



- Please tick: Total and Permanent Disability claim
 Total but Temporary Disability claim
 Group Salary Continuance claim

Statement of claim by member

Plan name (if applicable) Policy number/Plan number

1 Title Surname Given name(s) Maiden name

2 Private address
 Street number and name Town/Suburb State Postcode
 Home phone () Work phone () Mobile

3 Occupation Date of birth / /

4 Employer's business trading name and address

5 Date of last day at work / /

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

Part A – Statement of claim (Complete either 1 or 2)

1 Injury claim – Answer all of question 1 if your claim is in respect of an injury.

What is your injury? (State the nature and extent of injuries. If to a limb, state whether left or right.)

When did the injury occur? Where did the injury occur?

Date / / Time am/pm

State exactly how the injury occurred

State names and addresses of any witnesses of the injury

2 Illness claim – Answer all of question 2 if your claim is in respect of an illness.

What is the nature of the illness?

When did you first become aware of it? / /

Member's statement (continued)

Part B – Medical history

When did you first attend a doctor or a hospital for your illness/injury? Provide full name and full address of that doctor or hospital.

Date of first visit / / Date of last visit / /

Doctor/Hospital/Medical practice

Street number and name Town/Suburb State Postcode

Telephone () Facsimile ()

Who is your usual doctor (if different from above)

Doctor/Medical practice

Street number and name Town/Suburb State Postcode

Telephone () Facsimile ()

How long have you attended this doctor/medical practice?

3 Have you attended any other doctor during the last five years for this or for any other disability, injury or illness?

Yes No

If yes give details:

Date	Reason	Name and address of doctor	Contact no.	Treatment/medication
/ /				
/ /				
/ /				
/ /				
/ /				

4 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:

Date	Reason	Name and address of doctor	Contact no.	Treatment/medication
/ /				
/ /				
/ /				
/ /				

5 (a) Have you, as a direct result of this disability, been unable to perform the normal duties of your usual occupation?

Yes No If yes, give details including the period(s) of disability and list the duties you are unable to perform:

Period		Details	
From	/ / To / /		
From	/ / To / /		

(b) Have you been able to work in **any** occupation 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 / /		

Member's statement (continued)

Part C – Occupation details

What is/was your occupation title at the time you stopped work as a result of the disability?

Are you self-employed? Yes No

Business/Employer's name Business/Employer's address

Please describe your usual work duties

(a) What hours did you work in your usual occupation? Start Finish

(b) What were the average hours worked per week over the last six months prior to disablement?

(c) (i) Were you: Full-time Part-time Casual/contract Self-employed/business owner (either wholly or partly)

(ii) If you were part-time or casual, how many days per week did you work on average over the six months prior to disablement?

Since the injury/illness occurred, have you been able to do any work in your business or occupation, or to engage in any other occupation?

Yes No If yes, give dates and extent of work.

When did you cease work?

What is your current capability to work because of your injury/illness? Can do all work Can do some work Can do no work

If still disabled, when will you be able to return to work?

If no longer disabled, when did you resume work? Part-time Full-time

In what areas did you work? (eg office, factory, building site, underground mine)

How long have you been in that role?

Did you supervise other employees? Yes No

Did you operate machines or use special equipment? Yes No If yes, provide details of the type of equipment.

Were you required to travel as part of your normal duties? Yes No

If yes, how many kilometres per week and in what type of vehicle did you travel?

Kilometres per week Type of vehicle

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

Distance from home Method of travel

Please attach a copy of your current driver licence

Please list insured income details:

Base annual salary ¹	Superannuation	Bonuses and guarantee (SG) contributions ²	Income from company commissions ³	Income from company profit distributions ⁴	Total other sources (please provide details below ⁵)
\$	\$	\$	\$	\$	\$

- 1 Include salary packaged items (eg motor vehicles, pre-tax [salary sacrificed] superannuation contributions etc).
- 2 Include only SG contributions if included as a feature of the policy.
- 3 Please note bonuses and commissions are only considered as insured income where the insurer has previously agreed in writing with the policy owner to include them as insured income.
- 4 Only applicable for a person insured who owns part, or all of the business.

5 Details of income from other sources
 (eg trusts, service companies, hobby farms etc).

Member's statement (continued)

Please provide your accountant's name and address:

Accountant's name Phone
 ()

Street number and name Town/Suburb State Postcode

Before your present occupation, did you work in any other full-time or part-time occupation? Yes No If yes, please give details.

Period			Occupation			Employer
From	/	/	To	/	/	
From	/	/	To	/	/	
From	/	/	To	/	/	

What level of education or other qualifications and special courses did your job require?

Part D – Other insurances

Has a claim been made or do you intend to make a claim for any of the following: (please tick)

	Yes	No	Weekly benefit	Name and address of benefits provider (For social security benefits, show branch office and pension number)
Worker's compensation?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Motor vehicle?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Third party insurance?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Social security?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Unemployment benefits?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Any other benefits or insurance?	<input type="checkbox"/>	<input type="checkbox"/>	\$	

Do you have any other sources of income? Yes No If yes, please provide details.

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.

Are you insured against injury, illness, disability or trauma under any other insurance? Yes No Please provide details of insurer/s (including other AXA insurance) including benefit amounts and whether or not you have made or intend to make a claim.

Are you currently a member of a Health Insurance Fund for hospital cover? Yes No If yes, please give details including the name of the fund concerned.

Member's statement (continued)

Section B – Personal history (if space is 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 (if No see (b))
- (b) Do you need an interpreter? If so, in which language?
- 3 (a) What is your height and weight? Height Weight
- (b) What is your dominant hand? Left-handed Right-handed
- 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) How many standard drinks containing alcohol do you consume per week on average? standard drinks per week

Section C – General (if space insufficient, please 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 D – 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 and managing your claim, we may need to disclose your personal information to other parties, such as claim assessors, loss assessors, reinsurers, medical and financial professionals, the trustee of your super fund (if this claim relates to cover provided to you as a superannuation fund member), government authorities, judicial or dispute resolution bodies and AXA Australia Group companies.

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.

**Please check the information you have provided in Sections A–C is true and correct.
Please complete Section E.**

Section E – Declaration

You must fully complete the section below

Declaration

I hereby declare that the information in this statement is true, correct and complete. I acknowledge responsibility for its completeness and accuracy whether the answers have been written by myself or by any person on my behalf. I understand and agree that if I make any false or fraudulent statements or fail to advise AXA Australia of any relevant information regarding my claim, AXA Australia may refuse to pay and proceed to cancel my claim and/or my cover. I understand that I can be prosecuted if I make any fraudulent statement. 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.

Name

Signature

Date

Please return completed form to:

AXA Australia, Group Insurance

GPO Box 4927 VV

MELBOURNE VIC 8060

Facsimile: (03) 8688 5258