Total and Permanent Disablement claim form

ZURICH

This form is to be completed by the life insured and the policy owner.
Please have your treating doctor complete the Physician's Report on pages 6-8 of this form.
To avoid delays, check that all questions have been answered fully. Please use BLOCK LETTERS.

Policy Number

Claim Reference Number

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 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

Title Surname

Given names Date of birth / /

Address State Postcode

Contact numbers Home ( ) Mobile

Fax ( ) Email

2 Illness or injury details

Please complete if your disability is as a result of illness

Date symptoms first noticed / /

Details of diagnosis

Date condition diagnosed / /

Name of practitioner who diagnosed condition

Address State Postcode

Please provide details of your illness (including symptoms, severity and treatment)

Go to Section 3

Zurich Australia Limited ABN 92 000 010 195, AFSLN 232510. 5 Blue Street North Sydney NSW 2060.

2 Illness or injury details (continued)

Please complete if your disability is as a result of injury

Date of injury / /

Nature of injury including diagnosis

Please briefly describe the circumstances of the accident (including where it occurred)

Name of medical practitioner you are attending

Address State Postcode

3 Details of your condition

(a) Have you previously had the same or a similar condition? Yes ◯ No ◯ If 'Yes', please provide dates and details

(b) How does this condition affect your ability to perform your occupational duties?

(c) How does your condition affect your daily activities (such as leisure activities, personal grooming, house keeping etc)?

(d) Have you undergone rehabilitation or a return to work program? Yes ◯ No ◯ If 'Yes', please provide details

(e) Have you ever been required to undergo a period of hospitalisation? Yes ◯ No ◯ If 'Yes', please provide details

Date admitted	Date discharged	Name of hospital	Reason
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

4 Occupation details

(a) What was your occupation prior to your condition?

(b) What are the contact details of your company or employer?

Company or Employer's name

Address State Postcode

Contact number Mobile

(c) If you are self employed

(i) Structure of your business? Sole Trader ◯ Partnership ◯ Company ◯ Trust ◯

(ii) Number of employees in your business? – Part-time employees Full-time employees

(d) Please provide details of all duties of your occupation including percentage of time spent in each

Duties	Percentage
	%
	%
	%
	%

(e) How long have you been in this occupation?

(f) Please provide the date you ceased work – Full-time / / Part-time / /

(g) Have you been able to do any work in any occupation since you suffered from your condition? Yes ◯ No ◯

(i) If 'Yes', please provide details, including type of work performed and hours spent performing this work

(ii) If 'No', have you sought alternative employment or voluntary work? Yes ◯ No ◯

If 'Yes', please give details

(h) What level of education did you complete? (eg Year 12)

(i) Please specify your qualifications. Please include any courses attended, skills or trade apprenticeship qualifications

Qualifications	Year completed

(j) Have you previously worked in any other occupation? Yes ◯ No ◯ If 'Yes', please provide details

Occupation	Period	Employer/Business name	Duties
	to		
	to		
	to		
	to		

5 Domestic duties

Please provide details of the domestic duties you currently undertake

6 Hobbies and interests **(eg memberships, fishing, golf, reading, etc)**

Please provide details of your current hobbies, interests and pastimes including frequency

7 Healthcare providers

Name of usual doctor

Address State Postcode

Please provide details of all healthcare providers (including doctors, physiotherapists, acupuncturists, chiropractors, counsellors or any other healthcare provider) consulted in the past 3 years.

Name Qualifications or specialty

Address State Postcode

Date first consulted / / Reason for the consultation

Name Qualifications or specialty

Address State Postcode

Date first consulted / / Reason for the consultation

Name Qualifications or specialty

Address State Postcode

Date first consulted / / Reason for the consultation

Name Qualifications or specialty

Address State Postcode

Date first consulted / / Reason for the consultation

8 Payment details

Preferred method of claim payment ◯ Cheque ◯ Direct credit

Direct credit details

Please provide bank account details where you would like the funds to be deposited. Please note that the name of the account must be in the name of the policy owner.

Name of financial institution

Branch address State Postcode

Account name

Bank/State/Branch (BSB number) | | | | – | | | | Account Number | | | | | | | | | |

9 Declaration and authority

I declare that the statements I have made on this form are true and correct in every particular. I also understand that any false statement, concealment of material facts, or omission may result in the policy being cancelled or cause a benefit not to be payable.

I authorise any Hospital, Physician, or any other person who has attended me, any other insurance company, my employer or accountant, to provide to Zurich Australia Limited any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatments and copies of all hospital or medical and financial records. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Name of life insured

Signature of life insured Date

✗ / /

Name of policy owner

Signature of policy owner Date

✗ / /

Name of witness

Signature of witness Date

✗ / /

Any questions?

Call 131 551 or email life.claims@zurich.com.au

Please return completed form to:

Zurich Australia Limited
Life Risk Claims
Locked Bag 994
North Sydney NSW 2059

Physician's report

ZURICH

To be completed by the patient's treating doctor or specialist.
The patient is responsible for the cost of completing this form.

LCPHYSREP

Policy Number

Claim Reference Number

1 Patient's details

Title Surname

Given names Date of birth / /

What is the patient's usual occupation?

Height Cm Weight Kg

Are you the treating: GP ◯ OR Specialist ◯ What is your area of speciality?

Who referred this patient to you?

(a) Please advise reason for consultation

Date first consulted / /

(b) When did the patient first consult you for the current condition? Date / /

(c) When did the current condition commence? Date / /

(d) Please provide a full report on the patient's current condition including cause, symptoms and diagnosis

(e) What is the current status of the patient's condition?

(f) Please provide details of past and present treatment, including medication for this condition

(g) What treatment is planned for the future?

(h) Is there a history of this condition or any condition likely to have contributed to or be connected with the patient's current condition?
Yes ◯ No ◯ If 'Yes', please provide details

(i) Is the patient's current condition related to their occupation in any way?
Yes ◯ No ◯ If 'Yes', please provide details

LIFE RISK CLAIMS PHYSICIANS REPORT

1 Patient's details (continued)

(j) Please provide a history of consultations and treatments for the current condition

Date / / Consultation including nature of symptoms and diagnosis and results of tests performed

Treatment prescribed

Results

Date / / Consultation including nature of symptoms and diagnosis and results of tests performed

Treatment prescribed

Results

Date / / Consultation including nature of symptoms and diagnosis and results of tests performed

Treatment prescribed

Results

(k) Is there a family history of this condition? Yes ◯ No ◯ If 'Yes', please provide details

(l) Please provide details of all doctors and healthcare providers

Name Qualifications

Address State Postcode

Contact number Date consulted / /

Name Qualifications

Address State Postcode

Contact number Date consulted / /

1 Patient's details (continued)

(m) Please provide details of the patient's capabilities and limitations in relation to their occupation as a result of their current condition

(i) Capabilities (what the patient can do)

(ii) Limitations (what the patient cannot do)

(n) Do you consider these limitations to be permanent and untreatable?

Yes ◯ No ◯ If 'Yes', please provide details

(o) Is the patient likely to be able to work in their own occupation now or in the future?

Yes ◯ No ◯ If 'Yes', please provide details

(p) Is the patient likely to be able to work in any other occupation now or in the future?

Yes ◯ No ◯ If 'Yes', please provide details

(q) Please provide the date you certified the patient to be unable to work – Full-time / / Part-time / /

(r) Please provide any further information that will help us understand the patient's condition

(s) Are you completing claim forms on behalf of the patient for any other insurance company in relation to this condition?

Yes ◯ No ◯ If 'Yes', please provide the name of the company

2 Declaration

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

Name Qualilfications

Address State Postcode

Contact number Facsimile

Signature of treating doctor or specialist Date

✗ / /

Privacy

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Any questions?

Call 131 551 or email life.claims@zurich.com.au

Please return completed form to:

Zurich Australia Limited
Life Risk Claims
Locked Bag 994
North Sydney NSW 2059