

Claim for Sickness and Injury Benefit

CHECKLIST

Prior to forwarding your claim to the address above please ensure you have:

- | | |
|--|---|
| <input type="checkbox"/> Answered all the questions | <input type="checkbox"/> Signed and dated the claim form |
| <input type="checkbox"/> Had your attending Doctor complete the relevant section | <input type="checkbox"/> Completed all declarations on page 4 |

Please be advised that we will be unable to assess your claim if all requested information is not provided.

PRIVACY OF INFORMATION

What Information we collect

The forms we require you to complete to make a claim only ask you for information that is necessary for us to assess your claim. We may also obtain personal information on you from any other forms or health statements you complete, or from a third party who provides information with your consent or from your Financial Institution who provides details on your loan contract to which this insurance relates. The information we obtain from these parties may include financial, medical or employment history, as it may impact on the claim being assessed.

If you don't give us the information

If you do not give us all the information requested, we may not be able to process your claim.

How we use the information

We use the information we collect on you to assess your entitlement to benefits in respect of any claim submitted.

Disclosures

We will only disclose information about you to a third party if we need to in order to process, investigate and assess any claims. The parties to whom we may disclose your information include:

- Reinsurer's, Doctors, hospitals, clinics and other providers of health services from whom we request opinions or reports, Loss assessors and investigators, Legal Counsel, External complaints and dispute resolution bodies.
- Any person to the extent necessary, in our view, in order to carry out any instruction or authority you give us.

We may also disclose information about you to a third party if required by law. Your Financial Institution may keep a copy of any forms or information you provide to us through their office.

Access to information

You are entitled to access your personal information, except in some limited circumstances outlined in the *Privacy Act 1988 (Cth)*. You can request access to your personal information by writing to us.

Privacy enquiries or complaints

We have internal procedures in place to ensure that any concerns you may have relating to privacy of your information are resolved promptly, including access to our Internal Dispute Resolution Panel. If we are unable to resolve your complaint internally, you can direct your complaint to the Director, Compliance, Office of Federal Privacy Commissioner, either on 1300 363 992 or by mail to GPO Box 5218, SYDNEY, NSW 2001.

Please ask us if you have any queries on what personal information we collect or how it will be used. A copy of our Privacy Policy is available on request.

PERSONAL DETAILS

Full Name Mr/Mrs/Miss/Ms/Other

Date of Birth

Address

Postcode

Complete Telephone Number

Policy Number

Name of Financial Institution

Membership Number

INSURED'S STATEMENT

This claim form only asks you for information that is necessary for us to assess your claim. All questions must be answered or delays in the assessment of your claim may result.

Loan Details

Current Policy Number

Loan Number

Repayment Amount

Do you have an insured line of credit or an overdraft? YES NO

INSURED'S STATEMENT con't

Employment Details

Occupation at time of disability	Length of time in that occupation in years	
<input type="text"/>	<input type="text"/>	
Hours worked per week	Name of Employer	Employers Telephone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medical Details

Name of your usual Doctor

Address of your usual Doctor Postcode

Telephone Number How long has he/she been your Doctor in years?

If less than 12 months please give names, addresses, telephone numbers and dates of all the doctors consulted in the past 5 years:

Name	Address	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone Number <input type="text"/>	Attended from <input type="text"/> / <input type="text"/> / <input type="text"/>	to <input type="text"/> / <input type="text"/> / <input type="text"/>
Name	Address	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone Number <input type="text"/>	Attended from <input type="text"/> / <input type="text"/> / <input type="text"/>	to <input type="text"/> / <input type="text"/> / <input type="text"/>

Disability Details

When did you last work? When did you first attend a doctor this time? When did you go back to work? When do you expect to go back to work?

/ / / / / / / /

Are you claiming disability benefits from any other insurance company? YES NO

Have you submitted a claim for Workers Compensation or are you intending to do so? YES NO

If YES, please give the name and telephone number of the company and person dealing with the claim:

Complete this section if claiming for an Accident

Please describe how and where the accident happened

Date of accident Time of accident

/ / AM/PM

Injuries sustained

Complete this section if claiming for a Sickness

Describe the circumstances of the Sickness which prevents you from working including the history of the condition over the past 5 years (if any):

Have you suffered from a similar problem(s) previously? YES NO

If YES, how often did you consult your doctor? WEEKLY MONTHLY OTHER (please explain)

Please give details of previous consultations below:

Consultation Date	Time off work		Name and Addresses of Doctors/Hospitals etc.
	From	To	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

IF THERE IS NOT ROOM FOR ALL INFORMATION, PLEASE ATTACH A SEPARATE DOCUMENT

DOCTORS STATEMENT

Attending Doctor's Statement – Doctor only to complete entire section

Mr/Mrs/Miss/Ms/Other

is/was prevented from working as (nature of employment)

Diagnosis

Date and time he/she was first treated

Cause as stated to you by patient

If there is more than one condition, please specify which condition is predominantly preventing the patient from performing his/her usual occupation

and is/was therefore unable to work (Date disability commenced) to (Date disability ended) to (Anticipated date of recovery)

If you are unable to estimate the date of recovery, do you believe the period of disability will last:

less than three months three to six months more than six months

Is the patient fit to perform alternative duties? YES NO If YES, from what date?

Do you need to see this patient again? YES NO If YES, when?

Is this patient claiming Worker's Compensation for this disability? YES NO

The treatment recommended is/was

The prognosis is

Are there any other medical conditions which may have a bearing on the current disability? YES NO

Describe

Would you say that any of the above are primary contributions to the current disability? YES NO

If YES, what conditions and why?

Has he/she received medical diagnosis, treatment or attention previously for this or a similar disability or related cause? YES NO

Have further consultations been necessary since then? YES NO

If Yes, please give details of frequency of consultations and/or dates

Please give the name and address of first treating doctor

Name

Address

Postcode

Give names and addresses of all other doctors attended or specialists to whom referred, with relevant dates:

Name

Address

Postcode

Telephone Number

Date of attendance

Name

Address

Postcode

Telephone Number

Date of attendance

Are you his/her regular doctor? YES NO

If YES, how long? _____ Years

Name

Telephone

Address

Postcode

Signature

Date of attendance

DECLARATION AND AUTHORITY

1. I agree that all costs incurred in obtaining evidence in relation to my claim (including the cost of obtaining information from any doctor, hospital or employer) will be at my own expense.
2. I declare that the statements and particulars supplied by me on this form are true and correct (including those not in my own handwriting) and that I have not withheld any information relevant to this claim. I understand that I will not receive any payment if my claim is fraudulent.
3. I declare that I have read and understand the Privacy of Information statement on page 1 and consent to all matters contained in the statement.

Insured's Name

Signature

Date

 / /

MEDICAL AUTHORITY

I authorise any doctor, hospital or clinic to provide CUNA Mutual Life Australia Limited ABN 83 089 981 073, CUMIS Insurance Society Inc. ABN 72 000 562 121 and CUNA Mutual Australia Limited ABN 75 089 981 037 with all information and copies of documents regarding my medical history including details of medical conditions, treatment, prognosis, tests, x-rays or ultrasounds and any reports from other doctors, hospitals or clinics. A photocopy of this authority is deemed to be as effective as the original.

Insured's Name

Signature

Date

 / /

EMPLOYER AUTHORITY

I authorise my employer (or former employer) to provide CUNA Mutual Life Australia Limited ABN Limited 83 089 981 073, CUMIS Insurance Society Inc. ABN 72 000 562 121 and CUNA Mutual Australia Limited ABN 75 089 981 037 with all information and copies of documents requested by them regarding my employment and any sickness of injury I have suffered. A photocopy of this authority is deemed to be as effective as the original.

Insured's Name

Signature

Date

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