

PAGES 1–2 ARE TO BE COMPLETED BY YOU AND PAGES 3–4 ARE TO BE COMPLETED BY YOUR TREATING DOCTOR

INSTRUCTIONS FOR COMPLETION OF THIS FORM

- Please ensure that you and your doctor answer all questions.
- If this form is not fully completed assessment of your claim will be delayed and your benefits may not be processed.
- You are required to complete pages 1 – 2 of this form prior to consultation with your doctor.
- **In completing this form you must tell us about ALL the work you do, whether paid or unpaid, including voluntary work.**
- Throughout this form, the term “work” refers to your own or any other occupation, either paid or unpaid.
- Please note “as before” or “same as before” are not acceptable entries and will delay the assessment of the claim and/or jeopardise payment of benefits.
- **If there is a fee associated with completion of this form by your doctor, payment is your responsibility.**
- Should you require assistance in completing this form, please call us on (02) 8252 7900 during business hours.
- If there is not enough space for an answer please attach a separate page.

GETTING BACK TO WORK

- Talk to your nominated treating doctor about what parts of your work you can do and any medical restrictions that should apply. You can also encourage your nominated doctor to talk to your employer about any suitable duties that may be available.
- Talk with your employer about developing a return to work plan. A return to work plan outlines the actions to be undertaken to assist you to return to work.

Claim Number: _____

SECTION 1. CLAIMANT DETAILS *(to be completed by claimant)*

Mr Mrs Miss Ms Other *(please specify)* _____ Surname: _____

Given Name(s): _____

Date of Birth: : / : / : : Occupation: _____

Home Phone: (0) _____ Mobile Phone No.: (0) _____

Email Address: _____

Mailing Address

Street Number/Name: _____

Town/Suburb: _____ State: _____ Postcode: _____

1. a) Name of your current medical condition/s: _____
- b) Please provide details of your current symptoms _____

2. Provide details of **all** treatment since the last Form, including all medications/dosages/frequency

Name of Doctor/Medical attendant	Date of consultation	Type of treatment including medication	Frequency of treatment
_____	: / : / : : :	_____	_____
_____	: / : / : : :	_____	_____
_____	: / : / : : :	_____	_____

3. Has your condition improved since your last submitted Form?

- No... go to **Question 4**
- Yes... If “Yes”, please provide details: _____

4. Were you referred to any Specialist/s?

- No... go to **Question 5**
- Yes... If “Yes”, please provide the name/s and address/es and any pending appointment/s you may have:

Name of Doctor/Medical attendant	Address	Date of consultation
_____	_____	: / : / : : :
_____	_____	: / : / : : :
_____	_____	: / : / : : :

5. Have you been admitted to hospital since your last submitted Form?

- No... go to **Question 6**
- Yes... If “Yes”, please provide details: _____

6. a) Have you returned to work?

No... go to **Part b)**

Yes... If "Yes", please provide details:

Date commenced: : / : / : : : Occupation: Hours per week: Duties Performed:

Name and address of employer:

Gross Income earned \$

PLEASE ATTACH A COPY OF YOUR PAYSリップ OR CONFIRMATION LETTER FROM YOUR EMPLOYER FOR THE PERIOD WORKED AND AMOUNT PAID

b) Please advise when you expect to return to work.

Partial Duties: : / : / : : : Full Duties: : / : / : : :

7. Has your return to work been delayed?

No... go to **Question 8**

Yes... If "Yes", please provide details:

8. List all your daily activities and the time spent performing these activities. (This includes work which is voluntary or otherwise, and any domestic and social activities you undertake):

9. List below the duties of your occupation that you are able and unable to perform. (Please list all duties of your occupation. Tick which column is applicable for each duty)

Duties	Able to Perform	Unable to Perform
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

10. Are you undertaking any further study or training courses?

No... go to **Question 11**

Yes... If "Yes", please provide details:

Institution: Date Commenced: : / : / : : :

Course Name: Duration: Frequency of Attendance:

11. a) Are you receiving benefits from a third party (e.g. Workers' Compensation, Centrelink, Transport Accident/CTP, Department of Veterans' Affairs, court settlement, Employer Benefits)?

No... go to **Part b)**

Yes... If "Yes", please provide details:

Gross monthly benefit amount \$ Type of benefit Frequency of payment: Weekly Fortnightly Monthly

Claim/Reference number Contact name

b) Please provide details below if you are in receipt of any other income whatsoever:

Payment Source: Gross amount per week \$

PLEASE ATTACH A COPY OF THE PAYMENT ADVICE OR PROOF OF INCOME FOR THE ABOVE

12. Are you still employed?

Yes

No... If "No", please provide reasons and date employment ceased. In addition, please provide a copy of your Employment Separation Certificate. **No further payments can be made until this is received.**

: / : / : : :

Declaration

I hereby declare that the information in this claim form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise the insurer, AIP, of any relevant information regarding my claim, the insurer may refuse to pay and cancel my claim. I understand that I can be prosecuted if I make false statements.

Name:

Signature:

Date: : / : / : : :

SECTION 2. TO BE COMPLETED BY YOUR TREATING DOCTOR

Claimant's Full Name: Claim Number:

Date of Birth: : / : / : : : Height: cm Weight: kg

Progress Report

INSTRUCTIONS FOR COMPLETION OF THIS FORM

- Please complete this form after the Claimant has completed their section.
- Ensure that you answer **all** questions.
- Please note "as before" or "same as before" are not acceptable entries and will delay the assessment of the claim and/or jeopardise payment of benefits.
- In completing this form you must tell us about **ALL** the work the Claimant does, whether paid or unpaid, including voluntary work.
- **If there is a charge in association with completing this form, payment is the responsibility of the Claimant.**
- We encourage an objective assessment of the Claimant's condition.
- Should you require assistance in completing this form please call us on (02) 8252 7900 during business hours.
- If there is not enough space for an answer please attach a separate page.

1. Current Diagnosis:

2. List all conditions contributing to the claimant's inability to work and the extent to which each contributes to their incapacity.

Condition	Percentage
..... %
..... %
..... %
..... %

3. a) When did you last **examine** the Claimant? Advise of your findings on examination, including symptoms and objective signs causing disability:
 : / : / : : :

b) Has the Claimants condition improved, deteriorated or remained the same?

4. Advise of the treatment (including medication) being provided and the response to this treatment:

Type of treatment including medication	Frequency of treatment	Result/Response
.....
.....
.....

5. Advise the date/s and result/s of any tests or scans performed since the last submitted Form. Attach copies of these results/tests.

Date	Test/Scan Type	Result
: / : / : : :
: / : / : : :
: / : / : : :
: / : / : : :

6. Have you referred the Claimant to any Specialist/s since the last submitted Form?

- No... go to Question 7
 Yes... If "Yes", please provide details:

Name of Doctor and speciality	Address	Referral Date
.....	: / : / : : :
.....	: / : / : : :
.....	: / : / : : :

7. Has the Claimant been hospitalised since the last submitted Form?

- No... go to **Question 8**
 Yes... If "Yes", please provide a copy of the hospital discharge summary and any accompanying reports.

8. Please advise of any planned future treatment and whether you have considered a change in the current treatment plan:

.....
.....

9. List the Claimants daily living activities and specify those that they can and cannot perform:

Activity	Can Undertake	Cannot Undertake	Reasons
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

10. List all duties of the Claimants occupation and specify those that they can and cannot currently perform:

Occupational Duty	Can Undertake	Cannot Undertake	Reasons
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

11. Has the Claimant returned to work?

Yes... If "Yes", provide the date and the capacity in which they returned to work including any restrictions. Date: : / : / : : :

No... If "No"; a) Provide the dates as to when you expect the Claimant to return to work:

Part Duties Date: : / : / : : : Full Duties Date: : / : / : : :

b) Would the Claimant benefit from an occupational rehabilitation programme?

Yes No Provide reasons for your response:

c) Do you feel that the Claimant is motivated (regardless of condition) to return to work?

Yes No Provide details as to what brings you to this conclusion:

12. Advise of any complications or any other factors that may prolong the Claimant's condition:

.....

13. Have you provided any information to another Insurer in respect of the Claimant for this or related condition?

No... go to **Question 14**

Yes... If "Yes", please provide below the name of the Insurer and the reason/s for provision of information:

.....

14. Provide any additional comments/remarks:

.....

.....

Declaration and Certification

I hereby declare that the above statements are true and correct.

**I hereby certify that I have personally examined the above mentioned patient.
He/She will be unfit for full duties from / / to / / inclusive.**

Signature:

Date:

: / : / : : :

Name: Phone Number: (.....)

Street Number/Name:

Town/Suburb: State: Postcode:

Qualifications: Treating Specialist: Yes No Specialty: