INSURANCE ADVISERNET
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CLAIM FORM
TOTAL & PERMANENT DISABLEMENT BENEFIT

Section 1: Claimant's Statement

Privacy Act 1988 – Our obligations under the ACT

The Privacy Act 1988 ("the Act") sets out a number of principles that we must comply with in the collection, security, storage, use and disclosure of personal information. These principles are known as the National Privacy Principles. The following information is provided to you in accordance with these Principles.

The organisation collecting information about you is Hannover Life Re of Australasia Ltd ("HLRA"). If you ask us, we must provide you with access to the personal information we hold about you. We may be entitled to refuse access to some information as set out in the Act. Your right to access this information is set out in our Privacy Policy, which is available on request.

The information we collect will be used to access and process your claim. The information may also be used if you are applying for insurance cover from us. The information we collect may be disclosed to other organisations, including but not limited to, medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation, an organisation that is duly appointed to manage the administration of such insurance policy, or interpreters.

If you fail to provide us with all or part of the information we require, we will be unable to assess and process your claim.

To ensure your claim is processed promptly, please complete the details below.

The Total and Permanent Disablement benefit option is applicable only to Superior Life Cover Policies. You must have taken out cover for this optional benefit to be eligible to claim. Please check your Policy Schedule if you are unsure.

PART A POLICY DETAILS

Policy number:

PART B POLICY OWNER DETAILS

Title: First name: Surname:

Date of birth: Weight (kg): Height (cm): Gender: ☐ Male ☐ Female

Country of birth: Are you an Australian resident? ☐ Yes ☐ No

Postal address:

Suburb: State: Postcode:

Home phone: Work phone: Mobile phone:

E-mail address:

Language spoken at home: Is an interpreter required? ☐ Yes ☐ No

PART C EMPLOYER'S DETAILS

Name of Employer/Company:

Work address:

Suburb: State: Postcode:

Telephone number: Commencement date:

PART D DETAILS OF YOUR INJURY OR ILLNESS

1. If you are submitting this application more than 12 months after the date on which you last worked please state the reasons for the deferral:

2. Please state the reasons why you ceased work:
(If you have ceased work due to Redundancy, Resignation or Termination please provide a copy of the relevant documentation)

3. Please state the exact nature of the injury or illness that caused you to cease work:

4. On what date did the injury occur or did you first become ill?

5. Please give details of all doctors, physiotherapists, chiropractors etc. consulted by you, including any hospital treatment you may have received in relation to your disability.

Name of doctor	Address	Date of first consultation	Date of most recent consultation

6. Are any of the doctors named in (5) above the usual doctor you attend?
If NO, please provide details of your usual doctor: ☐ Yes ☐ No

Doctor's name: Telephone number:

Address:

PART D DETAILS OF YOUR INJURY OR ILLNESS (CONTINUED)

7. Have you ever suffered from the same or similar illness?
If YES, please supply details

☐ Yes ☐ No

Date of episode	Period off work	Name of attending doctor

PART E OCCUPATIONAL DETAILS

1. What was your job title?

2. Please describe all your work duties in detail:

3. How many hours did you normally work each week?

4. On what date did you last work?

5. Please list all of the work duties your disability prevents you from performing:

6. Since ceasing work with your employer, have you been able to perform work of any kind?
If YES, please supply details:

☐ Yes ☐ No

Period of work	Job title	Name of attending doctor	Part time	Full time	Income earned (before income tax)
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

7. Have you applied for any jobs since ceasing work
If YES, please supply details:

☐ Yes ☐ No

PART E OCCUPATIONAL DETAILS (CONTINUED)

8. Are you now able to perform any duties of your occupation?
If YES, please list which duties you can perform:

☐ Yes ☐ No

9. What level of education do you have?

☐ Primary ☐ Secondary ☐ Tertiary

10. What qualification or licensing certificates to you have?
Please supply details:

11. Do you have any other training or skills?
If YES, please supply details:

☐ Yes ☐ No

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12. Please supply details of all previous jobs you have performed and/or enclose a copy of your resume

Employer	Description of jobs	Approximate dates

13. Please list any work you think you may be able to perform in the future:

14. Have you received, or are you entitled to claim any benefits under any insurance policy such as income protection, lump sum total and permanent disablement or trauma, or any benefit such as Worker's Compensation, Invalid Pension, Sickness benefit, Veterans Affairs benefits or unemployment benefits?
If YES, please supply details:

☐ Yes ☐ No

Period	Type of benefit	Name and company address	Case manager and telephone number	Claim number

PART E OCCUPATIONAL DETAILS (CONTINUED)

15. Please state your current daily activities:

Please ensure that all questions have been answered before you proceed further.

PART F PAYMENT AUTHORITY

Once the claim has been accepted the benefit will be credited to the account below.

Name of bank: Name of account holder:

BSB number: ☐☐☐ - ☐☐☐ Account number: ☐☐☐☐☐☐☐☐

PART G DECLARATION AND CONSENT

I acknowledge:
(a) this declaration forms part of my claim for a Total and Permanent Disability benefit.
(b) that, if I fail to provide all or part of the information HLRA requires to assess this claim, it will not be assessed and processed.

I understand that, in order to assess and process my claim for a benefit, HLRA may need information about me including but not limited to medical, financial, legal and employment. I consent to HLRA obtaining my information about me from medical practitioners that I have consulted at anytime and any that HLRA wishes to appoint to examine, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, my past and present employers and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also consent to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosure is necessary to HLRA to perform its functions.

Policy owner's signature: Date:

PART H DISCLOSURE OF INFORMATION – DOCTOR'S AUTHORITY

For the purpose of assessing my claim for a Total and Permanent disability benefit, I authorise my current medical practitioner, and any other medical practitioner or health professional I have consulted or may consult in the future, or that Hannover Life Re of Australasia Ltd ("HLRA") appoints to examine me, to disclose information about my health and related matters to HLRA. A photocopy of this authorisation will be valid as the original.

Policy owner's signature: Date:

PART I POLICY DISCHARGE AND DECLARATION

Please note this section of the form will only be used if HLRA accept liability for the claim

I hereby request payment of the benefit payable for the Total and Permanent disability benefit in full satisfaction for all claims whatsoever under the Policy and do hereby discharge HLRA from all liability there under other than for payment of the benefit.

As the policy owner I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim.

I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information HLRA requires to assess this claim, it will not be assessed and processed.

Policy owner's signature: Date:

Section 2: Employer's Statement in connection with a claim for a Total and Permanent Disablement benefit.

To be completed only if Policy Owner is an employee.

PART A TO BE COMPLETED BY AN AUTHORISED REPRESENTATIVE OF THE EMPLOYER

Name of employer:

Full name of employee: Date of birth:

Employee's address:

Suburb: State: Postcode:

Date joined company:

1. Date the employee was last at work:

2. Why did the employee cease work?

3. Have there been any periods of absence?
If so list the periods and reasons:

4. Employee's job title:

5. Precise duties performed by the employee:
Please list:

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6. Number of hours normally worked each week:

7. The education, training or qualifications required to perform the job:
Please list:

8. The education, training, qualifications and past experience of the employee:
Please list:

9. Number of people supervised by the employee:

PART A TO BE COMPLETED BY AN AUTHORISED REPRESENTATIVE OF THE EMPLOYER (CONTINUED)

10. Did the employee spend any significant work on the following activities?

Activity	Proportion of time spend (%)	Activity	Proportion of time spend (%)	Activity	Proportion of time spend (%)
Driving		Walking or standing		Lifting or carrying	
Climbing		Crawling or kneeling			

11. Did the employee's duties allow him/her to move freely during work hours or was he/she confined to a set space or position?

12. Is the employee's job still open? ☐ Yes ☐ No

13. Do you have any other jobs appropriate to the employee's level of skill and experience? ☐ Yes ☐ No

14. Have any alternative jobs been offered to the employee? ☐ Yes ☐ No
If YES, please give details:

15. Describe any previous jobs the employee has done while employed by you. Include time spent in each job.

16. Can the employee speak, read, and write English? ☐ Yes ☐ No

17. Give details of the weekly income the employee was paid at the time of disablement:

18. Give details of any amounts you are currently paying to the employee: *(eg Worker's Compensation, salary)*

19. Is a claim being made for:

Temporary Disablement? ☐ Yes ☐ No

Permanent Disablement? ☐ Yes ☐ No

20. Other comments (eg, any other comments you may have which you believe may be relevant to the assessment:

I declare that I am authorised to answer the above questions on behalf of the employer; and that the responses to the questions on this Statement are true.

Signed on behalf of the Employer : Date:

Section 3: Total and Permanent Disablement - Confidential Medical Report

This document is to be fully completed by the registered Medical Practitioner treating the insured person. The cost of this report is the Claimant's responsibility.

Please note that the information required to be completed in this document is in relation to the insured person.

Please note that it is the insured person's responsibility for the payment of all fees associated in the completion of this document.

In order to ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this document are fully addressed and answered.

If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing.

PART A CLAIMANT'S DETAILS

Claimant's family name: Claimant's given name:

Occupation: Date of birth:

Claimant's address:

Suburb: State: Postcode:

PART B QUESTIONS TO BE ANSWERED BY THE CLAIMANT'S MEDICAL PRACTITIONER

Please attach a separate statement if space is insufficient for any answer

1.

a) On what date did you first attend the claimant in connection with his/her illness or injuries?

b) On what date did the illness or accident occur?

c) What was the date of your last attendance?

d) Has the Claimant an appointment to consult you again? ☐ Yes ☐ No
If YES, please supply an approximate date

2. On what date did the Claimant become completely unable to perform all the normal duties of his/her occupation:

3. Please provide details of other doctors seen by the claimant in connection with this disability:

Name of Doctor	Address	Telephone	Date of first consultation

4. Please state the history of the illness or injury, including the exact nature and severity of the condition and give particulars of any treatment which has been necessary, including dates where relevant. Please also provide full details and results of any tests performed. Please give full details of the current condition.

PART B QUESTIONS TO BE ANSWERED BY THE CLAIMANT'S MEDICAL PRACTITIONER (CONTINUED)

Please attach a separate statement if space is insufficient for any answer

5. Has hospital admission been necessary? ☐ Yes ☐ No

If YES, please give name of hospital (s) and relevant dates:

Admission date	Discharge date	Name of hospital

6. Has surgical treatment been necessary? ☐ Yes ☐ No

a. If YES, please state what operation(s) was/were performed?

Operation	Date performed

b. If YES, please supply details of post-operative course:

7. Has the Claimant suffered from the same or similar or related condition? ☐ Yes ☐ No

If NO, do you consider the disablement to be connected in any way with a previous illness or injury or unfavourable features of the patient's history? ☐ Yes ☐ No

If YES, please provide details:

8. In respect of the claimant's present illness or injury, have you given any certificate to another insurance company, or in connection with Worker's Compensation, Social Security, sick leave benefits from the claimant's employer or for any other reason? ☐ Yes ☐ No

If YES, to whom?:

9. At the current time, can the claimant do his/her normal job? ☐ Yes ☐ No

If NO, which work duties is the claimant unable to perform?

If YES, from what date was he/she fit to return to work?

PART B QUESTIONS TO BE ANSWERED BY THE CLAIMANT'S MEDICAL PRACTITIONER (CONTINUED)

Please attach a separate statement if space is insufficient for any answer

10. If you do NOT expect the claimant to EVER return to his/her normal work do you think he/she will EVER be able to do a job for which he/she is reasonably fitted by education, training or experience? ☐ Yes ☐ No

If NO, please give detailed reasons:

If YES, please list examples of jobs which in your opinion would be appropriate:

PART C DECLARATION

Please note this section of the form will only be used if HLRA accept liability for the claim

I hereby certify that I have personally attended the above named patient and that all the information supplied by me in this Report is true. I agree that HLRA may provide copies of this Report to any medical specialist from whom HLRA seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or oganisation to whom HLRA is obligated under the Privacy Act 1988 to give access to this Report.

Family name: Given name:

Qualifications:

Address:

Signature: Date: HHH

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Please return completed form to IA Life via one of the following methods:

Scan and email (with your name and policy number as the subject line) to claims@ialife.com.au

Mail to PO Box 471, Seaforth NSW 2092