

Zurich Australia Limited Health Events Claimant's Statement



Filling in this statement

Please complete all sections, use black ink and mark boxes like this with an X.

1 May we disclose information included in this claim form to your adviser?
No Yes

2 Claimant's details

Policy number(s)

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Date of birth:

Daytime contact
phone number:

Email address

3 Postal address

Suburb/Town

State:

Postcode:

4 Residential address (if different to postal address)

Suburb/Town

State:

Postcode:

5 Which body system are you claiming for?

6 What condition are you claiming for?

7 When did you first notice your symptoms?

8 When was your condition first diagnosed?

9 What investigations have you undergone (include dates)?

10 What treatment, including surgery, have you had and for how long have you had this treatment?

11 Have you suffered with any complications of your disease or disorder?

No Go to next question

Yes Provide details below

12 Have you previously suffered from or received treatment for a similar or related disease or disorder?

No Go to next question

Yes Provide details below

- 13 Give the name and contact details of the doctor/specialist who is currently treating you.

Current treating doctor/specialist

Initials Surname

Practice name and address

Phone number
 ()

- 14 Give the name and contact details of any other doctor/specialist you may have consulted in the last 5 years.

Doctor/specialist 1

Initials Surname

Practice name and address

Reason

Phone number
 ()

Initial date consulted Last date consulted
 / / / /

Doctor/specialist 2

Initials Surname

Practice name and address

Reason

Phone number
 ()

Initial date consulted Last date consulted
 / / / /

Doctor/specialist 3

Initials Surname

Practice name and address

Reason

Phone number
 ()

Initial date consulted Last date consulted
 / / / /

- 15 Have you previously submitted a trauma or TPD claim?

No *Go to next question*
 Yes Provide details of when and for what below

.....

- 16 Have you claimed or are you claiming for a trauma or TPD benefit from any other insurance company?

No *Go to next question*
 Yes Provide details below

.....

- 17 Are you a member of a private health fund?

No *Go to next question*
 Yes Provide the name and medical fund below

.....

For Health Event category A Musculoskeletal body system only

18 Are you still working?

No What was your last day at work?

Yes

19 What percentage amount of time is spent in each of the following areas?

	% of time
Administration	
Supervision	
Manual	
Travel	

Total duties (must add up to 100%)

20 Provide a description of the key areas of skill relating to your occupation and percentage of time spent with each occupational duty.

Key areas of skill	Percentage

21 Do you anticipate that you will be able to do any of these key duties in the foreseeable future?

No Go to next question

Yes Provide details below

22 Have you attempted or do you intend to undergo any form of rehabilitation or retraining?

No Go to next question

Yes Provide details below

23 What is your highest educational qualification?

Less than year 12

Year 12 or equivalent/IB Diploma

Tertiary degree

Professional

Trade qualified

Other Provide details below

24 Has your employer offered you alternative employment or if self employed do you have alternative employment?

No Go to next question

Yes Provide details below

25 Are you currently engaged in any other employment or activity for which you receive income?

No Go to next question

Yes Provide details below

26 Please provide any additional information or comments that will help assess this claim.

27 Please read this before answering the question about payment details

It is important that the account information requested below is correct as Zurich Australia Limited will not be held responsible for delays or other damage due to incorrect details being provided.

- To ensure faster payment and for your protection, payment will only be effected by Electronic Funds Transfer.
- Payment will only be made to the life insured.
- No payment to a third party will be allowed.
- We will require proof of the account (cancelled cheque, bank statement with account number and name of account holder shown).

Name of account holder	
<input type="text"/>	
Bank name	
<input type="text"/>	
Account type	
<input type="text"/>	
Bank account BSB	Bank account number
<input type="text"/>	<input type="text"/>

28 Please provide the marked documents together with this statement.

- Certified copy of birth certificate
- Withdrawal form – attached
- Certified copy of passport or drivers licence
- PBS authority – attached
- Medicare authority – attached
- Activities of Daily Living form
- Any medical reports
- Other Provide details below

29 Health Events claim declaration

the claimant:

- now wish to claim to the Health Events benefits of the Zurich Australia Limited ("Zurich") Life Limited policy; and
- declare that my answers to the claims questions on pages 1–4 of this form and the statements and representations I make on pages 1–4 [and otherwise in my discussions with Zurich on the phone] are complete and true to the best of my knowledge and

belief, and that I have not withheld any relevant information from Zurich;

- authorise any medical practitioner, hospital or any other person to furnish Zurich, or any of its representatives, any details relating to illness or injury of the insured person(s) or such other information as may be necessary to consider this claim;

authorise Zurich to disclose my personal information (which may include sensitive or health information) to the following parties:

- Any physician, hospital or any other healthcare provider who has attended or examined me in order for them to supply Zurich with full particulars of my medical history including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.
- Any claims assessor, investigator, medical professional, healthcare provider, insurance reference service, credit reference service, legal or accounting firm, auditor, employer, consultant or reinsurer for the purposes of producing a report concerning my claim.
- Any benefit provider such as other insurers or Government departments (including for the purposes of Workers Compensation, other insurers, Centrelink or similar benefit providers) that provides benefits in the event of my sickness and/or injury.
- And I further consent to those parties collecting information about me and releasing to Zurich their report, including any information they may hold about me as relates to Zurich's administration of the policy, including this claim.

I acknowledge and agree that:

- any written statements (including affidavits) of all the doctors or other physicians who attended or treated me and all other papers submitted in support of this claim, form part of this claim;
- the supply to me of this form or any other forms related to my claim does not constitute an admission of my claim by Zurich;
- any benefits payable in respect of this claim shall be forfeited if I, or anyone acting on my behalf or with my knowledge and consent, have knowingly withheld any relevant information or submitted any false information in respect of the claim;
- upon payment by Zurich of the benefits hereby claimed, Zurich is wholly discharged from all liability in respect of such benefits.

Claimant's name
<input type="text"/>
Claimant's signature (Please sign in black ink)
<input type="text"/>
Date signed
<input type="text"/>

This document is current as at October 2016 and is issued by Zurich Australia Limited ABN 92 000 010 195 AFSL 232 510 ("we", "us", "our" or "Zurich" as the context requires).

Zurich Australia Limited

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