

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"/> | %    | %      |

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](http://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 |
|------|---------|----------------|------------|---------------------|
|      |         |                |            |                     |
|      |         |                |            |                     |
|      |         |                |            |                     |

**C Additional details**

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

| Name | Address |
|------|---------|
|      |         |
|      |         |
|      |         |

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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