



To be completed by the claimant.

Instructions for the claimant

- You are required to complete your section of this form before the consultation with your Medical Attendant.
- Please ensure you read each question carefully and answer each question fully. Please print your answers clearly. If the form is not fully completed the assessment of your claim will be delayed.
- Throughout this document, the term 'work' refers to your own or any other occupation, either paid or unpaid.
- If there is insufficient space for you to answer any questions please attach further details on a separate sheet.
- Please have the Progress Certificate section of this form completed by your Medical Attendant.
- If you have any questions regarding the completion of this form please phone our Customer Service Centre on 131 737.

Name of life insured/claimant	Plan number	Claim number

1 Give details of all consultations since your last claim form.

Name and address of doctor/s	Date of consultation
	/ /
	/ /
	/ /
	/ /

2 What duties of your occupation are you unable to perform?

3 Since your claim with us have you been able to attend to any duties of your business or any other occupation, whether paid or unpaid?

No Yes If yes, please provide details of the duties attended to and the extent of work performed

Duties performed	Extent of work performed	Date/s
		/ /
		/ /
		/ /
		/ /

4 While you are unable to work, what are your daily activities?

5 (a) What date do you expect to return to work (whether paid or unpaid)?

Full time

Part time

(b) Have you already returned to work (whether paid or unpaid)?

No Yes If yes, please provide the date you returned to work

(c) If you have returned to work, what is your total gross weekly income (net of business expenses) since returning?

\$

6 Have you received, or are you entitled to receive, benefits from workers' compensation, transport accident, common law or any other source whatsoever?

No Yes If yes, please provide details (including weekly entitlement, name and address of organisation who paid the benefit).

Weekly entitlement

Details

7 Do you confirm that if you have not returned to your profession, business or occupation, either totally or partially, it is due solely and directly to your disablement and that such continued absence is absolutely necessary as a result of injury or illness?

Yes No If no, please provide details

Declaration

I hereby declare that the statements in this form are true and correct in every respect. I agree that if I have made any false or misleading statement in respect of my claim, the cover may be terminated by the insurer and all my premiums paid and my right to compensation forfeited. I acknowledge that I remain ready to provide the insurer such further evidence of my claim as may be required.

Signature

Date



To be completed by Medical Attendant

Instructions for the Medical Attendant

- Please ensure that you answer all questions fully. It is imperative that all information you provide about this claim is accurate and complete to enable us to assess your patient's claim.
- After completing this certificate, which is to be furnished at the expense of the insured, please return it directly to AXA Australia.
- If you have any questions regarding the completion of the form please call our Customer Service Centre on 131 737.
- If there is insufficient space for you to answer any questions please attach further details on a separate sheet.

Patient's full name

1 (a) What is the nature of the condition?

(b) Is there any complicating factor affecting or prolonging this condition?

Yes No (If yes, please provide details)

(c) What is your prognosis?

2 (a) Is the patient still under your care for this condition?

Yes No If no, what was the date discharged?

(b) What was the date of last attendance?

(c) Has the patient been referred to any other Doctor/Health Professional for treatment? Yes No

If yes, please provide details, including the name, address and type of profession

3 What are the objective clinical signs of the condition?

4 What is the current treatment plan for possible return to work and is any change to the plan proposed?

5 (a) What specific duties of their usual occupation is your patient still unable to perform and why?

(b) When do you anticipate that your patient will be able to return to their usual occupation on a full time or part time basis?

/ /	/ /
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Full time

Part time

6 Are there any factors known to you that are having, or may have, a positive or negative influence upon your patient's return to work?

7 What action, if any, is being taken to overcome the factors referred to in Question 6?

Thank you for taking the time to complete this certificate.

Declaration

I declare to the best of my information, knowledge and belief, that the information I have provided on this form is true and correct in every respect. I understand that the information I have provided will be relied upon by AXA Australia when assessing the patient's claim.

X

Signature

/ /

Date

Medical Attendant's details (please print)

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Title

Given names

Surname

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Address

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Postcode

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Qualifications