Accident Protection/Accident Plan

TOTAL AND PERMANENT DISABLEMENT
EVENT DATE AFTER 30 JUNE 2017

Please read carefully and complete sections "A" to "H".

- If you were employed please have your employer complete "Statement of employer' at Section "I".
- Please type your answers in the boxes provided before printing and signing the form. Alternatively, please print clearly using a black pen.
- If the space below is inadequate or you wish to provide further information, please attach additional documents.
- If you are unable to complete this form, your guardian, attorney or nearest relative may do so. However they will need to provide details of their relationship and documentary evidence of same.
- Please have your usual Medical Practitioner and your Specialist complete one Medical Practitioner's Statement each.
- Any charge for the completion of these forms is your responsibility.

You can return your fully completed form via email to **Directlifeclaims@cba.com.au** or you can mail it to **AIA Australia Direct Life Claims, PO Box 309, SILVERWATER NSW 2128**.

Section A – Your (the Insured) details

Policy number

Title | Surname | Given name(s)

Contact phone number | Email address

Section B – Employment details

1. Were you employed or self-employed at the time of your accident?

No ☐ **Please provide the following details:**

a What is the reason or reasons you were not employed at the time of the accident? (please tick (✔) the appropriate box)

- Unemployed ☐
- Home duties ☐
- Company/business closure ☐
- Disability pensioner ☐
- Retired ☐
- Full-time carer ☐
- Other – please provide details ☐

b What was your source or sources of income while not employed?

c What was the date you were last employed (date last physically worked)?

/ /

Yes ☐ **Please provide the following details:**

a What occupation were you performing before your accident?

b How long have you been in your current occupation?

Years Months

c What date did you last physically work in this occupation? / /

d Are you currently employed with the company/business?

☐ Yes ☐ No

Section B – Employment details (continued)

e What is the name and the contact details of your employer, or if self-employed, the name and contact details of your business?

Business name

Business address

State Postcode

Phone | Facsimile | Email address

Section C – Disability details

1. Please list the injury(ies) for which you are claiming Total and Permanent Disablement

Injury	Date of accident causing injury	First medical consultation	Name of Medical Practitioner or Health Provider	Doctor's location
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		

2. Please provide full details of the accident which led to your injury(ies), including the cause and location of the accident. If police and/or ambulance attended the accident please give contact details.

3. Have you suffered from the injury(ies) (listed in Question 1) previously?

No ☐

Yes ☐ **Please provide details below**

Injury	Date of accident	Name of Medical Practitioner or Health Provider	Treatment
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

Section C – Disability details (continued)

4. As a result of your condition(s) (listed in Question 1 above) have you ceased ALL work (whether paid or unpaid work)?

No ☐ **Please provide details of the work you are currently performing**

Yes ☐ **What date did you cease ALL work?**

/ /

5. Have you been able to return to work in any capacity since the date you ceased work?

No ☐

Yes ☐ **Date returned from, Date to, Hours worked**

6. Are you currently undergoing any treatment for your injury(ies)?

No ☐

Yes ☐ **Please provide details below**

7. Have you been hospitalised as a result of your injury(ies)?

No ☐

Yes ☐ **Please provide details below**

Hospital	Date admitted	Date discharged	Reason
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

8. Did the injury(ies) causing your condition result directly or indirectly from any of the following? (please tick (✔) the appropriate box)

A self-inflicted injury or self-harm	☐
Committing or attempting to commit a criminal offence	☐

9. Did the injury(ies) arise from, or is the condition(s) connected to either wholly or in part to any disease, bodily or mental infirmity, or medical or surgical treatment?

No ☐

Yes ☐ **Please provide details below**

Disease, bodily or mental infirmity, or medical or surgical treatment	Onset	Diagnosis	Medical Practitioner/ Health Provider
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you, or are you undergoing any rehabilitation, or any return to work programs?

☐ No ☐ Yes ▶ If 'Yes', please provide details below:

Rehabilitator provider	Type of rehabilitation/program	Start date	End date
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Section C – Disability details (continued)

11. Are you in receipt of, or have you made a claim for, any of the following:

Please tick (✔) appropriate box for each			
Salary, wages or business income	☐ No	☐ Yes	▶ If 'Yes', please provide details below
Worker's compensation	☐ No	☐ Yes	▶ If 'Yes', please provide details below
Compulsory third party insurance	☐ No	☐ Yes	▶ If 'Yes', please provide details below
Centrelink disability pension	☐ No	☐ Yes	▶ If 'Yes', please provide details below
Other government pension or allowance	☐ No	☐ Yes	▶ If 'Yes', please provide details below

Section D – Medical Practitioner's details

Please provide details of your usual Medical Practitioner.

1. Title | Given name(s) | Surname

Full address

State | Postcode

How long have you been attending this Medical Practitioner?

☐ Years ☐ Months

2. Name and details of other Medical Practitioners or Health Providers you consulted for this condition(s)

Name	**Address**	**Initial consultation**
		/ /
		/ /
		/ /
		/ /

Section E – Education and training

Please complete the following tables, including details such as:

- Year completed secondary school and final qualification gained or last year/grade of study
- TAFE or University study undertaken with dates, qualification obtained and institution name
- Tertiary qualifications completed through Registered Training Organisations (RTOs)
- Work experience or placements completed as part of any study
- Vocational training/apprenticeships/traineeships
- English language courses

Name of Qualification

Institution/Training Organisation

Details of any work experience/placements as part of this course (name of organisation, dates, duties undertaken, etc.)

Date commenced / /

Date completed / /

Section E – Education and training (continued)

Qualification

Institution

Work experience/placements

Date commenced / /

Date completed / /

Qualification

Institution

Work experience/placements

Date commenced / /

Date completed / /

Licences

- Class of current licence and any experience in driving heavy or specialist vehicles
- Any other work related licences or tickets, such as forklift, crane driving or welding

Date valid to	Licence or ticket	Details/experience
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		

Complete the table below, ticking the box with the response which best describes your level of ability for each listed skill.

Skill	Levels of ability			
	Very good	Good	Average	Poor
Reading	☐	☐	☐	☐
Writing	☐	☐	☐	☐
Maths	☐	☐	☐	☐

Other

Provide details of any in-house or on the job training you have completed e.g. WHS training, computer skills, office based skills, manual handling training.

Section F – Privacy consent

Please note: If you do not complete the Privacy Consent we may not be able to assess your claim.

AIA Australia's Privacy Policy

In this section, 'we', 'our' and 'us' means AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia).

This section summarises key information about how we, and the AIA Australia Group, handle personal information. More information can be found in the full version of the AIA Australia Group Privacy Policy which can be found at **aia.com.au/privacy**. The AIA Australia Group comprises CMLA Services Pty Ltd ABN 88 622 557 251, Jacques Martin Pty Ltd ABN 55 006 100 830 and Jacques Martin Administration and Consulting Pty Ltd ABN 24 006 787 748 AFSL 235037 as well as AIA Australia, AIA Financial Services Limited ABN 68 008 540 252 AFSL 231109 and their related bodies corporate.

Collecting information

The information we collect about you as a customer includes information such as your identity and contact details, other personal details such as age, gender and financial information. We will not be able to administer this product for you without this information.

How we collect it

We collect this information directly from you and from others such as service providers, agents, advisers, brokers, employers or family members. Where you provide AIA Australia with information about someone else you must have their consent to provide their information to us as described in the AIA Australia Group Privacy Policy.

The law may require us to identify our customers. We do this by collecting and verifying information about you and persons who act on your behalf. The collection and verification of information helps to protect against identity theft, money-laundering and other illegal activities. We may disclose your personal information in carrying out verification. E.g. we may refer to public records to verify information and documentation or we may verify with an employer that the information that you have given is accurate.

What we collect

Depending on whether you are an individual, trustee, company or other type of organisation, the information we collect may vary.

In some instances, we may collect medical and lifestyle information. Where we need to obtain lifestyle and medical information from health professionals or other parties, we will ask for your consent, except where otherwise permitted by law.

If you're commonly known by two or more different names, you must give us full details of your other name or names.

Where it is necessary to do so, we also collect information on individuals such as company directors and officers (where the company is our customer), as well as customers' agents and persons dealing with us on a 'one-off' basis.

Also, during your relationship with us we may also seek and collect further information about you and about your dealings with us.

Accuracy

It's important you provide us with accurate and complete information. If you don't, you may be in breach of the law and we may not be able to provide you with products and services that best suit your needs.

CBA Group Companies

Commonwealth Bank of Australia ABN 48 123 123 124 AFSL 234945 (CBA) has agreed to distribute our and AIA Australia Group products and services. For some AIA Australia Group members, CBA provides services that support our products and services or those of other AIA Australia Group members. Accordingly the AIA Australia Group will disclose personal information to CBA to help it distribute products or to enable it to provide services to AIA Australia Group members. For AIA Australia Group members who rely on CBA to provide services, some personal information (but not sensitive information) may be visible on CBA systems. For more information on how information relating to CBA Group Companies is managed please refer to our full privacy policy at **aia.com.au/privacy**.

We may also share information for identity verification and foreign tax compliance reporting in respect of which we and the CBA have agreed to act on each other's behalf. This allows us to both use the same customer information for these purposes without needing to each ask for the information separately. The information shared may include, for example, names, contact details, date of birth, product details and identity numbers such as foreign tax identification or driver's licence numbers.

How do we use your personal information?

We collect, use and exchange your customer information so that we can:

- establish and verify your identity and assess applications for products and services
- price and design our products and services
- administer our products and services
- manage our relationship with you
- manage our risks and help identify and investigate illegal activity, such as fraud
- contact you, for example if we need to tell you something important
- conduct and improve our businesses and improve your customer experience
- comply with our legal obligations and assist government and law enforcement agencies or regulators
- identify and tell you about other products or services that we think may be of interest to you.
- to manage and administer our and our Affiliates' and partners' business activities, products and services, including the AIA Vitality program.

We may also collect, use and exchange your information in other ways permitted by law.

Electronic communication

If you've given us your electronic contact details, we may use these details to provide information to you electronically, for example, sending reminders via SMS or email. You may also receive information on AIA Australia Group products and services electronically.

Direct marketing

If you don't want to receive direct marketing from us or want to update your direct marketing preferences, you can tell us by calling 13 3982 between 8am to 6pm (AEST/AEDT), Monday to Friday.

Gathering and combining data to get insights

Improvements in technology enable organisations, like us, to collect and use information to get a more integrated view of customers and provide better products and services.

The AIA Australia Group may combine customer information it has with information available from a wide variety of external sources (for example census or Australian Bureau of Statistics data). We are able to analyse the data in order to gain useful insights which can be used as mentioned above.

In addition, AIA Australia Group members may provide data insights or related reports to others, for example to help them understand their customers better. These are based on aggregated information and do not contain any information that identifies you.

Section F – Privacy consent (continued)

Protecting your information
We comply with the Australian Privacy Principles as incorporated into the Privacy Act 1988 (Cth). The Privacy Act protects your sensitive information, such as health information that's collected on insurance applications.

Who do we exchange your information with?
We may exchange your personal information with members of the AIA Australia Group, so that the AIA Australia Group may adopt an integrated approach to its customers. AIA Australia Group members may use this customer information in the same way we use your information (see 'How do we use your personal information?').

Third parties
We may exchange your information with third parties where this is permitted by law or for any of the purposes we use your information.

Third parties include:

- those who refer your business to us
- any person acting on your behalf, including your financial adviser, solicitor, accountant, executor, administrator, trustee, guardian or attorney
- external product providers into which you might direct some of your investment or other product providers to which your investment might be transferred
- where we are required to under domestic or foreign law
- medical practitioners (to verify or clarify, if necessary, any health information you may provide)
- reinsurers and auditors
- claims-related providers such as assessors and investigators (so that any claim you make can be assessed and managed), insurance reference agencies (where we're considering whether to accept a proposal of insurance from you and, if so, on what terms)
- organisations to whom we may outsource certain functions
- government and law enforcement agencies or regulators
- entities established to help identify illegal activities and prevent fraud.
- the life insured, policy owner or beneficiaries of a policy issued by us.

In all circumstances where our contractors, agents and outsourced service providers become aware of customer information, confidentiality arrangements apply. Customer information may only be used by our agents, contractors and outsourced service providers for our purposes.

We may be required to disclose customer information by law, e.g. under Court Orders or Statutory Notices pursuant to taxation or social security laws or under laws relating to sanctions, anti-money laundering or counter terrorism financing.

Sending information overseas
From time to time we may send your information overseas, including to other AIA Group members and to service providers or other third parties who operate or hold data outside Australia. Where we do this, we make sure that appropriate data handling and security arrangements are in place. Please note that Australian law may not apply to some of these entities.

Information may also be sent overseas to complete certain transactions (such as the assessment of your insurance application or management of your claim), or where this is required by law and regulation of Australia or another country. Other overseas parties can include reinsurers, medical or rehabilitation practitioners.

For more information about which countries we may send your information to, see below under 'Further information'.

Viewing your personal information

You can (subject to permitted exceptions) request access to your personal information by contacting us in writing:

Email: **CMLAcustomerrelations@cba.com.au**

Write to: Customer Relations, PO Box 234, PARRAMATTA NSW 2124

We may charge you for providing access. For more information about our privacy and information handling practices, please refer to the AIA Australia Group Privacy Policy, which is available through **aia.com.au/privacy**.

Making a privacy complaint
We accept that sometimes we can get things wrong. If you have a concern about your privacy you have a right to make a complaint and we'll do everything we can to put matters right. For information on how to make a complaint, see below under 'Further information'.

Further information
The AIA Australia Group Privacy Policy contains a more detailed explanation of how we collect, use and share your personal information, as well as the privacy complaints process. Please read this by visiting **aia.com.au/privacy** or contact us on 13 3982.

Signature

✗

Section G – Consent for Accessing 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.

Section G – Consent for Accessing Health Information (continued)

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 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 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.

Full name

Signature of life to be insured

Date of signature

/ /

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.

Current name of life to be insured

Signature of life to be insured/Life Insured

Date

/ /

Section H – Declaration and authority

- I declare that the answers to all questions on this form are true and correct, and I have not withheld any relevant information.
- I understand that any false statements may lead to my claim being denied and may also lead to my policy being cancelled.
- I acknowledge and consent to such uses and disclosures of my personal information as indicated in the Privacy Consent.
- I consent to and authorise AIA Australia seeking information from my employer, accountant, other insurers or government bodies.
- I declare that it is my intention that a photocopy of this authority shall have the same effect as the original authority signed by me.

1. If Employed, I have had my employer complete the Statement of employer ☐ No ☐ Yes ☐ N/A

2. I have had my treating Medical Practitioner complete the Medical Statement ☐ No ☐ Yes

3. I have attached copies of all relevant test results and medical reports ☐ No ☐ Yes

4. I have attached a certified copy of my driver licence or birth certificate or passport (required) ☐ No ☐ Yes

Your signature

X

Date

/ /

Please print your name

Your date of birth

/ /

Your home address

State Postcode

Section I – Statement of employer

To be completed by your employer

1. What is the name of the business (please include Trading name if different)?

2. What is the business' Australian Business Number (ABN)?

3. Employee's details

First name

Surname

Date of birth

/ /

Date employment commenced

/ /

Job/Position held

Hours worked per week

4. Please either list the employee's main duties below or attach a copy of their Job/Position Description.

5. Did the Employee stop all work?

☐ No ☐ Yes ▶ If 'Yes', please provide details below:

a. On what date did the Employee stop all work? / /

b. What was the reason why they stopped all work?

c. Has the employee returned to work?

☐ No ☐ Yes ▶ If 'Yes', please provide date the employee returned to work.

/ /

d. Are there any suitable duties/hours available?

☐ No ☐ Yes ▶ If 'Yes', have you offered these to the employee? Please provide details.

e. Are they still employed with the organisation?

☐ Yes ☐ No ▶ If 'No', please provide date last employed.

/ /

Section I – Statement of employer (continued)

6. Declaration and Authority

I declare that the answers to all questions on this form are true and correct, and I have not withheld any relevant information.

Full name

Position or Title

Your signature

✗

Date

/ /

Please provide details of your phone contact number and email address

Contact phone number

Email address

Personal Life Claim

MEDICAL PRACTITIONER'S STATEMENT

Instructions on completing this form:
- This form is to be completed by the patient's Medical Practitioner.
- Any charge for the completion of this form is the responsibility of the patient.
- Please type your answers in the boxes provided before printing and signing the form. Alternatively, please print clearly using a black pen.
- If there is insufficient space for answers or further information, please attach additional documents to this form.

Section A – Patient's details

Title | Surname | Given name(s)

Date of birth
/ /

Male ☐ Female ☐

Section B – Medical details

1. Are you the patient's usual treating Medical Practitioner?

No ☐ ▶ If 'No', is the patient's usual treating Medical Practitioner at the same practice as you?

No ☐ ▶ If 'No', how long have you known the patient? ____ Years ____ Months
and, what is the name and location of the patient's usual treating Medical Practitioner?

Yes ☐ ▶ If 'Yes', how long has the patient been attending the practice? ____ Years ____ Months

Yes ☐ ▶ If 'Yes', how long have you known the patient and how long has the patient been attending the practice?

Length of time you have known the patient: ____ Years ____ Months

Length of time patient attending practice: ____ Years ____ Months

Section C – Loss of function questions (only complete this section if the patient is claiming this criteria)

1. Please indicate (by ticking (✔)) which of the following losses has been suffered by the patient, and the date the loss occurred:

		Date performed
The complete and irrecoverable loss of sight in both eyes	☐	/ /
The complete and irrecoverable loss of hearing in both ears	☐	/ /

2. Has the patient suffered permanent loss of sight (aided and unaided)?

No ☐ Yes ☐ ▶ If 'Yes', please indicate which eye (for both eyes tick both right and left):

Right ☐ Left ☐

a. What is the visual acuity of the right eye? Uncorrected ____/____ Corrected ____/____

b. What is the visual acuity of the left eye? Uncorrected ____/____ Corrected ____/____

c. What is the degree of remaining binocular visual field arc? ____degrees

d. Please provide copies of latest test results

Section C – Loss of function questions (only complete this section if the patient is claiming this criteria) (continued)

e. Please provide the name and qualifications of the person who made the assessment, and confirm how they determined it to be a permanent loss:

3. Has the patient suffered permanent loss of hearing (natural or aided) in both ears?

No ☐ Yes ☐ ▶ If 'Yes', please answer the questions below:

a. Please provide copies of latest test results

b. Please provide the name and qualifications of the person who made the assessment, and confirm how they determined it to be a permanent loss:

c. What techniques (e.g. cochlear implant) have been used or are planned to recover hearing and what is the prognosis?

Section D – Unable to work (only complete this section if the patient is claiming this criteria)

1. What is your understanding of the patient's usual occupation, hours worked and duties?

Occupation

Hours worked per week / /

Duties

2. From what date due to injury did the patient become unable to work in any capacity? / /

3. Has the patient returned to any work (e.g. light or alternative duties, reduced hours or another occupation) since the date of disability?

No ☐ Yes ☐ ▶ If 'Yes', please provide details below including a description of the work, duties and hours:

4. Is the patient capable of, or is currently undertaking, any rehabilitation or Return to Work Programs?

No ☐ Yes ☐ ▶ If 'Yes', please provide details of any rehabilitation or return to work plans undertaken, current or in the future. However, if the patient is capable but none undertaken or planned please explain why:

5. In your opinion will the patient be able to:

a. Return to his/her usual duties and hours he or she will be able to perform per week:

Date expected to return / / Hours per week / /

Please elaborate on your answer above in question 5a, i.e. the reason (including limitation and restrictions) the patient will not be able to return to his/her usual duties or why they will be able to return to his/her usual duties:

Section D – Unable to work (only complete this section if the patient is claiming this criteria) (continued)

b. Perform similar duties he or she is reasonable suited to?

No ☐ Yes ☐ ▶ If 'Yes', please provide the date of expected return and hours he or she will be able to perform per week:

Date expected to return / / Hours per week

Please elaborate on your answer above in question 5b, i.e. the reason (including limitation and restrictions) the patient will not be able to return to his/her usual duties or why they will be able to return to his/her usual duties:

Section E – Unable to perform home duties (only complete this section if the patient is claiming this criteria)

1. In your opinion is the patient due to injury permanently unable to perform any of the following home duties listed below,and if 'Yes',the date from which the inability occurred?

	No	Yes	Unsure	If applicable, the date the inability commenced
Cleaning the usual place of dwelling	☐	☐	☐	/ /
Purchasing household food and items used for cleaning	☐	☐	☐	/ /
Preparing meals for the household	☐	☐	☐	/ /
Performing for the household laundry services such as washing or ironing	☐	☐	☐	/ /
Driving or transporting family to and from school, sport, work or social events	☐	☐	☐	/ /
Taking care of a child or family member dependents	☐	☐	☐	/ /

2. Are there any other home duties that the patient is permanently unable to perform?

No ☐ Yes ☐ ▶ If 'Yes', please provide details below:

Section F – Disability details

1. Please list each medical condition causing or contributing to patient's disability.

Medical Conditions	Cause of condition	Is the condition permanent?
a.		☐ No ☐ Yes
b.		☐ No ☐ Yes
c.		☐ No ☐ Yes
d.		☐ No ☐ Yes

2. Please provide the following details for the condition or conditions causing permanent disability.

First onset of symptoms	Initial consultation	Date of diagnosis	Method of diagnosis
a.		/ /	
b.		/ /	
c.		/ /	
d.		/ /	

3. From what date was the patient incapacitated from all work due to the conditions above? / /

4. Has the patient ever had the same or similar condition?

No ☐ Yes ☐ ▶ If 'Yes', please provide details below:

Medical Conditions	First onset of symptoms	Date of diagnosis	Medical Practitioner/ Health Professional
	/ /	/ /	
	/ /	/ /	

Section F – Disability details (continued)

5 Was the above indicated condition(s) caused exclusively as the result of accidental injury(ies)?

No ☐

Yes ☐ **Please provide details of how the accidental injury(ies) caused the condition(s) and are they consistent with the accident**

6 Was the injury(ies) caused directly or indirectly by any intentional self-inflicted injury or any attempt at suicide?

No ☐

Yes ☐ **Please provide details below**

7 Was the patient under the influence of alcohol or illicit drugs when the accidental injury(ies) occurred?

No ☐

Yes ☐ **Please provide details below**

8 Did the injury(ies) arise from, or is the condition(s) connected to, any disease, bodily or mental infirmity, or medical or surgical treatment?

No ☐

Yes ☐ **Please provide details below**

Disease, bodily or mental infirmity, or medical or surgical treatment	Onset	Diagnosis	Medical Practitioner/ Health Provider
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

9 What is the patient's current treatment, and if the patient is not improving please provide reason(s)?

10 Has the patient reached maximum medical improvement?

Yes ☐

No ☐ **Please provide details below**

11 Please provide the following details of any periods of hospital confinement resulting from the condition(s):

Hospital name	Hospital location	Admission	Discharge
		/ /	/ /
		/ /	/ /

Section F – Disability details (continued)

12 Please provide details of other Medical Practitioners/Health Providers the patient has attended for the condition(s):

Medical Practitioner/Health Provider	Location	First attended	Last attended
		/ /	/ /
		/ /	/ /
		/ /	/ /

13 Is the patient affected by any other chronic illness or injury?

No ☐ Yes ☐ ▶ If 'Yes', please provide details below:

Medical Conditions	First onset of symptoms	Date of diagnosis	Medical Practitioner/ Health Professional
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

Section G – Medical Practitioner's declaration

Title | Surname | Given name(s)

Practice address

State | Postcode

Field of practice (e.g. General practitioner, cardiologist, etc.) | Qualifications

Healthcare Provider Identifier (HPI) | Business phone number | Email

I have attached copies of all relevant test results and medical reports ☐ No ☐ Yes

I certify that:

- I am an Australian registered Medical Practitioner, and
- I have examined the patient and all details in this Medical Statement are correct.

Further, I consent to AIA Australia providing copies of the statement to any Medical Specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of the claim.

Your signature | Date

✗ / /