



We require proof of the Life Insured's date of birth before we pay any benefit. If proof of age has not already been submitted, please attach your original birth certificate to the form.

Plan number

Statement of claim by life insured

1 Name in full Mr Mrs Miss Ms Other please specify

 Surname (please print) Given name(s) Maiden name

2 Private address

 Street number and name Town/Suburb State Postcode

 Telephone

3
 Last occupation Date of birth

4 Last employer's business trading name and address:

5 Date of last day at work

6 Employer's business trading name and address at time of initial disability (if different to Q4)

Section A – Details of disablement (If space insufficient, attach a separate sheet, which is to be signed and dated).

1 State the nature and cause of the disability and name and address of any witness, if an accident.

2 (a) State the date when you were first attended by a doctor for this disability and the name and address of that doctor.

 Doctor's name Date of first visit

 Address Date of last visit

2 (b) State the name and address of your usual doctor if different from the above doctor.

3 Has any other doctor attended you for this disability? Yes No If 'Yes', give details.

Date of 1st visit	Date of last visit	Name and address of doctor	Treatment/medication
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4 Have you attended any other doctor during the last five years for any other disability, injury or illness? Yes No If 'Yes' give details.

Date of 1st visit	Date of last visit	Name and address of doctor	Treatment/medication
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

5 Have you sought treatment, in relation to this disability, from a physiotherapist, acupuncturist, chiropractor or any person practicing an alternative medicine? Yes No If 'Yes', give details of treatment and name and address.

6 (a) Have you, as a direct result of this disability, been incapable of following the normal duties of your usual occupation? Yes No If 'Yes', give details including the period(s) of disability.

Period	Details
From / / to / /	
From / / to / /	

(b) Have you been able to work in ANY job whether full or part time, paid or unpaid since you were disabled? Yes No If 'Yes', give details.

Period	Position	Employer
From / / to / /		
From / / to / /		
From / / to / /		

7 (a) Before your present occupation, did you work in any other full or part-time occupation(s)? Yes No If 'Yes', give details of each occupation and approximate dates.

Period	Occupation	Employer's name
From / / to / /		
From / / to / /		
From / / to / /		

(b) When do you expect to be able to return to work in either a full or part time capacity? / /

8 (a) Would you be prepared to return to work in ANY part-time capacity if ANY employer offered you a position? Yes No If 'Yes', what type of employment would you prefer?

(b) Do you wish to return to employment? Yes No

(c) Has rehabilitation ever been recommended to you? Yes No If 'Yes', give details including date of completion.

(d) If you have not been recommended to undertake rehabilitation would you be prepared to do so? Yes No

9 Are you insured with or have you previously made a claim against AXA Australia in respect of this or any other illness, injury or disability? Yes No If 'Yes', give details and dates.

Period	Policy numbers	Details
From / / to / /		
From / / to / /		
From / / to / /		

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10 Are you insured elsewhere against illness, injury or disability? Yes No If 'Yes', give details of insurer(s) including whether or not you have made or intend to make a claim.

11 (a) Have you made a claim in respect of this or any other disability under Workers' Compensation, Superannuation or any other compensation or pension plan? Yes No If 'Yes', give details of Insurer and Claim No. if known.

(b) If 'No', do you intend to lodge a claim? Yes No

12 (a) Are you in receipt of benefits from any other source? (eg Sickness, Unemployment benefit, Invalid pension, Service pension). Yes No If 'Yes', give details, including Pension No.

(b) If 'No', do you intend to apply for benefits? Yes No If 'Yes', give details.

13 (a) Was the illness, injury or disability the result of a motor vehicle/cycle accident? Yes No

(b) Are you in receipt of benefits relating to this accident? Yes No If 'Yes', give details.

(c) If 'No', do you intend to apply for benefits? Yes No If 'Yes', give details, if 'No', why not?

Section B – Personal history (if space insufficient, attach a separate sheet, which is to be signed and dated)

1 (a) At what age did you leave school?

(b) What is your level of education – Primary, Secondary, Tertiary?

(c) What qualifications do you have?

2 (a) Do you speak English fluently? Yes No

(b) Do you need an interpreter? If so, in which language?

3 What is your height and weight? Height cm Weight kg

4 (a) Do you currently or have you in the past 12 months smoked tobacco?

Yes No If 'Yes', state nature and quantity daily eg 40 cigarettes, 3 pipes, etc.

(b) Do you take alcohol? Yes No If 'Yes', state type and quantity daily.

Section C – Occupation details (if insufficient space, attach a separate sheet, which is to be signed and dated)

1 What was your exact job title at the time of ceasing employment?

2 How long had you been in that job?

3 Please describe in detail the exact nature of your duties

Super Directions Personal Super Plan **Total and Permanent Disablement claim**

4 Did you operate machines or use special equipment or tools? Yes No If 'Yes', please give details

5 (a) In what area did you work (office, loading dock etc)?

(b) Were you employed in a supervisory capacity? Yes No If 'Yes', how many people did you supervise?

6 What level of education or other qualifications did your job require eg special courses, etc?

7 What hours did you work? From to

8 Did you travel on the job? Yes No If 'Yes', how many kilometres per week?

What type of vehicle?

9 How far from home was your place of employment and how did you travel to work?

Section D – General (If space insufficient, attach a separate sheet, which is to be signed and dated)

1 Please describe your sports, hobbies, interests and social activities.

2 What daily/weekly exercise do you undertake?

3 Any other comments that you consider may be relevant to your claim.

Section E – Privacy

Use and disclosure of personal information

The privacy of your personal information is important to you and also to AXA Australia. The purpose of collecting your information is to assess your claim. This includes information about health, financial situation, occupation and lifestyle. If the information you give is not complete or accurate, we may not be able to provide you with the full benefits of your Plan.

In assessing your claim, we may need to disclose your personal information to other parties, such as claim assessors, loss assessors, reinsurers, medical and financial professionals, government authorities, judicial or dispute resolution bodies.

You are entitled to request reasonable access to information we have about you. We reserve the right to charge an administration fee for collating the information you request.

For our policy on Privacy refer to www.axa.com.au or contact AXA Australia Customer Service on 131 737.

Section F – Declaration

Declaration

In completing and lodging this form I formally wish to make a Total and Permanent Disablement Claim on

Plan number

I the life insured, hereby declare that the above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written in by me or by any person on my behalf.

I have read and understood the Privacy Disclosure Statement above. I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement.

Signature

Date