



# Salary Continuance progress claim form

To be completed by the claimant

## Part A

### Instructions for the claimant

- You are required to complete your section (Part A) of this form **before** the consultation with your Medical Attendant.
- The Medical Attendant will complete Part B of this form during the consultation.
- 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.

Name of Life insured/member	Policy number	Claim number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Current address	Contact phone number
<input type="text"/>	( ) <input type="text"/>

### Period to which this form relates

From  /  /  to  /  /

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

Name and address of doctor(s)	Date of consultation
<input type="text"/>	/ /
<input type="text"/>	/ /
<input type="text"/>	/ /
<input type="text"/>	/ /

2 (a) What duties of your occupation are you currently able to perform?

(b) What duties of your occupation are you currently unable to perform?

3 Since your claim with us, have you been able to attend to any duties of your occupation/other work?

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

Duties performed	Extent of work performed	Date(s)
<input type="text"/>	<input type="text"/>	/ /
<input type="text"/>	<input type="text"/>	/ /
<input type="text"/>	<input type="text"/>	/ /
<input type="text"/>	<input type="text"/>	/ /

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

**Salary Continuance progress claim form (continued)**

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**   Full time  Part time

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

\$

6 Have you received, or are you entitled to receive, benefits from workers' compensation, transport accident compensation, 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 \$

Name of organisation

Claim number

Name of claims officer/contact

Direct telephone number

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?

No  Yes 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 policy 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

## Part B

### 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 there is insufficient space for you to answer any questions please attach further details on a separate sheet.

Please complete this application in black pen only using block letters.

Patient's full name	Date of birth	Plan number	Member number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### Period to which this form relates

From  to

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 of discharge?

(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?

**Salary Continuance progress claim form (continued)**

5 (a) What specific duties of their occupation is your patient currently able to perform?

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(b) What specific duties of their occupation is your patient currently unable to perform and why?

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

Full time  Part time

(d) When do you anticipate that your patient will be able to return to work in any capacity considering their education, training and experience. Please list anticipated date.

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?

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

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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.

Signature

Date

<b>X</b>	/ /
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**Medical attendant's details (please print)**

Title	Surname	Given name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Postal address**

Street number and name	Town/Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Telephone	Facsimile
( )	( )

Qualifications

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