Claim form

ZURICH®

Income replacement

This form is to be completed by the life insured. To be completed only on the request of the Zurich claims area.
To avoid delays, check that all questions have been answered fully. Please use BLOCK LETTERS.

Policy Number ☐☐☐☐☐☐☐☐

Your privacy

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any Personal or Sensitive Information ('Information'), you should know the following information.

We collect, use, process and store personal information and, in some cases, Sensitive Information about you in order to comply with our legal obligations and in order to assess your claim ('purposes').

Where relevant for this purpose, we will disclose this information (other than sensitive information such as health information) to the Trustee of your Superannuation Fund, to your adviser (and the licensed dealer or broker he or she represents), affiliates of the Zurich Insurance Group Ltd, to other insurers and reinsurers, to our agents, contractors, service providers and administrators, doctors and where we are required or permitted to by law.

Where relevant, to assess your claim, we will also disclose personal information, including sensitive information such as health information to medical practitioners, other health professionals, other insurers and reinsurers, legal representatives and other consultants. By signing this claim form, you consent to those organisations and other professionals collecting, and us disclosing sensitive information about you for this purpose.

If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of your claim may be delayed or we may not accept the claim.

Zurich may obtain Information from government offices and third parties to assess a claim.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your Information to, a list of countries in which recipients of your Information are likely to be located, details of how you can access or correct the Information we hold about you or make a complaint, please refer to the Privacy link on our homepage – **www.zurich.com.au**, contact us by telephone on 132 687 or email us at **privacy.officer@zurich.com.au**

1. Life insured details

☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Surname Given names Date of birth / /

Address State Postcode

Work phone number ( ) Mobile Email

2. Injury details

Complete this section if disability arose from an accident

A. When did the accident occur?

Date / / Time ☐ am ☐ pm

Place / Street

Town / Suburb

B. Did Police or First Aid Services attend the accident scene?

☐ No

☐ Yes ▶ please advise police station or first aid service to which the accident was reported

Name of officer Date / /

Address State Postcode

C. Please provide full details of how injury occurred

D. Describe the injuries sustained

E. Describe the restrictions that remain and how these affect your ability to work to full capacity

3. Illness details

Complete this section if disability arose from an illness

A. Date symptoms first appeared

Date / /

B. Date of diagnosis

Date / /

C. Please provide full details of your illness

D. Please describe all your current symptoms and how these affect your ability to work to full capacity

4. History of condition

Have you suffered from this or a similar condition before?

☐ No

☐ Yes ▶ please advise all dates of occurrence and nature of the illness, injuries or disabilities

5. Treatment details

A. Did you require ambulance transport?

☐ No

☐ Yes

B. Did you attend hospital?

☐ No

☐ Yes

Were you admitted to hospital?

☐ No

☐ Yes ▶ please advise all dates of occurrence and nature of the illness, injuries or disabilities

If you answered 'Yes' to (B) please advise names of hospitals and dates of attendance/admission

Name of hospital Date / /

Name of hospital Date / /

Name of hospital Date / /

C. Date you first consulted a doctor

Date / /

D. Name of doctor

Speciality Contact number ( )

Address State Postcode

E. Name of your USUAL doctor

Speciality Contact number ( )

Address State Postcode

F. (i) Have you undertaken rehabilitation or has it been recommended?

☐ No

☐ Yes ▶ please provide details of the rehabilitation

(ii) Names and full address of all doctors consulted, together with dates of medical treatment

Name of doctor

Speciality Contact number ( )

Address State Postcode

From / / To / /

Name of doctor

Speciality Contact number ( )

Address State Postcode

From / / To / /

Name of doctor

Speciality Contact number ( )

Address State Postcode

From / / To / /

Name of doctor

Speciality Contact number ( )

Address State Postcode

From / / To / /

If you need more room, please attach a separate page, signed and dated by you.

6. Occupation details

A. Job Title

Date commenced in this role or position / /

B. Occupation description

7. Employed person

If you were employed by another person or persons at the date of disability, please advise

A. Business name

Business address | State | Postcode

B. Nature of business

C. Employer's contact name

Employer's contact name

Employer's contact number ( )

D. What was your income at the time of disability?

Annual wage and/or salary	$
Motor vehicle	$
Superannuation	$
Other non cash benefits	$
TOTAL ANNUAL INCOME	**$**

8. Self-employed person or employed by your own company

A. If you were self-employed or employed by your own company at the date of disability, please advise

Business name

Business address | State | Postcode

B. Nature of business

C. What was the income of your business for the following periods?

	Last 12 months	Last financial year
Business turnover	$	$
Cost of goods sold	$	$
Gross profit	$	$
Expenses	$	$
NET PROFIT	**$**	**$**

D. What has been the effect of your disability on your business

E. Have you employed any replacement staff?

☐ No ▶ please advise why replacement services have not been obtained

☐ Yes ▶ please provide details including names of replacement persons, duties performed and cost of replacement persons

F. Name of your business accountant

Name | Contact number ( )

Address | State | Postcode

9. Loss of income

A. On what date did you cease full time work as a result of your illness or injury?

Date / /

B. Have you now returned to part time or full time work?

☐ No ▶ when do you expect to return to full time/part time work

Full time / / Part time / /

☐ Yes ▶ date you returned to work. Please advise full details of work performed since your return

Date / /

Details

C. If you have undertaken any work please advise if you have derived any income from your activities

☐ No

☐ Yes ▶ please advise earnings, net of expenses but before tax since returning to work

$

D. (i) Has your disability caused a reduction of more than 20% in your income?

☐ No

☐ Yes ▶ what is your estimate of the amount of income lost per month?

$

(ii) How did you estimate this loss (eg profit and loss or payslip etc)?

10. Duties of your occupation

Please list here each duty of your occupation that you performed before you became sick or were injured	How many hours per week did you normally perform this duty?	What percentage of your income was normally earned from performing this duty?	Please tick whether you are now able to perform this duty partially or not at all
1.	1.		☐ partially ☐ not at all
2.	2.		☐ partially ☐ not at all
3.	3.		☐ partially ☐ not at all
4	4		☐ partially ☐ not at all
5.	5.		☐ partially ☐ not at all
6.	6.		☐ partially ☐ not at all
7.	7.		☐ partially ☐ not at all
total hours worked per week* (before sickness or injury) =	HOURS		

***Add items 1 to 7**

11. Other benefits

Have you received or claimed for any other income or benefits for this disability?

☐ No

☐ Yes ▶ please provide details (eg, insurer name, contact name, reference number)

Amount $

Period of which this amount relates From / / To / /

12. Benefit payment options

Preferred method of payment

☐ Cheque

☐ Direct Credit

Direct Credit Details

Please provide the bank account details where you would like the funds to be deposited.

Name of Financial Institution

Branch address State Postcode

BSB Number ☐☐☐ – ☐☐☐ Account Number ☐☐☐☐☐☐☐☐☐

Account name

13. Superannuation contributions option

Fund name

Address State Postcode

Phone number ( ) Member number

14. Declaration and disclosure of information

I acknowledge that further claims under the policy are conditional on the satisfactory completion of this form and the Physicians Report (which is to be obtained solely at my expense).

I declare that the statements I have made on this form are true and correct in every particular. I also understand that any false or misleading statement or any concealment or omission of material facts, may result in Zurich Australia Limited refusing to meet my claim.

I authorise any hospital, physician, medical practice, therapist or other person, who has attended me, or any other insurance company, or employer or accountant, to provide Zurich Australia Limited with any and all information with respect to any sickness, injury, my medical history and medical consultations, prescriptions or treatments and copies of all hospital, medical and financial records.

I agree that a photocopy of this authority shall be considered as effective and valid as the original.

Signature of life insured Date

✗ / /

Name of witness

Signature of witness Date

✗ / /

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Physician's report

To be completed by the patient's treating doctor or specialist. The patient is responsible for the cost of completing this form. To avoid delays, check that all questions have been answered fully. Please use BLOCK LETTERS.

Policy Number ☐☐☐☐☐☐☐☐

1. Patient's details

☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Other

Surname Given names Date of birth / /

Address State Postcode

How long have you known this patient?

Are you the patient's usual general practitioner?

☐ No

☐ Yes

Please provide details of any previous consultations of significance

2. History and diagnosis

A. Date patient first visited you for this condition

Date / /

B. Did you examine the patient?

☐ No

☐ Yes ▶ please advise your objective findings on examination

C. Date of diagnosis

Date / /

Clinical diagnosis (including any complications)

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D. Is this disability caused by

- [ ] Work related Injury
- [ ] Sports accidents
- [ ] Degenerative process
- [ ] Other accidents
- [ ] Other cause – please provide details

3. Evidence of diagnosis

- [ ] Please enclose copies of reports from current X-rays, ECGs or pathology etc.

4. Nature of treatment

A. Treatment prescribed (including surgery and medication, if any)

B. Dates of subsequent visits

Date / / Date / / Date / / Date / /

C. When is the patient next due to visit?

Date / /

D. Is the patient compliant with treatment and consults to date?

- [ ] No
- [ ] Yes ▶ please describe

E. Have you referred this patient for specialist opinion?

- [ ] No
- [ ] Yes ▶ please advise

Name Contact number

Address State Postcode

F. Have you referred this patient for rehabilitation?

- [ ] No
- [ ] Yes

5. Degree of impairment

A. On what date did your patient cease to be able to work on a full time basis as a result of the medical condition?

Date / /

Please state reason

B. What are the usual activities involved in the patient's occupation to your knowledge (eg please comment on the amount of physical tasks and sedentary tasks required)?

C. What tasks of their usual occupation is your patient ABLE to perform?

D. What activities of their usual occupation is your patient UNABLE to perform?

E. How does their disability impact them from performing these activities?

6. Prognosis

A. In your opinion when will patient recover sufficiently to resume their occupation?

Full time / / Part time / /

B. General comments on patient's progress since commencement of treatment

7. Other benefits

(eg. Workers Compensation, Social Security benefits)

Are you providing information on this patient to any other organisation?

☐ No

☐ Yes ▶ please advise

Name of organisation Contact number ( )

Address organisation State Postcode

8. Declaration

I declare that, to the best of my knowledge, the information provided is true, correct and complete.

Name Contact number ( )

Qualifications

Address State Postcode

Signature of treating doctor or specialist Date

✗ / /

Privacy

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Any questions? Call 131 551

Please return the completed form to us:

By post, to **Zurich Australia Limited, Life Risk Claims, Locked Bag 994, North Sydney NSW 2059**, or

By email, as a scanned attachment, to **life.claims@zurich.com.au**