Claim for Total and Permanent Disablement Benefit

MEDICAL ATTENDANT'S STATEMENT

Colonial First State

To be completed by attending 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 completed documents to AIA Australia Wholesale Life Claims, PO Box 322, SILVERWATER NSW 2128

Section A – Patient's details

Patient's full name

Patient's date of birth / /

Address

State Postcode

Patient's record number for your practice

On what date were you first professionally acquainted with your patient? / /

On what date did your patient first attend and/or consult with any other medical practitioner in your practice, if earlier than the above? / /

Did you know your patient personally before they consulted you professionally?

☐ No ☐ Yes ▶ If 'Yes', since when and in what capacity?

What is your patient's: Weight kg Height cm

Section B – Details of medical condition(s)

1. List all medical diagnoses causing impairment preventing your patient from working, and the dates of diagnosis. List any complications as secondary diagnosis. (Please note that the terms like 'stress' and 'psychological condition' are not acceptable and the use of them will delay the assessment of the patient's claim.) **If the member is suffering from a psychological or psychiatric condition, the diagnosis should be from the Diagnostic and Statistical Manual of Mental Disorders and must meet the manual's criteria.**

Primary diagnosis	**Date of diagnosis**	**1st consultation date**
	/ /	/ /
	/ /	/ /
Secondary diagnosis	**Date of diagnosis**	**1st consultation date**
	/ /	/ /
	/ /	/ /
	/ /	/ /

2. How frequently do you consult with your patient in relation to these condition(s)

3. Has your patient ever suffered the same or similar or comparable condition(s) previously?

☐ No ☐ Yes ▶ If 'Yes', please provide details, including dates of onset and presentation, previous treatment undertaken, effects on work capacity and any other outcomes.

Section B – Details of medical condition(s) (continued)

4. If your patient has suffered this condition previously were they able to continue working, either part-time or full-time?

☐ Yes ☐ No ▶ If 'No', please include relevant periods of work cessation.

5. Outline any ongoing complications, incapacity or other clinical issues arising from any previous condition(s), as listed above, or from any other illness or injury.

6. What tests, examinations or reports have led you to formulate your diagnosis as outlined in Q1?
Provide copies of any relevant reports or test results that support the above diagnosis. (Pathology, imaging, operation notes etc). To help avoid follow up requests, ensure that critical reports, such as histopathology of solid neoplasms, have been included.

7. What were the presenting symptoms of the current condition and when did they first arise?

Symptoms	Severity	Date from
		/ /
		/ /
		/ /
		/ /

8. How have these symptoms changed over time?

9. In relation to persisting symptoms, including pain and fatigue, are there any that you cannot correlate well with any examination findings or investigations?

☐ No ☐ Yes ▶ If 'Yes', please give details.

10. What were the presenting clinical signs?

11. How have these clinical signs changed over time?

12. Have there been any inconsistencies between any of the symptoms or signs as noted by you or others? Have there been any other reasons for you to question the validity of any of the symptoms or signs displayed?

☐ No ☐ Yes ▶ If 'Yes', to either, provide further details.

Section C – Treatment and management plan

1. What initial management did you advise and what was the outcome?

2. Have there ever been concerns about compliance with any health practitioners' treatment advice? Include compliance with advice about any tobacco, alcohol or other substance use.

☐ No ☐ Yes ▶ If 'Yes', provide details, including details of current compliance.

3. If your patient has ever been hospitalised in relation to the current condition, please provide details of the hospital, including admission and discharge dates. **Attach a copy of all admission and discharge summaries in your records.**

Hospital	Reason for admission	Admission	Discharge
		/ /	/ /
		/ /	/ /
		/ /	/ /

4. If your patient has undergone surgery or any other procedural intervention, provide further details.
Provide copies of relevant operation notes in your records.

Surgeon's name	Procedure	Date
		/ /
		/ /
		/ /

5. If not included in any other response, list all medication used in management

Medication (prescribed or unprescribed)	Dosage	Date of commencement	Date of changes and reason
		/ /	/ /
		/ /	/ /
		/ /	/ /

6. Apart from those included in any other response, what have been the outcomes of treatments to date? List responses to medications, results of procedural interventions.

7. What changes to management do you anticipate in the future and when? Include details of any planned medication changes, investigations, referrals, hospital admissions, surgery or other procedural intervention.

8. Provide details of any other Health Practitioners, including specialists or allied health professionals' attending the patient for assessment or management of their condition.

Name of specialty	Reason for involvement	Contact details (phone)

Section D – Occupation and current capacity to work

1. What is your understanding of your patient's occupation?

2. To the best of your knowledge please advise the patient's occupational background.

3. To the best of your knowledge, your patient's pre-disability work capacity was;

Full-time ☐ ____ hours per week
Part-time ☐ ____ hours per week
Casual ☐ ____ hours per week

4. Comment on activities relevant to your patient based on their usual occupation **before illness or injury** and list any related restrictions **following their injury or illness** commenting on current capability.

Pre-Injury activity					**Current capacity**	
Activity	**Never**	**Rarely**	**Often**	**Every workday**	**Comment on capacity to perform activity 'Yes','No' or 'N/A'**	**Comment on restriction if not capable of pre-injury function. If Permanent indicate permanence with a 'P'.**
Example: Lifting > 20 kg			✗			
Walking on even ground						
Walking on uneven ground						
Climbing Stairs						
Sitting						
Standing						
Computer work						
Customer Service						
Kneeling						
Bending						
Climbing/Working at heights						
Driving						
Lifting < 9 kg						
Lifting 9 kg – 20 kg						
Lifting > 20 kg						
Carrying < 9 kg						
Carrying 9 kg – 20 kg						
Carrying > 20 kg						
Reaching (above shoulder)						
Reaching (below shoulder)						

5. Does your patient have a psychological or psychiatric diagnosis listed in Section B?

☐ No ☐ Yes ▶ If 'Yes', please complete the following:

Psychological Function	**Is there a restriction?**		**Details of restrictions where applicable.**
Follow basic instructions	☐ No	☐ Yes	
Perform work tasks	☐ No	☐ Yes	
Maintain concentration	☐ No	☐ Yes	
Maintain energy	☐ No	☐ Yes	
Relate to others (socialise)	☐ No	☐ Yes	
Problem solving	☐ No	☐ Yes	
Retention of information	☐ No	☐ Yes	
Other	☐ No	☐ Yes	

Section D – Occupation and current capacity to work (continued)

6. Can your patient perform light, alternative or modified duties (with machinery, tools or workplace modifications if required)? If so, please provide details including details of applicable limitations or restrictions.

7. Do you consider the patient will be able to return to their usual occupation?

☐ No ☐ Yes ▶ If 'Yes', please indicate the following:

Part time – Expected return date	Hours per week		Full time – Expected return date
/ /		**and/or**	/ /

8. Do you consider the patient will be able to return to any occupation they are reasonably suited?

☐ No ☐ Yes ▶ If 'Yes', please indicate the following:

Part time – Expected return date	Hours per week		Full time – Expected return date
/ /		**and/or**	/ /

9. What is your patient's prognosis?

10. If you consider your patient will never work again in any capacity due to the claimed condition, please provide a date that this applies from and provide your reasons in detail.

Section E – Rehabilitation and additional information

1. Has your patient undertaken any formal rehabilitation assistance to aid in a possible return to work?

☐ No ▶ If 'No', please outline the details why.

☐ Yes ▶ If 'Yes', please provide details below including details of the rehabilitation provider, the period rehabilitation was undertaken and the outcome.

2. If no to the above, would your patient benefit from a referral to a rehabilitation provider to assist in developing a return to work plan?

☐ No ☐ Yes ▶ Please give your reasons for this conclusion

3. Are there any anticipated barriers to recovery of work capacity that are not directly related to the diagnosed medical condition? Include known details of past, current or future work and family circumstances that may affect recovery. Comment on ability to travel to, from and as part of any work. Comment on litigation and other claims (see question 5 in this section).

Section E – Rehabilitation and additional information (continued)

4. Do you believe maximum rehabilitation has been achieved in each impairment?

☐ No ☐ Yes ▶ Please explain your response.

5. Have you competed any other claim forms for your patient, or are you otherwise aware of your patient receiving or seeking any income or benefits from any of the following sources while disabled?

a. Any other life insurance policy ☐ No ☐ Yes

b. Workers Compensation ☐ No ☐ Yes

c. Compulsory Third Party Insurer ☐ No ☐ Yes

d. Superannuation Fund ☐ No ☐ Yes

e. Centrelink ☐ No ☐ Yes

f. Department of Veteran Affairs ☐ No ☐ Yes

g. Any other source _____

If you have completed any claim forms or reports as noted above, please attach a copy of each.

Provide any further remarks you believe relevant. Attach any additional information that we have not requested but you think will facilitate AIA Australia's understanding of your patient's condition.

To assist with the assessment and ongoing management of your patient's claim we would appreciate if you could complete the checklist below, and provide relevant documentation where applicable:

☐ Specialist reports.

☐ Any test results and reports (Imaging eg MRI, histopathology, pathology reports).

☐ Any admission and discharge summaries.

☐ Any other information that may assist your patients claim.

Section F – Medical attendant's details and declaration

Name of Medical Attendant (please print)

Practice address

State Postcode

Postal address (if different)

State Postcode

Email address

Telephone number ( )

Facsimile number ( )

Mobile number

Qualifications, Specialty and Specialty subtype as registered with The Australian Health Practitioner Regulation Agency

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 Limited, 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

X

Date

/ /