Claim Form
Total and Permanent Disablement

STATEMENT BY CLAIMANT. Please answer ALL relevant questions fully, not doing so could result in delays in processing your claim.

Plan Name | Member No. (if superannuation owned) | Policy No.
MP

SECTION A – Personal Details

Claimant Name | Date of Birth / /

Residential Address | Postcode

Telephone (home) | (work) | (mobile)

Your last physical day at work? / /

E-mail *(for correspondence)*

SECTION B – Claim Details

1. What is the nature of your injury/sickness?
(If an injury, please provide full details of the extent of your injuries. If to a limb, specify whether left or right.)

2. When did the injury or symptoms of your sickness first occur? Date / / Time am/pm

If your claim is for an injury – please answer question 3
If your claim is for sickness – please answer question 4

3. If your claim is for an injury, please advise:

(a) How did the injury occur (including what caused it and the events leading up to the injury)?

(b) Where did the injury occur? (Please provide the full address details of the place where the injury occurred.)

(c) Were there any witnesses to the injury? ☐ Yes ☐ No If '**Yes**', please provide their names and telephone contact details (if known).

4. (a) If your claim is for sickness, on what date was the diagnosis made? Date / /

(b) Please describe your current symptoms and their severity.

SECTION C – Treatment for this Condition

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

Name of doctor/medical provider who made the diagnosis

Field of Practice (i.e. GP, cardiologist, etc.) Telephone

Address

(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 number of your usual doctor or medical provider.

Name Telephone

Address

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

2. Were you hospitalised for this condition? ☐ Yes ☐ No
If '**Yes**', please provide details below and copies of your discharge summaries (attach a separate sheet if required).

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

3. Have you ever had the same or similar injury or sickness before? ☐ Yes ☐ No If '**Yes**', please advise the following:

(a) the date the injury or sickness occurred. / /

(b) what was the nature of the injury or sickness?

(c) please provide the names and contact details of any doctors or medical providers you consulted (attach a separate sheet if required).

Name	Address and telephone contact details
	Tel:
	Tel:

SECTION C – Treatment for this Condition (continued)

4. Do you have a Return to Work Plan or have you discussed one with your doctor or employer? ☐ Yes ☐ No
If '**Yes**', please provide details (including the name of the rehabilitation provider and their contact details).
If '**No**', please provide the reason and whether you believe occupational rehabilitation (eg. Return to Work Plan, studying, re-training, up-skilling etc.) could assist you.

SECTION D – Medical History

1. Give the dates and reasons for all other consultations with your usual doctor or medical provider and medications taken during the last 3 years.

Date	Reason	Medications taken (other than for cold or influenza)

2. Have you attended any other doctor or medical provider (other than detailed in Section C question 1) during the last 3 years? ☐ Yes ☐ No
If '**Yes**', please give details below.

Date	Reason	Name, address and telephone contact number of doctor	Medications taken (other than for cold or influenza)
		Tel:	
		Tel:	
		Tel:	

3. 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 of sick leave you required.

SECTION E – Occupation Details

1. Employer Name

Street Address Postcode

Contact Numbers (phone) (facsimile)

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

3. Please provide details of your usual work duties and % of time spent on those duties.

Work duties	% of time spent
1	
2	
3	
4	
5	
6	
	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 (eg. office, factory, building site)?

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

7. How many hours per week, on average, did you work in the last 3 months prior to ceasing work?

8. Did you supervise other employees? ☐ Yes ☐ No

9. Please indicate (✔) the following requirements of your usual job, where applicable.

	Never	Occasional (i.e. less than 33% of the time)	Frequent (i.e. approximately 50% of the time)	Continuous (i.e. more than 66% of the time)
Lift/Carry 20 kg and over	☐	☐	☐	☐
Lift/Carry, 5 to 19 kg	☐	☐	☐	☐
Lift/Carry, under 5 kg	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐

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

% Sitting % Standing % Walking % Bending % Lifting

% Driving % Climbing % Crawling % Kneeling

11. Were you required to travel as part of your usual occupation? ☐ Yes ☐ No
If '**Yes**', please state the following:

(a) how many kilometres per week did you travel? km

(b) please provide details (nature of travel and type of vehicle, eg. car, bus, train, plane, truck, ferry etc.)?

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

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

Other employer name/s and contact details (if different to Section E, question 1)	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 Benefits

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 – Checklist

1. ☐ I have attached a certified copy of my: ☐ Driver's Licence or ☐ Passport or ☐ Birth Certificate

2. ☐ I have provided any other information that was requested or that may assist my claim.

3. ☐ I have provided my Doctor with my Plan Name and Member Number (if applicable) so he/she can complete the Medical Attendant's Statement.

4. ☐ I have fully completed this form, to ensure my claim is assessed promptly.

SECTION K – 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 the insurer, 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 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 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 also authorise AIA Australia to contact me directly to obtain personal and sensitive information in the course of investigating, assessing and managing my claim.

AUTHORITY TO OBTAIN INFORMATION

I hereby authorise any individual, organisation or entity within any of the above categories (a to h) that holds my personal and sensitive information to release that information to AIA Australia Limited on request, for the purpose of investigating, assessing and managing my claim.

I hereby authorise any medical practitioner, medical provider, health professional, hospital, dentist or other person who has attended me, to release to AIA Australia Limited or its representatives all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records.

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

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

Name *(please print)*	Claimant's signature	Date
	✗	/ /

IF A CLAIM IS APPROVED

Proceeds paid by the insurer to the Trustee relating to Total and Permanent Disablement (TPD) or Terminal Illness (TI) insurance will be paid to the member's account on the day that they are received by the Trustee. The amount received by the Trustee will be added to their superannuation savings, invested in the investment option (or options) that was selected by the member for the investment of their accumulated superannuation benefits. Where no investment selection was made by the member the amount received by the Trustee will be invested in the default Balanced investment option. If you wish to change the investment option your TPD benefit is paid into, please contact us on 132 467 or by info@intrust.com.au.

Privacy

This section summarises key information in of the AIA Australia Privacy Policy, which may be updated from time to time. For further information, please review the most up to date full version of the AIA Australia Privacy Policy on AIA Australia's website at www.aia.com.au.

AIA Australia Limited is part of the AIA Group. Your privacy is important to us and AIA Australia Limited is bound by the privacy principles which apply to private sector organisations under the Privacy Act, and other laws which protect your privacy. AIA Australia Limited, AIA Financial Services Limited, AIA Group and their related bodies corporate and joint venture partners (together referred to as "AIA Australia", "we", "us" and "our") provide you the following notification and information about our Privacy Policy and your rights.

Why we collect personal information

We collect, use and disclose personal information (including sensitive information) for purposes set out in our Privacy Policy, including to process your applications, enquiries and requests in relation to insurance and other products, for underwriting and reinsurance purposes, to administer, assess and manage your insurance and other products, including claims, and to provide, manage and improve our products and services. We may not be able to do these things without your personal information. We may also collect, use and disclose personal information to understand your needs, interests and behaviour, personalise our dealings with you, to verify your identity, authority to act on behalf of a customer and personal information, maintain and update our records, manage our relationship with you, comply with local and foreign laws and regulatory requests, detect, manage and deal with improper conduct and commercial risks and for reporting and research purposes. We may also notify you of offers and other information about products or services we think may interest you. If you do not wish to receive these direct marketing communications, you may indicate this where prompted or by contacting us as set out in our Privacy Policy. If you do not wish to receive these direct marketing communications, you may indicate this where prompted or by contacting us as set out in our Privacy Policy.

How we collect, use and disclose personal information

We may collect your personal information from various sources including forms you submit and our records about your use of our products and services and dealings with us, including any telephone, email and online interactions. We may also collect your information from public sources, social media and from the parties described in our Privacy Policy. We are 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 our Privacy Policy. Where you provide us with personal information about someone else you must have their consent to provide their personal information to us in the manner described in our Privacy Policy.

We may collect your personal information from, and exchange your personal information with, our affiliates and third parties, including the life insured, policy owner or beneficiaries of your insurance policy, our service providers, your representatives (including your financial adviser), the trustee and administrator of a superannuation fund, your employer or bank, health providers, partners used in our activities or business initiatives, reinsurers, insurance brokers and intermediaries, regulatory and law enforcement agencies, and other parties as described in our Privacy Policy. Parties to whom we disclose personal information may be located in Australia, South Africa, the US, Europe, Asia and other countries including those set out in our Privacy Policy.

Where we provide 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.

Other important information

By providing information to us or your adviser (and the licensed dealer or broker they represent), the trustee or administrator of a superannuation fund, or other representative or intermediary, submitting or continuing with a form or claim, or otherwise interacting or continuing your relationship with us, you confirm that you agree and consent to the collection, use (including holding and storage), disclosure and handling of personal information (including sensitive information) in the manner described in the most up to date version of our Privacy Policy on our website and that you have been notified of the matters set out in the AIA Australia Privacy Policy before providing personal information to us. You agree that we 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 our website at www.aia.com.au or by contacting us on 1800 333 613 to obtain a copy. You have the right to access the personal information we hold about you, and can request the correction of your personal data if it is inaccurate, incomplete or out of date. Requests for access or correction can be directed to us using the details in the 'Contact us' section below. Our Privacy Policy provides more detail about our 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 we will deal with that complaint, and your opt-out rights.

For the avoidance of doubt, the Privacy Policy applicable to the management and handling of personal information will be the most current version published at www.aia.com.au shall supersede and replace all previous 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, applications, underwriting and claim forms, Product Disclosure Statements and other insurance and disclosure statements and documentation.

Contact us

If you have any questions or concerns about your personal information, please contact us as set out below:

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

Medical Attendant's Statement

Forming part of the
Total and Permanent Disablement Claim Form

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 information (including sensitive information). This information must be handled, collected, used and disclosed in accordance with the Privacy Act 1988 (Cth) and the AIA Australia Privacy Policy as updated from time to time. 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.

Plan Name | Member No. (if applicable)

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) **Please attach a copy of your patient's clinical notes relevant to their condition, including medical evidence that supports your assessment date of total and permanent disability.**

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

(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 Privacy Policy, and authorise AIA Australia to do so.

Name *(please print)* Qualification(s)

Signature Date / /

Address Postcode

E-mail

Telephone Facsimile