Beazley | AMIST Super Income Protection

claim form

Australian Income Protection®

A Beazley Group company

AMISTSUPER
AUSTRALIAN MEAT INDUSTRY SUPERANNUATION TRUST

Australian Income Protection Pty Ltd
AFS No 289089

about Beazley

Beazley Group is a specialist insurance business with operations in Europe, the US, Asia and Australia. Beazley manages five Lloyd's syndicates and in 2011, underwrote gross premiums worldwide of $1,712.5 million. All Lloyd's syndicates are rated A by A.M. Best.

Beazley entered the Australian insurance market in 2008 initially with a Personal Accident offering. Since then Beazley Australia has grown impressively in a relatively short period of time. The product offering has been expanded to include several Contingency products, most recently Beazley entered the group disability market following the purchase of Australia Income Protection.

key contacts

For help completing this form or to obtain further copies please contact the claims team:

Toll free:	1300 559 362 (not available from mobile phones)
Phone:	+61 (2) 8252 7900
Email:	info@aipi.com.au
Postal address:	Australian Income Protection Pty Ltd Claims Department PO Box R1196 Royal Exchange NSW 1225

For AMIST Super membership queries please contact:

Toll free:	1800 808 614
Phone:	+61 (2) 8571 5453

Claim form contents

How to complete this form

Please note your policy has a 30 day waiting period. No benefits are payable during this period.

Instructions:

1. Section A is to be completed by you, the claimant.
2. Section B is to be completed by your treating doctor.
3. Section C is to be completed by your employer.
4. Please forward your completed Claim form to Australian Income Protection Pty Ltd.
   - a. post: **Australian Income Protection Pty Ltd**
     PO Box R1196
     Royal Exchange
     NSW 1225
   - b. fax: +61 (2) 9252 6643
   - c. email: info@aipi.com.au
5. If you have any enquiries please call **Australian Income Protection Pty Ltd** on +61 (2) 8252 7900 or 1300 559 362 (only from landline)

Important notice

In order to alleviate any delay in the processing time of your claim, please ensure the following:

- The claim form is returned with all fields completed. Incomplete forms will be returned to obtain missing information.
- It is essential that you provide us with the name and address of your Medical Practitioner(s) for the past 5 years, as requested in Section A – Claimant's Section.
- For employees: A wage report is to be provided from your employer detailing each weekly/fortnightly/monthly wage for the 12 months prior to the date of incapacity, as requested in Section C – Employer's Section.

  If you are self employed, you must submit a copy of last financial year's Tax Return or Notice of Assessment issued by the Australian Taxation Office.
- If your condition is for a psychological condition, we require you to obtain a medical report from your treating psychiatrist/psychologist. Please note that medical certification can only be issued by a treating psychiatrist.
- All medical certificates must state the medical condition rendering you unfit for work and be issued by the doctor who consulted you during the certified period.
- Any claims related to Workers Compensation, Compulsory Third Party or any other insurance providers, you are required to provide a copy of your Acceptance/Decline letter and if liability has been accepted please provide copies of all benefits paid.
- In order for us to process any payments in relation to your claim, please complete Section A of the Individual Tax File Number Declaration form (which can be obtained from selected newsagents).
- If police were involved in any incident resulting in this claim, please provide a copy of the police report.

Any fraud, misstatement or concealment by you in relation to any matter affecting this insurance in connection with making of any claim under it, will give us the rights provided for in the Insurance Contract Act, including where appropriate the right to reduce or refuse payment of any claim.

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Claim No:	

Section A - Claimant's section - to be completed by the claimant

All questions must be completed and claim form signed before we can process your claim.
(Please print responses clearly in BLOCK LETTERS)

Your details

Title: First name(s):

Last name:

Address:

Suburb: State: Postcode:

Postal address:

Phone: ( ) Mobile:

Fax: ( )

Email:

Preferred contact: Email ☐ Phone: ☐ Mail: ☐

Date of birth: / / Gender: Male ☐ Female ☐

Height: Weight: Smoker: ☐ Non smoker: ☐

Have you or are you known by any other name? If so, please state:

All Claims will be paid via Electronic Funds Transfer, please provide the following information:

Bank:

Account name:

BSB: Account number:

Membership number:

(Please call **AMIST Super** on **1800 808 614** or **+61 (2) 8571 5453** if you do not know your membership number)

Employment details

Employer:

Address:

Suburb: State: Postcode:

Work phone: ( ) Work fax: ( )

Email:

Length of employment: Years: Months:

Occupation:

Usual duties:

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Claim No:	

Medical information

Is your condition: Injury: Yes ☐ No ☐

Sickness: Yes ☐ No ☐

Date of injury or first symptoms of sickness: / / Time occured: am/pm

Date you first sought medical attention for current condition: / /

Name and extent of injury/sickness:

If injured, please state what you were doing and how it happened:

Was surgery required? Yes ☐ No ☐

If yes, when was the surgery? / /

Have you suffered from this injury/sickness before? Yes ☐ No ☐

If yes, what was the date of the previous injury/sickness: / /

Please provide details

Name and address of your Medical Practitioner(s) for the past five years:

You must fully complete your Medical Practitioner's information below or your claim may be delayed up to 10 weeks while we obtain a full Medicare history report.

Name:

Address:

Suburb: State: Postcode:

Phone: ( ) Fax: ( )

Date first attended: / / Date last consulted: / /

Years attended:

Name:

Address:

Suburb: State: Postcode:

Phone: ( ) Fax: ( )

Date first attended: / / Date last consulted: / /

Years attended:

(If you have visited more than two Medical Practitioners over the past five years, please provide their information with this claim form)

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Additional benefits checklist: (please tick either Yes or No to each question)

If you answer Yes to any of the below, please provide proof of claim / benefit. For example: provide acceptance letter, decline letter and copies of benefits paid.

Are you receiving any additional benefits from your employer?

Sick leave: Yes ☐ No ☐

Annual/holiday leave: Yes ☐ No ☐

Long service leave: Yes ☐ No ☐

Other:

Was your injury/sickness work related? Yes ☐ No ☐

If yes, have you or are you going to lodge a claim for Workers Compensation? Yes ☐ No ☐

Insurance Company for Workers Compensation:

Claim number:

Contact person:

Contact details:

Have you or will you lodge a motor accident claim? Yes ☐ No ☐

Have you or will you lodge a claim for any sports insurance benefit? Yes ☐ No ☐

Have you or will you lodge any other type of insurance claim? Yes ☐ No ☐

If yes, please provide details of the insurance claim below:

Insurance company:

Policy number:

Contact details:

Type of policy:

Claim form check list:

- Have all sections been completed?
- Have you supplied a list of all treating doctors over the last 5 years?
- Has your employer supplied a report showing a breakdown of weekly wages for the 12 months preceding the date of incapacity?

Your claim will be delayed unless all sections are complete. Send the completed form to:

Australian Income Protection Pty Ltd
Attn: Claims Department
PO Box R1196
Royal Exchange NSW 1225

Fax: +61 (2) 9252 6643
Email: info@aipi.com.au

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Authority

I hereby authorise any hospital, physician, employer, insurer, Health Insurance Commission or other person who have attended me to furnish to Australian Income Protection Pty Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Worker's Compensation claims or claims with any other insurer to be released to Australian Income Protection Pty Ltd. I agree that a scanned, photocopied or fax copy of this authorisation shall be considered as effective and valid as the original.

I also authorise Australian Income Protection to release any information requested by AMIST Super or its representatives in relation to my AMIST Super claim.

Declaration

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recovery there under or in respect of past or future claims shall be forfeited.

Full name:

Address:

Date of birth: / /

Signature: Date: / /

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Third party authority (optional – complete only if required)

If you require us to release or discuss information regarding your claim with another person, please complete and sign the following authority form and return it to our office with your fully completed claim form and any additional information required for the assessment of your claim.

To be completed by the claimant

Title: First name(s):

Last name:

I hereby authorise:

Title: First name(s):

Last name:

Address:

Suburb: State: Postcode:

Phone: ( ) Mobile:

Fax: ( )

Email:

Date of birth: / /

Relationship to claimant:

to liaise with Australian Income Protection in respect to my claim. If in future I no longer require the above mentioned person to act as a third party, I will notify Australian Income Protection in writing.

Signature of claimant:

Name of claimant:

Date: / /

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Claim No:	

Section B - Doctor's section - to be completed by the Doctor

Please have this section completed by your regular treating Doctor that you have seen for this condition.

Patient's Details: (Please print responses clearly in BLOCK LETTERS)

Title: First name(s):

Last name:

Address:

Suburb: State: Postcode:

Age: Date of birth: / /

Height: Weight:

Is the patient's condition: Injury: Yes ☐ No ☐

Sickness: Yes ☐ No ☐

Date of injury or onset of sickness: / /

Date you were first consulted: / /

Date diagnosed: / /

Date incapacity commenced: / /

Are you the patient's usual doctor? Yes ☐ No ☐

If yes, how long have they been attending your practice: Years: Months:

Please list dates of all consultations in relation to the patient's condition:

1. / /	2. / /	3. / /	4. / /
5. / /	6. / /	7. / /	8. / /

Injury/sickness details:

Please provide your diagnosis of their condition:

Please provide an outline of their symptoms:

In your opinion, what caused the current condition:

Please provide an outline of past treatment:

Please outline your recovery/treatment plan:

History:

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In your opinion, is the injury or sickness work related? Yes ☐ No ☐

Is the patient's current condition related to any previous injury/sickness? Yes ☐ No ☐

If so, did you treat the patient for the previous injury/sickness? Yes ☐ No ☐

Has the patient been referred to a specialist for his/her problems? Yes ☐ No ☐

If yes, could you please supply the contact details? Yes ☐ No ☐

Title: First name(s):

Last name:

Address:

Suburb: State: Postcode:

Phone: ( ) Fax: ( )

In your opinion, does the patient require surgery for the condition? Yes ☐ No ☐

If yes, has the patient already undertaken the surgery? Yes ☐ No ☐

Date surgery was undertaken: / /

Please provide copies of any medical reports issued by the hospital

Medication/Treatment:

Has the patient been taking medication for their condition? Yes ☐ No ☐

If yes, please state the medication and the date prescribed:

Date: Medication:

Date: Medication:

Date: Medication:

Date: Medication:

Have you advised the patient, that their condition no longer requires any treatment or ongoing medical supervision, including the use of any prescribed medication? Yes ☐ No ☐

If yes, on what date was that advice given? / /

What is your prognosis?

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Claim No:	

Doctor's Authority

I, Title: First name(s):

Last name:

Of, Practice:

In the state of: being a registered medical practitioner, have examined

Patients Name: and certify the following to be a true description of his/her condition:

Furthermore, I certify that the patient is:

a. Totally unfit for his/her usual duties:

From: / / To: / / (inclusive)

b. Fit for suitable duties:

From: / / To: / / (inclusive)

Restrictions:

Bending ☐

Lifting ☐ up to kg

Standing ☐ up to hours

Other (please specify)

c. Fit for full duties from: / /

If this patient remains unfit for their usual occupation, what is the estimated date of return to work on:

a. Restricted duties/hours: / /

b. Normal duties/hours: / /

Signed:

Date:

Qualifications:

Address:

Suburb: State: Postcode:

Phone: ( ) Fax: ( )

Email:

Please note: Australian Income Protection is not liable for the costs associated in the completion of this section.

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Claim No:	

Section C - Employer's section - to be completed by your Employer

Employee details: (Please print responses clearly in BLOCK LETTERS)

Employee name: Employee number:

Employed since: / / Date of injury or onset of sickness: / /

Has been incapacitated since: / /

To the best of your knowledge, describe where and how the incapacity occurred:

Has the employee been performing their full duties and full hours prior to the date they were incapacitated?

Yes ☐ No ☐

If no, please provide details:

Employed type: Full-time ☐ Part-time ☐ Casual ☐ Contractor ☐

Work status: Employed ☐ Terminated ☐ Resigned ☐

(If the employee is no longer employed, please attach a copy of the Employment Separation Certificate)

If the employee is capable of returning to work on alternate/restricted duties are you prepared to provide these?

Yes ☐ No ☐

Job description:

Please advise the duties and tasks performed on a daily basis, including the hours per day and days per week:

Percentage of manual work % Percentage of non-manual work %

Is lifting required in the employee's role? Yes ☐ No ☐ Max Weight kgs

Wage Report

To calculate the weekly benefit, we require a wage report showing a weekly/fortnightly/monthly breakdown for the 12 months preceding the date of incapacity.

12-month weekly wage report supplied: Yes ☐ No ☐

Average per week gross: $

From the date of incapacity, he/she received:

$	Normal Pay	from	/ /	to	/ /
$	Sick Pay	from	/ /	to	/ /
$	Workers Compensation	from	/ /	to	/ /
$	Other	from	/ /	to	/ /

If other, please specify:

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Claim No:	

Workers compensation information
This section MUST be completed even if the claim is not work related:

Are you self insured for Workers Compensation? Yes ☐ No ☐

Name of current Workers Compensation Insurer:

Policy number:

Is the employee's condition work related? Yes ☐ No ☐

Is the employee on a current Workers Compensation claim? Yes ☐ No ☐

If yes, does your company have an agreement to top-up the Workers Compensation benefits? Yes ☐ No ☐

Company representative's details:

Signature:

Title: First name(s):

Last name:

Position:

Company Name:

Address:

Suburb: State: Postcode:

Phone: ( ) Fax: ( )

Mobile: ( )

Email:

Date: / /

Employer check list:

- Have all questions of Section C been completed?
- Have you supplied a wage report showing a weekly breakdown for the 12 months preceding the date of incapacity?
- Have you completed the Workers Compensation details?