Claim for terminal illness benefit

CLAIMANT STATEMENT

Instructions on completing this form:
- Please read carefully and complete all sections A through I.
- Please print clearly and use a black pen to assist document imaging.
- If there is insufficient space for answers, please attach additional information to this form.
- If the claimant is unable to complete this form, their guardian, attorney or other representative may do so. Please have the two attached medical statements completed, one by your usual medical practitioner and one by your treating specialist.
- Any charge for the completion of these forms is your responsibility.

Return the completed documents to: Colonial First State, Reply Paid 27, Sydney NSW

Section A – Claimant's details

Plan name

Account number

Surname

Given name(s)

Residential address

State Postcode

Contact number

Email (if available)

Is a representative completing this form on the Claimant's behalf?

☐ No ☐ Yes ▶ If 'Yes', please provide details of representation and attach a copy of the relevant legal document.

Section B – Details of medical condition

1. What is the condition(s) being claimed?

2. Did this condition(s) result from (please tick one of the boxes):

☐ Illness ☐ Injury, or ☐ not applicable

a. Provide details of the illness or how the injury occurred

3. Please provide the following details in relation to the condition(s)

Condition(s)	Date of first onset of symptoms	Date of initial consultation	Date of earliest diagnosis	Date first hospitalised
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

Condition(s)	Name and address of current treating specialist and/or General Practitioner

▶ Form continued next page

Section B – Details of medical condition (continued)

Condition(s)	Name and address of hospital

Section C – 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 address of medical practitioner you first consulted for this condition(s) (if same as Q1 above, write 'Same as above')

State Postcode

3. Name and details of other medical practitioners or health providers you consulted for this condition(s)

Name	Address	Initial consultation
		/ /
		/ /
		/ /

Section D – Employment details

1. Have you ceased all work?

☐ No ☐ Yes

▶ If 'No', please provide details of your current work below

Employer's name Position Hours per week

Section E – Other insurance details

1 Have you claimed, or are you intending to claim, on another insurance policy as a result of your condition(s)?

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

Insurer	Type of cover	Amount	Date policy commence
		$	/ /
		$	/ /
		$	/ /

Section F – Additional information

Please note: If you answer 'Yes' to any of the following questions, please advise the number of pages attached.

1. I have attached the two completed Medical Attendant's statements. ☐ No ☐ Yes ▶ pages
2. I have attached all test results (MRI, CT scan, laboratory tests, etc.) and any relevant medical notes. ☐ No ☐ Yes ▶ pages
3. Where space provided for the questions was inadequate, I have attached a supplementary response. ☐ No ☐ Yes ▶ pages
4. I have attached additional information which may assist in the assessment of my claim. ☐ No ☐ Yes ▶ pages

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.

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.

Name

Signature ✗ Date / /

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 / /

Section H – Privacy of your personal information

Our privacy policy contains information on how we collect, use and disclose your personal information (including disclosure to overseas recipients). Visit **aia.com.au/privacy** for a copy.

Section I – Declaration

I declare that the answers to all questions on this form are true and correct, including those not in my own handwriting and I have not withheld any information relevant to this claim.

I understand that if I make false or misleading statements or recklessly or intentionally fail to disclose information, AIA Australia may:

- Refuse to pay this claim.
- Recover benefits paid that were based on false or misleading information I provided.
- Be obliged to refer such cases to the relevant Authority.

I authorise and consent to AIA Australia and its authorised representatives seeking information from:

- other insurers,
- my past and present employers,
- my accountant or financial institution, and
- any relevant government bodies.

I authorise the release to AIA Australia or its authorised representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatments, and copies of all hospital or medical records, employment records and financial records relevant to my insurance cover or claim.

I have read and understood the “Privacy of your personal information” and I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section.

I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Name of claimant (please use block letters)

Claimant signature

✗

Date

/ /

Claim for terminal illness benefit

MEDICAL ATTENDANT'S STATEMENT

To be completed by treating medical practitioner
If there is a charge for the completion of this form or for associated copying of your records, it is the responsibility of your patient. Please note that AIA Australia reserves the right to release a copy of this statement and all attachments to the relevant Superannuation Fund Trustees (if any). With your authority and your patient's authority, AIA Australia may share this information with other Medical Practitioners and others involved in assessing this claim. Failure to provide complete information will delay the assessment of your patient's claim.
Return the completed documents to: Colonial First State, Reply Paid 27, Sydney NSW

Section A – Patient's details

Patient's full name

Date of birth
/ /

Patient's residential address

State Postcode

1. How long have you known your patient?

Years Months

2. How long has your patient attended the practice?

Years Months

3. Does the patient attend any other practice or practices?

☐ No ☐ Yes ▶ If 'Yes', please provide details including name of practice and address (If known)

Name of practice	Practice address

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /

5. Please provide the following details for each of the conditions listed in Q4 above.
Please also provide copies of the results for all tests performed and any reports completed.

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?

6. To the best of your knowledge and assuming reasonable medical treatment, what is your patient's expected survival period or prognosis as at today's date (please tick (✔) the appropriate box)

☐ Less than 6 months ☐ 6 to 12 months ☐ 13 to 24 months ☐ Greater than 24 months ▶ If greater than 24 months, please state estimated life expectancy.

Section A – Patient's details (continued)

7. a. To the best of your knowledge and assuming reasonable medical treatment, what is the likelihood of recovery or remission (as a percentage)?

%

b. Are there any other factors that influence or impact your patient's life expectancy (e.g. response to treatment, secondary condition)?

8. a. When did you first diagnose your patient to be suffering from this condition?

Date

/ /

8. b. If applicable, on what date did you consider your patient to have a life expectancy of less than 24 monthscondition?

Date

/ /

9. Has the patient ever had the same or similar condition (If known)?

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

Diagnosis	Date of diagnosis	Treatment provided/ recieved	Name of health professional consulted
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you previously (or will you be) completing forms/reports regarding this patient for another party (e.g. another insurer)?

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

Section B – Medical practitioner's details

Title

Surname

Given name(s)

Business address

State Postcode

Phone number

( )

Fax number

Qualifications

Email

I certify that I have examined the patient and that all statements made in this document are correct in all aspects. I consent to AIA Australia providing copies of this document 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. I further consent to AIA Australia's Chief Medical Officer contacting me to discuss this patient's claim.

Signature

✗

Date

/ /

Claim for terminal illness benefit
MEDICAL ATTENDANT'S STATEMENT

To be completed by treating medical practitioner
If there is a charge for the completion of this form or for associated copying of your records, it is the responsibility of your patient. Please note that AIA Australia reserves the right to release a copy of this statement and all attachments to the relevant Superannuation Fund Trustees (if any). With your authority and your patient's authority, AIA Australia may share this information with other Medical Practitioners and others involved in assessing this claim. Failure to provide complete information will delay the assessment of your patient's claim.
Return the completed documents to: Colonial First State, Reply Paid 27, Sydney NSW

Section A – Patient's details

Patient's full name

Date of birth
/ /

Patient's residential address

State Postcode

1. How long have you known your patient?

Years Months

2. How long has your patient attended the practice?

Years Months

3. Does the patient attend any other practice or practices?

☐ No ☐ Yes ▶ If 'Yes', please provide details including name of practice and address (If known)

Name of practice	Practice address

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /

5. Please provide the following details for each of the conditions listed in Q4 above.
Please also provide copies of the results for all tests performed and any reports completed.

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?

6. To the best of your knowledge and assuming reasonable medical treatment, what is your patient's expected survival period or prognosis as at today's date (please tick (✔) the appropriate box)

☐ Less than 6 months ☐ 6 to 12 months ☐ 13 to 24 months ☐ Greater than 24 months ▶ If greater than 24 months, please state estimated life expectancy.

Section A – Patient's details (continued)

7. a. To the best of your knowledge and assuming reasonable medical treatment, what is the likelihood of recovery or remission (as a percentage)?

%

b. Are there any other factors that influence or impact your patient's life expectancy (e.g. response to treatment, secondary condition)?

8. a. When did you first diagnose your patient to be suffering from this condition?

Date

/ /

8. b. If applicable, on what date did you consider your patient to have a life expectancy of less than 24 monthscondition?

Date

/ /

9. Has the patient ever had the same or similar condition (If known)?

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

Diagnosis	Date of diagnosis	Treatment provided/ recieved	Name of health professional consulted
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you previously (or will you be) completing forms/reports regarding this patient for another party (e.g. another insurer)?

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

Section B – Medical practitioner's details

Title

Surname

Given name(s)

Business address

State

Postcode

Phone number

( )

Fax number

Qualifications

Email

I certify that I have examined the patient and that all statements made in this document are correct in all aspects. I consent to AIA Australia providing copies of this document 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. I further consent to AIA Australia's Chief Medical Officer contacting me to discuss this patient's claim.

Signature

✗

Date

/ /