or access, including but not limited to those contained in or referred to in any telephone recordings and calls, websites and applications, underwriting and claim forms, Product Disclosure Statements and other insurance and disclosure statements and documentation.

Contact AIA Australia

If you have any questions or concerns about your Personal Information, please contact AIA Australia as set out below:

The Compliance Manager
AIA Australia Limited
PO Box 6111
Melbourne VIC 3004
Phone 1800 333 613

Retail Medical Attendant's Statement

Waiver of Premium

(Forming part of a Total and Permanent Disablement Claim)

To be completed by the doctor or medical provider you have mainly consulted for this disability.
If there is a charge for completing this form, the 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 | Date of Birth / /

Patient's Address

Occupation

Patient's height cm | weight kg | Is your patient left or right handed? ☐ Left handed ☐ Right handed

Does your patient smoke? ☐ Yes ☐ No If '**Yes**', please state substance, quantity and how long they have smoked.

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

2. (a) Are you the patient's usual doctor? ☐ Yes ☐ No
If '**No**', please advise the name, address and telephone contact details of their usual doctor.

Name of usual doctor | Telephone

Address

(b) If the patient was referred to you, please advise name, address and contact number of referring doctor.

Name of referring doctor | Telephone

Address

3. (a) Please confirm whether the condition is an injury or sickness. ☐ Injury ☐ Sickness

(b) Please describe the nature and extent of the patient's condition, its probable cause (if known) and the level of disability.

(c) Is the injury/sickness consistent with the patient's description of cause? ☐ Yes ☐ No If '**No**', please provide details.

4. (a) (i) On what date did the condition first occur? Date / / | Time am/pm

(ii) **Please advise the date that total and permanent disablement commenced and caused the patient to become unfit for work.** / /

(iii) Is the patient still receiving treatment? ☐ Yes ☐ No

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, Melbourne VIC 3004 Phone: 1800 333 613 Fax: 1800 832 266

(b) When were you first consulted for this condition? / /

(c) Please provide details of all subsequent consultations.

5. Are there any factors affecting or prolonging the condition? For example, does the patient have any contributing, concurrent or pre-existing conditions. ☐ Yes ☐ No If '**Yes**', please provide details.

6. If any tests or investigations have been performed (i.e. x-ray, CT Scans, MRI, blood tests, etc.) please provide results (or attach a copy of applicable reports if available).

7. (a) (i) What is the diagnosis and what are the objective clinical signs of the condition?

(ii) Date of diagnosis. / /

(b) What is your short term and long term prognosis?

(c) Please describe your patient's current symptoms.

(d) (i) Is your patient's illness considered terminal? ☐ Yes ☐ No

(ii) If '**Yes**', what is the patient's life expectancy?

(e) Has the patient suffered from this or a similar condition previously? ☐ Yes ☐ No If '**Yes**', please provide the following:

(i) date of previous injury/sickness / / (ii) period of disability

(iii) date of diagnosis / / (iv) prognosis

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

Date of referral	Name and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
/ /		Tel:
/ /		Tel:
/ /		Tel:

8. What is the current treatment plan (including names and dosages of any medication/s)?

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

(b) Do you consider any other treatment plan necessary and/or beneficial for recovery and return to work in their usual capacity? ☐ Yes ☐ No If '**Yes**', please comment.

(c) Has the patient been involved in any other medical, surgical, rehabilitation or other treatment you have scheduled? ☐ Yes ☐ No
If '**Yes**', please provide full details.
If '**No**', would the patient benefit from such a program, including Occupational Rehabilitation, eg. graduated RTW program, studying, re-training, etc.?

10. Was the patient hospitalised? ☐ Yes ☐ No If '**Yes**', please provide details below (attach a separate sheet if required).

Date admitted	Date discharged	Hospital name/Address and telephone contact details	Condition/Procedure
/ /	/ /	Tel:	
/ /	/ /	Tel:	
/ /	/ /	Tel:	

11. Have you given any other certificates concerning the patient's disability? ☐ Yes ☐ No If '**Yes**', please provide details.

12. (a) To the best of your knowledge, what are the duties of the patient's usual occupation?

(b) Does your patient work ☐ Full-time ☐ Part-time ☐ Casual ☐ Contractor

(c) Please state the duties and/or responsibilities the patient is **unable** to perform of their usual occupation, including the reasons why they are **unable** to perform them.

Work duty **unable** to perform	Reason they are **unable** to perform this duty

(d) How long do you expect the patient to be **unable** to perform these duties? From / / to / /

(e) Is the patient **able** to perform any of their **usual** occupational duties? ☐ Yes ☐ No

If '**No**', please go to question 12(f)

If '**Yes**', please enter the date the patient returned to work (or will be able to return to work): / /

Please provide full details including which duties the patient **can perform** and the number of hours per week these duties can be performed. (After detailing the duties below please go to question 13.)

Duties	No. of hours duties can be performed

(f) Will the patient be able to perform any work/duties within their education/training or experience in the future? ☐ Yes ☐ No

If '**Yes**', please give details below, including any **alternative** duties the patient is currently performing or will be able to perform in the future.

If '**No**', why do you think your patient is totally and permanently disabled?

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