

What you need to know



Thank you for choosing AXA for your financial protection needs. Please ensure that you have read this brochure prior to completing your claim form.

This guide is intended to assist you in the claims process. It does not replace or form part of your contract with AXA and nothing in this guide should be taken to affect your rights or obligations under your policy.

One of our aims is to ensure that we provide the assistance you need if you suffer from a sickness or injury which prevents you from working, so that you can make a successful return to work.

Summary of the benefits we can pay you

- 1 Total disability** – If you meet the policy definition for total disability we will pay you a total disability benefit according to the terms and conditions of your policy.
- 2 Partial disability** – If you return to work on a part-time basis, you may be eligible to receive a percentage of your weekly/monthly benefit. We may need to apply the formula found in your policy document. In some circumstances, we will require some financial information to assist in calculating your pre-disability income.
- 3 Offset and top-up payments** – If you are due to receive or are in receipt of benefits from anyone other than AXA – you may be eligible for a top-up payment or we may be entitled to take those payments into account and reduce the benefit we pay you. However, you need to let us know immediately if this applies to you.

For more detailed information on these benefits and how they are calculated, please consult your policy document or speak to your Claims Assessor.

Terms you should be aware of

Date of loss

Your date of loss is the date that you ceased all work and were under the care of a medical practitioner who has certified your inability to work.

Qualifying/waiting period

Most policy benefits have a waiting period which starts from the date of loss and is the amount of time that must elapse before any benefit may be payable. Please note that benefits are only paid from the end, and not the beginning, of the waiting period. Please check your policy terms and conditions for further details.

Your medical condition

In order for us to help you if you are sick or injured and cannot work, the claim form contains authorities so we can obtain information. We may use those authorities to request:

- regular medical reports
- past medical history

We may also consider independent medical opinions. We will obtain regular progress reports from you and your treating doctor, usually on a monthly basis. This information will help us understand how your condition impacts on your ability to work. The medical information we obtain may also be used to verify the declarations made in your application for insurance.

Returning to work and rehabilitation

Where appropriate under the terms of your policy, if medical opinion indicates that rehabilitation assistance may help you make a successful return to work, AXA may consider this and other return to work options with the assistance of your treating doctor.

We may also request further details of your occupation to assist in both the assessment of your claim and our assistance in your return to work.



Financial information

For us to assess your claim accurately and as quickly as possible, we need you to provide the following information relevant to the type of policy that you hold. Check with your financial adviser if you are unsure of what type of policy you hold.

Agreed value policy

If financial evidence was not provided at the time of application we reserve the right to ask for:

- tax returns and profit and loss statements relevant to when you took out the policy
- financial information to help us calculate partial return to work benefits or offsets.

Indemnity policy

At time of claim we will ask for:

- financial information from the last two years in order to determine how much to pay you
- financial information to help calculate partial return to work benefits of offsets.

During the course of your claim we may also request relevant financial information to verify your ongoing entitlement to total or partial disability benefits and to verify the declarations made in your application for insurance.

Completing forms and communication

To enable us to quickly process your claim, please fully complete all the forms and authorities we send to you and provide us with all the information we request as soon as possible.

A Claims Assessor will be in touch with you (and perhaps others such as your financial adviser and doctor) regularly to help assess your claim as speedily as possible.

What should I do if I have an enquiry or complaint?

If you have an enquiry about your claim, please contact our Customer Service Centre on 132 987. Please state the policy number and the precise nature of your enquiry. If our Customer Service Centre is unable to help, they will put you through to your claims assessor. Should your authorised claims assessor not be available to take your call, you will be contacted within 24 hours.

If you have a complaint about your claim, please contact your claims assessor or our Customer Service Centre in writing, stating the policy number and the precise nature of your complaint. We have an internal review process for dealing with complaints and as the insurer, we will respond to you in writing within 45 days, depending upon the nature of your complaint.

The Customer Service Centre address is:

AXA Australia
Customer Service Centre
PO Box 14330
MELBOURNE VIC 8001

If we are unable to resolve the matter to your satisfaction, external dispute resolution services may be available to you.

The Financial Ombudsman Service (FOS) is a service governed by an independent council which reports directly to the Federal Minister for Consumer Affairs. FOS can be contacted on 1300 780 808. Alternatively, you can write to:

Financial Ombudsman Service
GPO BOX 3
MELBOURNE VIC 3001

Checklist

Before submitting your claim, please ensure that the following checklist has been completed:

- Have you completed all sections of the claim form?
- Has your doctor completed the certificate of medical attendance section on the claim form?
- Have you signed and dated the authorities and declarations?
- If you have an indemnity policy, have you provided the last two years of financial information?
- Have you enclosed proof of identity? eg a certified copy of your drivers licence or passport.

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redefining / insurance



Instructions

Plan number

[Empty text box for Plan number]

- 1 Please ensure that you read each question carefully and answer each question fully. If this form is not fully completed the assessment of your claim will be delayed.
- 2 Your attending doctor must complete the Attending Doctor's statement. Any fee for the completion of this form is the responsibility of the claimant.
- 3 If you have any queries regarding completion of the form, please contact our Customer Service Centre on 132 987.
- 4 Return completed form to our Customer Service Centre at PO Box 14330, MELBOURNE VIC MC 8001.

Request for information - notice

Please note that upon lodgement of your claim or throughout the duration of your claim we may have cause to request the following:

- Medical reports/clinical notes from your treating doctors and specialists
- Authority to obtain a report from the Health Insurance Commission
- Periodical independent medical examinations
- Financial documentation
- Factual assessments/investigations/interviews
- Statements or separate questionnaires or other relevant information from you.

Privacy - use and disclosure of personal information

The privacy of your personal information is important to you and also to AXA. The purpose of collecting your information is to assess your claim. This includes information about your health, financial situation, occupation and lifestyle. If the information you give us is not complete or accurate, we may not be able to provide the products and services you have applied for.

We may need to disclose your personal information to other parties, such as reinsurers, medical and financial professionals, claims and factual assessors, judicial or dispute resolution bodies and AXA Australia companies, including companies such as AXA Australia Health Insurance.

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 our Customer Service Centre on 132 987.

Consent

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 above. I acknowledge that I can opt out from the use of that information for the purposes of direct marketing by telephoning 132 987.

Signed	Dated
<input checked="" type="checkbox"/>	<input type="text" value="/ /"/>

Witness	Dated
<input checked="" type="checkbox"/>	<input type="text" value="/ /"/>

Final checklist

- Have all questions been fully answered?
- Privacy consent signed
- Medical Authority signed
- Health Insurance Commission Authority signed
- Information Authority signed
- Declaration signed
- Attending doctor's statement fully completed

Note: If you have an Indemnity Plan please provide a copy of the last two years' tax returns (immediately prior to your disability commencing), to enable us to calculate your benefit entitlements.

Section A – Personal details

1 Full name Date of birth / /

Current residential address (we do not accept PO Box numbers)

Street number and name Town/Suburb State Postcode Country

Home phone () Business phone () Mobile phone

Height cm Weight kg Male Female

Section B – Claim details

2 Name the injury or sickness that is causing your disability:

3 Please provide your account of the injury or sickness:
Date / / Time
Place

How it occurred:

4 Please list all the duties you are unable to perform in your occupation:

5 If an accident, please provide name, address and telephone number of any witnesses to your injury/illness:

Name/how related	Address	Telephone
		()
		()

6 List name and address of attending doctor(s) for this injury/illness/disability:

Name/specialty	Address	Telephone
		()
		()
		()

7 (a) When did you cease ALL work?
Date / / Time

(b) Have you returned to work in your own or any occupation, either paid or unpaid?
Date – full time / / Date – part time / /

(c) If you have returned to work part time, what duties are you able to perform?

(d) When do you expect to return to work in your own or any occupation, either paid or unpaid?
Date – full time / / Date – part time / /

(e) If you will be returning to work part time, what duties will you be able to perform?

Section C – Employment

8 Occupation at the time you stopped work:

How long have you been in this occupation? yrs

9 On average how many hours per week did you work prior to your disablement?

10 Occupational duties: Please also indicate the percentage performed for each of the duties:

Duties	Percentage (%)
	%
	%
	%

11 Do you usually work from home? Yes No

If yes, please advise how many hours/days per week are worked at home, specific duties, and frequency and nature of contact with clients:

12 Do you have any trade/tertiary/professional qualification? Yes No

If yes, please describe:

13 Please select the following physical requirements of your occupation where applicable:

	Never/rare	Occasional	Frequent	Continuous	
Lifting, 20 kgs and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never/rare (0% - 10%)
Lifting, 7 - 19 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting, under 7 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occasional (11% - 40%)
Carrying, 20 kgs and over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carrying, 7 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent (41% - 70%)
Reaching above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Continuous (71% +)
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing - ladders, scaffolding etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing - ramps, steps, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Keyboarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office duties (admin, phone, clerical, photocopying)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

14 In your occupation, what percentage of time do you spend performing the following types of duties:

Sedentary/administrative	%
Supervising work	%
Light manual	%
Heavy manual	%
Total duties	100%

Initial claim form (continued)

15 Have you changed your occupation in the last six months prior to your illness/injury? Yes No If yes, why?

16 If you are not self-employed, is your job still available for you to return to? Yes No

17 Business name/employer's full name and address Telephone
 ()

18 If self-employed (Please select the appropriate box):

Are you a: Sole trader Partnership Company Trust

Please state your registered business name and address:

Please state your business phone number ()

(a) If Partnership – What is your share of partnership (Income and Expense Distribution) %

Who is/are the other active partners? (Please list all names)

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

(Please attach a separate sheet if there are more than three active partners)

(b) If a company – who are the directors and shareholders? (Please list all names)

1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

(Please attach a separate sheet if there are more than three director/shareholders)

(c) Have you hired a locum or replacement for your specific role? Yes No

What is the remuneration paid to the locum(s) or your replacement? \$

19 Total number of employees (excluding yourself): Full time Part time

20 Has your business ceased trading since you became disabled? Yes No

If yes, what date did the business cease trading?

If the business was sold, what was the date of sale?

21 If your business is still trading, please advise the names of the person(s), including family members, involved:

22 Were the above people involved in the business prior to your disability? Yes No If yes, what were their duties and hours?

23 Has there been a loss of income from the business due to your disability? Yes No Details of loss:

24 Have you bought or sold any/your business during the six months prior to the date you stopped work? Yes No

If yes, please provide details:

Section D – Financial

25 (a) Gross annual income in the 12 months prior to your disability \$

(b) Annual business expenses for the 12 months prior to your disability \$

26 Do you have any other source of income? Yes No If yes, please provide details:

Section E – Nature of injury or illness

27 Details of first treatment/consultation for this injury or sickness:

Date / / Name of doctor

28 What is your current treatment?

List treatment/medication	Name of physician/specialist or other treating provider	Frequency of treatment/dosage	Address of provider

29 Were you admitted to hospital for your injury/sickness? Yes No (Please include a copy of your hospital discharge summary)

From To

Name and address of hospital:

30 Was an operation performed? Yes No If yes:

(a) Nature of operation:

(b) Date performed:

(c) Name of the doctor:

31 Have you had this or similar injury/sickness before? Yes No If yes, when?

Name and address of doctor on the previous occasion(s):

Section F – Occupational rehabilitation

32 If not self-employed, has alternative employment been offered? Yes No

If yes, please list in the following table what duties you are still able/unable to perform, in respect of that alternative employment?

Duties	Able to perform	Unable to perform

33 Did you work at all between the onset of the sickness or the date of the accident and the first time you saw a doctor? Yes No

Initial claim form (continued)

34 Has occupational rehabilitation or a 'return to work' plan been attempted? Yes No
 If yes, please provide contact details of Rehabilitation provider:

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35 Has a return to work date in your own occupation, either paid or unpaid, been discussed with your doctor? Yes No Please provide details:

--

36 Please provide details of your current daily activities:

--

Section G – Other claims or insurance

37 Is a claim being made for disability against any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Other income protection/life insurance | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Workers compensation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Social security | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Third party motor vehicle accident | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Superannuation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other | <input type="checkbox"/> Yes <input type="checkbox"/> No |

(If you answered yes to any of the above, please complete the following table)

Name/Insurer	Type of claim	Policy No. Claim No.	Address/Phone No.	Liability accepted/ denied. If accepted state payment and frequency
				\$
				\$
				\$
				\$

Note: all details must be completed. Failure to fully complete the claim form will result in delayed assessment of your claim.

Medical Authority

I hereby authorise any doctor, dentist, hospital, or other person who has attended me, to release to the Insurer and its group of companies, its medical officer, or its representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Print name	Signed	Dated
	X	/ /

Information Authority

I hereby authorise any insurer, accountant or institution to release to the Insurer, its group of companies, or its representatives all information which the Insurer may request for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be effective and valid as the original.

I hereby authorise AXA to supply information relating to my claim to data matching services subscribed to by AXA.

I hereby authorise to provide refresher authorities or extra authorities for the request of information throughout the duration of the claim.

Print name	Signed	Dated
	X	/ /

Declaration

I hereby declare that the information in the Claim Form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to inform AXA of any relevant information regarding my claim, AXA may refuse to pay and cancel my claim. I understand that I can be prosecuted if I make any fraudulent statement.

Print name	Signed	Dated
	X	/ /



This form is to be completed by your attending doctor

Doctor – please complete this form and return it to the claimant

NB: If there is a charge for completion of this form, it is the responsibility of the claimant

Claimant's name

Date of birth

1

2 Are you the claimant's usual doctor? Yes No

3 Are you the claimant's treating GP/specialist? Yes No If specialist, what is your specialty?

(If specialist, please enclose a copy of the referring doctor's referral form.)

4 Is the condition: Injury Sickness

5 If sickness, when did symptoms first appear?

What are the current symptoms?

6 If injury, when did this incident occur?

7 Date the claimant was first ever seen by you?

8 Date the claimant was first seen for the current condition?

9 Date insured claimant advised to first cease work as a result of their current condition?

10 What is your current diagnosis and the date of diagnosis?

11 Has the claimant ever had the same or similar condition? (If yes, state when and describe)

12 Are there any other sicknesses or conditions affecting present condition:

13 Have you referred the claimant to any other doctor? Yes No If yes, please provide the name and address of that doctor:

14 If referred to you, give name and address of referring doctor:

15 If hospitalised:

(a) Provide name and address of hospital

(b) Dates of admission and discharge Admission Discharge

Admission Discharge

(c) If surgery performed, state the procedure

(d) Surgeon's name

16 Results of any medical investigations (Please attach copy of test results, if possible):

Attending doctor's statement
Initial claim form (continued)

17 What is the current treatment plan that is being prescribed? (Including medication)

18 To the best of your knowledge, is the claimant complying with the treatment?

19 Is a change in treatment contemplated? Yes No If yes, please provide details:

20 Please advise your understanding of the claimant's occupation:

21 Please describe the duties performed prior to the onset of the condition:

22 What occupational duties can the claimant currently perform and to what extent? (eg full time/part time)

23 What occupational duties can the claimant **not** perform and to what extent?

24 If still unable to return to work, when do you expect that the claimant may be able to return to work?

Full time / / Part time / /

(a) If part time what duties will the claimant be able to perform?

25 Has occupational rehabilitation been considered or attempted?

26 Do you have any comments on the future management of the claimant's condition?

27 Is this a worker's compensation case, or are you completing forms for this claimant for anyone else, including other insurance companies?

Yes No If yes, please give details:

(If you have reports from specialists, we would be pleased to receive copies)

28 Remarks and/or additional information:

Name Telephone

Street number and name Town/Suburb State Postcode

Qualifications Specialist Yes No

Signed Dated / /

Claims payment direct credit request/ Superannuation claim benefit payment request



Policy details

Policy number(s)

Customer details (please insert name in full)

Title

Surname

Given name(s)

Postal address

Street number and name

Town/Suburb

State

Postcode

Direct credit request

Financial institution and account details

Your benefit payment will be paid directly into your bank account/financial institution. To enable us to do this, please provide your details in the spaces provided below.

Name of bank/financial institution

Address of bank/financial institution

Town/Suburb

State

Postcode

Bank/Institution branch name

Account name

BSB number

Account number

Signature of policy owner(s)

Date

Superannuation benefit payment request

Superannuation fund details

If applicable to your policy, part of your benefit payment can be paid directly to your superannuation fund. To enable us to do this, please provide full name and banking details (including your membership number) of your superannuation fund below.

Name of superannuation fund

Address of superannuation fund

Town/Suburb

State

Postcode

Member number

Reference number (if required)

Bank/Institution name

Branch name

BSB number

Account number

Signature of policy owner(s)

Date



Authority to release personal Medicare claims information to a third party

Important information

Complete this form to request the release of personal Medicare claims information to a third party.

Any changes to this form must be initialled by the signatory. Your request will only be actioned if the form is completed, incomplete forms will be returned to you.

Information will only be provided for the dates listed on this form. Medicare records are available from **1 February 1984**.

This authority will remain valid for 12 months from the date signed unless the authority is expressly withdrawn.

Assistance

If you need assistance in completing this form visit www.medicareaustralia.gov.au call **132 011***, or visit your local Medicare office.

Lodgement

Send completed and signed form to:

**Information Release Section
Medicare Australia
GPO Box 9822**

in your capital city

or visit your local Medicare office.

Tick where applicable

* Call charges apply

Your details

1 Dr Mr Mrs Miss Ms Other

Family name

First given name

Other given name(s)

Date of birth

 / /

2 Medicare card number

Ref no.

Contact details

3 Permanent address

Postcode

Postal address (if different to above)

Postcode

4 Work phone number

 ()

Home phone number

 ()

Mobile phone number

Email

 @

Your authorisation

5 I,

(print your full name in **BLOCK LETTERS**)

authorise Medicare Australia to provide my Medicare claims history to the following organisation or person:

(print in **BLOCK LETTERS**)

For the period from / / to / /

(insert a full date range e.g. 01/05/2006 to 31/05/2007)

Declaration

6 I declare that the information on this form is true and correct.

Signature

Date

 / /

Privacy note

The information provided on this form will be used to establish your express authority in accordance with the secrecy provisions of the *Health Insurance Act 1973* for consideration to release your personal Medicare history to the person or organisation specified in question 5.

Sample Medicare claims history

The information in your Medicare claims history may include details that are not directly related to the purpose for which it is being requested. Medicare records are available from 1 February 1984.

A sample of the information that may be included in your Medicare claims history:

Date of service	Item	Item description	Benefit	Provider charge	Payment method	Date of lodgement	Date of processing	Rendering provider location and name	Ordering provider location and name
15 June 2007	00023	VR Level B Cons	\$32.10	\$32.10	Bulk Bill	08 July 2007	10 July 2007	Dr J Black 104 Smith Rd, Smithville	
06 July 2007	11700	ECG	\$23.50	\$32.50	Bulk Bill	02 Aug 2007	04 Aug 2007	Dr Smith, Suite 2b 8 Johns St, Melbourne	
15 Aug 2007	56807H	CT chest/ abd/pelv	\$420.00	\$680.00	Cash	16 Aug 2007	16 Aug 2007	Dr Smith, Suite 2b 8 Johns St, Melbourne	Dr W Brown 17 Hope Pl, Melbourne