



PROTECT YOUR INCOME!

WITH INCOME PROTECTION INSURANCE



What is Income Protection Insurance?

Protecting your income means that you are protecting your lifestyle. Income Protection insurance will provide you with a replacement for your income for up to 2 years in the event that a sickness or injury prevents you from working. This type of insurance is designed to help you continue with your day to day living expenses. Income Protection insurance cover is automatically provided, there are no medical questionnaires or examinations required to receive this cover. The insurance is arranged by Club Plus and is provided by the Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFS Licence 235035, referred to as CommInsure, one of the largest insurance providers.

How much Cover is provided?

Benefit	Up to 90% of your salary to age 70, up to the limit of the maximum amount of salary used for calculating Superannuation Guarantee (the limit is \$40,170 per quarter for the year ending 30 June 2010).
Waiting Period	There is a 21 day waiting period
Benefit Payment Period	The maximum period that a benefit will be paid is 2 years
Cost	The premium is 7.56% of the Superannuation Guarantee contributions that your employer makes to Club Plus on your behalf.

Who is eligible for Income Protection Insurance?

Income Protection insurance is available to members up to age 70 whilst your employer is paying Superannuation Guarantee contributions to Club Plus on your behalf and you have sufficient funds in your Club Plus Superannuation account to pay for premiums. You are automatically covered from the date you join the Club Plus fund, you are covered 24 hours a day, seven days a week, worldwide. Refer to the Member Booklet and Product Disclosure Statement for further details or call 1800 680 627 or visit clubplussuper.com.au to obtain a Member Booklet.

FOR MORE INFORMATION

For more information on Club Plus Income Protection please call 1800 680 627. Club Plus Financial Planning can help make sure you have enough insurance to protect you and your family. To discuss this further or arrange for an appointment call 02 9376 9419 or email tracey.mcdonald@clubplussuper.com.au





FOR EMPLOYERS

Frequently Asked Questions



To assist you with any queries you may receive throughout the claim process, we have included FAQs. Should you require any additional information, please contact your Case Manager on (02) 9115 6563.

What information does the Club/employer need to provide?

- Signed and completed Employer Claim Form
- 12 months of income data.

CommInsure calculates the average income including overtime and allowances received in the previous 12 months prior to going on claim. We need this information to ensure these amounts are included in the Income Protection Benefit.

How long will it take to assess the claim?

The Case Manager reviews all claim documentation provided and if important information is missing, will contact you and explain what is needed.

The Claimant will be advised if their claim has been admitted within 8 days of receipt of the claim forms. Where additional evidence* is required, it may take longer for CommInsure to determine if the claim will be admitted.

*additional evidence may include:

- Treating Doctor Report to advise the date of diagnosis, medical history, likely period of incapacity, treatment and rehabilitation plans.
- Copy of medical Investigations, i.e. x-rays.
- Job description and attendance records.
- Financial documentation to ensure correct remuneration.
- Information from another insurance or government institution regarding any other claims.
- Independent Medical Examinations may be required for the following reasons:
 1. Determine if rehabilitation is appropriate
 2. Confirm the diagnosis made by your treating doctor
 3. Provide expert advice on treatment options
 4. Determine how long you will require off work
 5. When it is safe to return to work

How long will it take CommInsure to assess any additional evidence if required?

CommInsure assess all claim documentation as soon as possible. They follow up all requests each fortnight however, do not always have control over how long third parties takes to prepare and forward the requested information.

When is the first payment due?

Benefits are paid twice monthly in arrears. Therefore the first payment is due around 2 weeks after the 3 week waiting period has expired. For example, if the doctor certifies a Claimant unfit for work from 10 July 2009, benefits are payable from 01 August 2009, and will be paid on 15 August 2009.

How do Sick Leave payments affect the Monthly Benefit?

The Income Protection Monthly Benefit is reduced by Sick Leave payments. To avoid unnecessary expiry of accrued Sick Leave, the Claimant is required to advise their Employer to cease paying Sick Leave entitlement.

Your claim
form is inside

INSTRUCTIONS

1. You fully complete Part A of the claim form including either the sickness statement or the injury statement.

2. Your doctor fully completes Part B of the claim form.

3. Your employer fully completes Part C of the claim form.

4. Ensure all the details are correct and that each section is signed.

5. Include the following documents;

• **Completed Tax File Declaration Form.**

Please obtain a current Tax File Declaration Form from your local newsagency or Post Office and fill in your details. Retain one copy for yourself.

• **Certified Proof of Age**

Please have a copy of your Birth Certificate/Passport or Drivers Licence 'Certified' and included with your forms. Your local Post Office will be able to direct you to authorised persons to certify your identification (eg. Justice of the Peace, Police Officer, Australia Post agent/employee, Chartered Accountant, etc.)

6. Send your completed Claim Forms, Tax File Declaration and Certified Proof of Age to:

CommInsure Claims Team
PO Box 322
SILVERWATER NSW 2128

EFT Details for Income Protection Claim

DETAILS

Account name

Bank name/branch

BSB

Account number

Name of insured (please print)

Signature of Insured



Date

/ /

COMMINSURE USE ONLY

Tick application box:

EFT to member

EFT to fund

Policy name

Policy number

Once your claim has been initially assessed by the ClubPlus Claims team; a Case Manager will be in touch with you to provide details of your assessment.

CommInsure will contact you within 24 hours of receipt of your Claim Forms

In the meantime, if you have any queries regarding how to fill in this form or the initial lodgement of the claim- please contact the

ClubPlus Claims Team on (02) 9115 6563

Please note that CommInsure reserves the right to release a copy of this statement to the relevant Superannuation Fund Trustees (if any).

Return the fully completed form to the CommInsure Group Risk Claims, PO Box 322, SILVERWATER NSW 2128

Please complete sections A, B, C and the Privacy Consent form of this claim form in your own words and arrange for your doctor to complete Sections D, E & F. If the space below is inadequate or you wish to provide further information, please attach additional documents to this claim form. Failure to provide complete information will delay claim assessment.

A Particulars of claimant

(Please print answers clearly)

1 Claimant's name Date of birth / /

Residential address Postcode

Address for correspondence Postcode

Home phone number () Mobile number

2 Name of employer Phone number ()

Employer's address Postcode

3 State your gross income and expenses (before tax)

	Last 12 months		Last 12 months
a Gross income from occupation	\$ <input type="text"/>	b Business expenses	\$ <input type="text"/>
c Income from other sources	\$ <input type="text"/>	d Please specify other sources	<input type="text"/>

4 Occupation

a Describe and list all income producing duties of your occupation, the approximate percentage of time spent on each duty and percentage of income it generates

Duty	Time	Income
<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"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

b Has there been a substantial change in the duties of your occupation over the last 12 months?

- No Go to question d
- Yes Go to question c

c Please provide details

d State the number of hours normally worked per week prior to disability

State the number of hours worked per week on average over the last 12 months

e Were you on maternity/paternity/study/unpaid leave or unemployed when you became disabled?

- No
- Yes What type of leave were you on?

What was your occupation prior to leaving work?

What was the reason for your unemployment or leave from work?

f Details of trade/professional qualifications or membership of a professional body

A Particulars of claimant - continued

6 How long have you been in your present employment?

State previous occupations and details of employment

7 Is any of your occupation performed at home?

No Yes To what extent?

8 Is your occupation full-time?

No Yes Number of hours worked per week

9 Do you smoke?

No Yes In what form and daily quantity?

How long have you been a smoker?

B Particulars of claim

(If insufficient space please attach supplementary statement)

1 Nature of injury or sickness

2 a Date of injury or first symptoms of sickness / /

b Have you ever suffered from this condition before?

No Yes When and for how long?

3 Date of first treatment by medical practitioner / /

4 If you have suffered an injury, state exactly what you were doing at the time and explain fully how the accident happened

5 Give details of the medical practitioner you are currently attending

Name

Address

Postcode

Speciality

6 Were you admitted to hospital?

No Yes Hospital name

Date admitted

Date discharged

7 Was an operation performed?

No Yes Nature of operation

Surgeon's name

Date performed

8 Please provide details of all consultations and treatments prescribed by a medical practitioner in relation to your illness/injury

Date first consultation	Date last consultation	Name of medical practitioner	Speciality	Address/ phone number	Treatment prescribed
/ /	/ /				
/ /	/ /				
/ /	/ /				

9 What is the name and address of your usual doctor? Name

Address

Postcode

When did you last consult him/her (prior to your current sickness/injury) and for what reason?

B Particulars of claim - continued

10 Do you have any chronic sickness, disease or physical defect?

No Yes Please provide details

C Sources of income

1 Are you receiving or do you expect to receive any income or benefits from any of these sources while you are disabled?

- a Your business, partnership or employer? No Yes
- b Any other disability income policy or insurer? No Yes
- c Your superannuation fund? No Yes
- d Social Security/Centrelink? No Yes
- e Any other source? No Yes

If yes, please provide details

Question	Source of payments	Frequency	Income benefits (Gross amount)	Date commenced	Lump sum benefits
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$
			\$	/ /	\$

2 Does any of this benefit represent accrued sick leave?

No Yes From / / To / / Amount \$

3 Are you eligible for and do you intend to seek compensation under

a Workers compensation?
 No Please advise why not
 Yes Name of insurer Amount \$ Claim number

b Third Party Insurance or in any Court of Law?
 No
 Yes Name of insurer/legal adviser Amount \$ Claim number
 Name of legal adviser Amount \$ Case number

c Common Law?
 No Please advise why not
 Yes Name of legal adviser Amount \$ Case number

4 Has the sickness or injury prevented you from working in your usual profession, business or occupation?

No Yes Partially disabled (from working) From / / To / /
 Totally disabled (from working) From / / To / /

5 Have you returned to work?

No Please indicate when you intend to return to work Part-time / / and/or Full-time / /
 Yes List all days returned to work

	Part-time	Full-time	Gross income earned
	<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	\$

Declaration

I declare that the answers to all the questions on this form are true and correct and that I have not withheld any information relevant to this claim. I understand that if I make any false or misleading statements, or fail to disclose relevant information, The Colonial Mutual Life Assurance Society Limited (CMLA) may refuse to pay this claim for benefits and may be entitled to cancel my cover under the policy.

Signature of the Claimant Date / /

CommInsure is a registered business name of The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809

Authorities

I consent to CMLA seeking and receiving medical information from any medical practitioner whom I may consult or who I have consulted in the past or who at any time has attended me, from any hospital or other medical institution. It is my intention that a photocopy of this authority shall have the same effect as an original authorisation signed by me.

Full name Signature of the Claimant Date / /

I consent to CMLA seeking and receiving information from my current or any former employer relating to my employment with that company. It is my intention that a photocopy of this authority shall have the same effect as an original authorisation signed by me.

Full name Signature of the Claimant Date

CommInsure is a registered business name of The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809

I consent to CMLA seeking and receiving information from any other insurance company (including Workers' Compensation insurer) or from any government body eg Centrelink, Department of Veterans' Affairs (DVA) or Workers' Compensation. Please provide appropriate reference number(s).

Centrelink reference number DVA reference number

Workers' Compensation/CTP Insurer and claim number

It is my intention that a photocopy of this authority shall have the same effect as an original authorisation signed by me.

Full name Signature of the Claimant Date

CommInsure is a registered business name of The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809

I authorise and direct the Health Insurance Commission to release to CMLA my full Medicare claim history up to the date of this authorisation as below. I acknowledge and understand that it will be my entire Medicare History and this may have details that are not related to my claim with CMLA.

Full name Date of birth Medicare number

Signature of the Claimant Date

CommInsure is a registered business name of The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809

Group Risk Life Insurance Underwriting/Claims Privacy Consent

In this Document

'We', 'us' and 'our' refer to: The provider of Group Risk Life Insurance: The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 a member of The Commonwealth Bank Group ('the Group') 48 Martin Place, SYDNEY NSW 2000.

'You' and 'your' refer to: The individual whose information we collect and hold for our purposes.

Collection of personal information

We collect personal information (including members' full name, address and contact details, salary and job classification) so that we may assess and administer insurance related matters. In certain circumstances, we may be required to collect information of a sensitive nature, for example, personal health information.

Where it is necessary to do so, we also collect information on individuals such as company directors and officers (where the company is our customer), as well as customers' agents and persons dealing with us on a 'one-off' basis.

We may take steps to verify the information we collect; eg. a birth certificate provided as identification may be verified with records held by the Registry of Births, Deaths and Marriages to protect against impersonation.

You need to provide us with accurate and relevant information

If you provide us with incomplete or inaccurate information, we may not be able to complete our assessment of your insurance related matter.

Other members of the Commonwealth Bank Group (Group)

We disclose personal information to other members of the Group only if it is necessary to assess and administer your insurance related matter. We are permitted by the Privacy Act to disclose personal information to other members of the Group.

Other disclosures

Personal information may be disclosed to:

- brokers and agents who refer your business to us, your superannuation fund and any organisations appointed by them to administer your insurance related matter;
- any person acting on your behalf, including your financial adviser, solicitor or accountant, executor, administrator, trustee, guardian or attorney;
- your employer;
- if you have life insurance: medical practitioners (to verify or clarify, if necessary, any health information you may provide), claims investigators and reinsurers (so that any claim you make can be accessed and managed), insurance reference agencies (where we are considering whether to accept a proposal of insurance from you and, if so, on what terms);
- other insurer to which your insurance is transferred by your employer or superannuation fund;
- organisations, including overseas organisations, to whom we outsource certain functions.

In all circumstances where our contractors, agents and outsourced service providers become aware of personal information, confidentiality arrangements apply. Personal information may only be used by our agents, contractors and outsourced service providers for our purposes. We may be allowed or obliged to disclose information by law, eg. under Court Orders or Statutory Notices pursuant to taxation or social security laws.

Access You may (subject to permitted exceptions) access your information by contacting:

Customer Relations, Commonwealth Bank Group, Reply Paid 41, SYDNEY NSW 2001. We may charge you for providing access.

Further Information For further information on our privacy and information handling practices, please refer to the Group's Privacy Policy Statement, which is available at www.commbank.com.au or upon request from any branch of the Bank.

Your acknowledgment and consent

Your signature below indicates your consent to such use and disclosures of your personal information as are indicated above.

Signature Name

Signature Name

Please note: If there is a charge for completion of this form, it is the responsibility of the patient. Additional relevant information may be attached to this form if space provided is insufficient.
Treating Medical Practitioner or Specialist to complete

A Patient's details

1 Patient's name Date of birth / /

Address Postcode

2 How long have you known the patient?

3 What is the patient's Height Weight

B Medical particulars

1 Diagnosis - Please provide full details of condition, and cause of disablement including any complications.
Note: Please be specific - the terms 'stress', 'stress condition' and 'psychological condition' are not acceptable.

2 Has the patient experienced any complications as a result of the condition? If so, please provide details.

3 What treatment has been undertaken and is further treatment planned? If so, please provide details.

4 If surgery was performed, please provide details

Surgeon's name	Procedure	Date
<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"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

5 If hospitalised, give name of hospital

6 Please indicate when and where you attended the patient in regards to the claimed condition

At patient's home	At your surgery	In hospital
<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"/>

7 When did the patient first consult you for the condition(s) described in Section B?

8 To the best of your knowledge

a When did the injury first happen or symptoms of the illness first appear? / /

b Has the patient ever had the same or similar condition?

No Yes Please provide details

c Does the patient have any other illnesses or past medical history of relevance?

No Yes Please provide details

d Does the patient have any other medical practitioners that you are aware of?

No Yes Please provide details

B Medical particulars - continued

9 Is this condition due to pregnancy? No Yes

10 To the best of your knowledge, to what extent is the patient's condition related to his/her employment or occupational duties?

11 Describe any other disease or infirmity affecting the patient's present condition

12 Please provide details of other medical practitioners to whom the patient has been sent for tests etc. regarding this condition

Medical practitioner

Name Address Qualifications Speciality Reason for referral

Name	Address	Qualifications	Speciality	Reason for referral
<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

C Additional details

1 If the patient was referred to you, please provide the following details of the referring medical practitioner

Name	Address
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

2 Are you providing certificates to any other insurer for this accident/illness?

No Yes Please provide insurer's name

3 To the best of your knowledge, is this incident likely to lead to a Worker's Compensation, Third Party or Common Law claim; or to a claim for benefit under Social Security, Superannuation or any other form of disability cover?

No Yes Please provide details

D Work capacity

1 To the best of your knowledge, the patient's pre-disability work capacity was:

- a Full-time: of hours per week
- b Part-time: of hours per week
- c Please list all the patients normal duties to the best of your knowledge

2 Since becoming disabled, the patient has been able to work:

a Normal duties/hours per week, from / / to / / N/A

b Restricted duties/hours per week, from / / to / / N/A

Please fill out the duties/hours per week the patient has been able to perform in this period

c No duties/hours per week, from / / to / / N/A

3 If the patient is still disabled, please give the approximate date he/she should be able to return to work:

a To their normal duties/hours / / b To restricted duties/hours / /

Please fill out the duties/hours per week the patient has been able to perform

D Work capacity – continued

c No duties/hours per week, from / / to / / N/A

d Never. Please provide the reasons why you consider this

Remarks and/or additional information

E Doctors details

Medical Practitioner/Specialist's details (please print answers clearly)

Name

Address Postcode

Phone number () Specialist No Yes

Qualifications

I certify that I have examined the patient and that all statements made in this certificate are correct in all aspects. I consent to The Colonial Mutual Life Assurance Society Limited (CMLA) providing copies of this certificate to any Medical Specialist from whom The Colonial Mutual Life Assurance Society Limited (CMLA) seeks an independent report or to any other person deemed necessary to assist in the assessment of the claim.

Medical Practitioner's/Specialist's signature

Date / /

Please note that CommInsure reserves the right to release a copy of this statement to the relevant Superannuation Fund Trustees (if any).
Return the fully completed form to: CommInsure Group Risk Claims PO Box 322 SILVERWATER NSW 2128

Please print clearly

Name of employer Employer's ABN

Employer address where claimant is working Postcode

Employee claimant

1 a On what date did this employee commence employment? / /

b Was this employee employed on a full-time, part-time, or casual basis?

- On commencement of employment Full-time Part-time Casual
- On termination of employment Full-time Part-time Casual

c Gross Salary as at date of disability \$

Please specify if this is ... Annual Monthly
Fortnightly Weekly

d On what date was this employee first unable to perform all of his/her normal duties as an employee because of the present disablement? (Medical Certificate supplied on cessation of work should be attached) / /

e What was the last date the employee physically attended work in any capacity? / /

f From your knowledge of the situation do you believe the employee will ever return to work? No Yes

2 What was the exact job title of the employee's usual occupation?

3 Please describe the exact duties performed (Please attach a job description and any additional information).

4 Please list below any machines or special equipment used by the employee. Were these machines operated manually or automatically?

5 Was the employee employed in a supervisory capacity? No Yes How many staff did the employee supervise?

6 Was the employee responsible for training and employing staff?

No Yes Please provide details

7 In what area did the employee work eg. office, loading dock, in the field, factory etc.?

8 What level of education or other qualifications does this job require, e.g. special courses etc.?

9 Number of hours the employee worked per week: a On commencement of employment b On termination of employment

10 Have there been any changes in hours worked?

No Yes When did the change occur?

11 Are you currently or have you previously been paying compensation benefits or other remuneration to the employee or, has any benefit been paid, or is any benefit due to be paid under the superannuation plan?

No Yes Please provide details

12 Are you aware of any benefits arising from the current disablement which the employee has claimed or is entitled to claim from any other source/s?

No Yes Please provide details

13 Please indicate the status of the employee and provide copies of relevant correspondence if applicable.

On sick leave Reason for sick leave _____
Has any of this sick leave been paid? No Yes - Please refer to Question 15

Terminated Reason for termination _____
Official date of termination ____ / ____ / ____

Retired (ill health) If so, what date ____ / ____ / ____ to ____ / ____ / ____

Workers Compensation If so, what date ____ / ____ / ____ to ____ / ____ / ____

Other _____
If so, what date ____ / ____ / ____ to ____ / ____ / ____

14 List all dates the employee was absent for any reason during the 12 months before the disability began.

Date	Reason	Date	Reason
____ / ____ / ____	_____	____ / ____ / ____	_____
____ / ____ / ____	_____	____ / ____ / ____	_____

15 Has the employee been paid any benefits (eg. sick leave)?

No Yes Type of benefit

From	To	Amount
____ / ____ / ____	____ / ____ / ____	\$ _____
____ / ____ / ____	____ / ____ / ____	\$ _____

16 Does any of this benefit represent accrued sick leave?

No Yes From ____ / ____ / ____ To ____ / ____ / ____ Amount \$ _____

17 If the employee had more than one job/position in his/her time with your organisation, please list all job titles and the time spent in each position.

Job titles	Dates
_____	____ / ____ / ____
_____	____ / ____ / ____

18 a Could the employee's skills be used in any other type of work within your organisation? No Yes

b If the employee should not be able to return to his/her regular occupation, do you have any alternative job openings? No Yes

19 What similar types of work would the employee's skills qualify him/her for?

a Has the employee ever performed any light, alternate or modified duties?


No Yes Please provide details of the duties performed and the dates these were performed.

Dates
____ / ____ / ____
____ / ____ / ____

20 Has the employee undergone any rehabilitation or a return to work plan?

No Yes Please provide dates and full details, including provider names and contact details.

Remarks and/or additional information _____

Signature of person completing questionnaire  _____ Date ____ / ____ / ____

Name (please print in block letters) _____

Phone number () _____ Job title _____

Organisation address _____ Postcode _____

Please attach any additional information you wish to provide to the back of this form.

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