

Make an AXA Total and Permanent Disability Claim

Thank you for contacting Swann Insurance

You must have access to a printer in order to access this form. If you do not have access to a printer, please contact our office on 1300 657 382 and an alternative will be sent.

HOW TO COMPLETE YOUR TOTAL AND PERMANENT DISABLEMENT CLAIM FORM

Your claim form must be completed in full. An incomplete form may cause delay in the assessment of your claim.

Please ensure:

- You (the insured) complete ALL pages of your total and permanent disablement claim form.
- Your treating Doctor has completed ALL pages of your total and permanent medical report claim form.
- That you (the insured) have signed and dated your claim form.
- That you (the insured) have completed the Authorities form.

Other useful information

It is important that all questions are correctly and fully answered by the policy holder. This will enable Swann Insurance to proceed with the processing of your claim; delays could occur if the claim is completed by someone other than the policy holder or if insufficient information is supplied. If for some reason the policy holder is unable to complete this form, please contact the office to discuss options.

Third Person authority to enquire

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the attached authorisation and return with your completed claim form.

Fax: 1300 657 370

Email: swann.cci.claims@swanninsurance.com.au

Post: Locked Bag 3274

Melbourne VIC 3001

Personal Details

1 Title Surname Given name(s) Maiden name

2 Private address
 Street number and name Town/Suburb State Postcode
 Home phone () Work phone () Mobile

3 Occupation Date of birth / /

4 Employer's business trading name and address

5 Date of last day at work / /

Section A – Details of disablement (if space is insufficient, attach a separate sheet, which is to be signed and dated)

Part A – Statement of claim (Complete either 1 or 2)

1 Injury claim – Answer all of question 1 if your claim is in respect of an injury.
 What is your injury? (State the nature and extent of injuries. If to a limb, state whether left or right.)

When did the injury occur? Where did the injury occur?

Date / / Time am/pm

State exactly how the injury occurred

State names and addresses of any witnesses of the injury

2 Illness claim – Answer all of question 2 if your claim is in respect of an illness.
 What is the nature of the illness?

When did you first become aware of it? / /

Part B – Medical history

When did you first attend a doctor or a hospital for your illness/injury? Provide full name and full address of that doctor or hospital.

Date of first visit Date of last visit

Doctor/Hospital/Medical practice

Street number and name Town/Suburb State Postcode

Telephone Facsimile

Who is your usual doctor (if different from above)

Doctor/Medical practice

Street number and name Town/Suburb State Postcode

Telephone Facsimile

How long have you attended this doctor/medical practice?

3 Have you attended any other doctor during the last five years for this or for any other disability, injury or illness?

Yes No

If yes give details:

Date	Reason	Name and address of doctor	Contact No.	Treatment/medication
/ /				
/ /				
/ /				
/ /				
/ /				

4 Have you sought treatment, in relation to this disability, from a physiotherapist, acupuncturist, chiropractor or any person practicing an alternative medicine? Yes No If yes, give details of treatment and name and address:

Date	Reason	Name and address of doctor	Contact No.	Treatment/medication
/ /				
/ /				
/ /				
/ /				

5 (a) Have you, as a direct result of this disability, been unable to perform the normal duties of your usual occupation?

Yes No If yes, give details including the period(s) of disability and list the duties you are unable to perform:

Period			Details	
From	/ /	To	/ /	
From	/ /	To	/ /	

(b) Have you been able to work in **any** occupation whether full or part-time, paid or unpaid since you were disabled? Yes No

If yes, give details:

Period			Position	Employer
From	/ /	To	/ /	
From	/ /	To	/ /	
From	/ /	To	/ /	

Part C – Occupation details

What is/was your occupation title at the time you stopped work as a result of the disability?

Are you self-employed? Yes No

Business/Employer's name Business/Employer's address

Please describe your usual work duties

(a) What hours did you work in your usual occupation? Start Finish

(b) What were the average hours worked per week over the last six months prior to disablement?

(c) (i) Were you: Full-time Part-time Casual/contract Self-employed/business owner (either wholly or partly)

(ii) If you were part-time or casual, how many days per week did you work on average over the six months prior to disablement?

Since the injury/illness occurred, have you been able to do any work in your business or occupation, or to engage in any other occupation?
 Yes No If yes, give dates and extent of work.

When did you cease work?

What is your current capability to work because of your injury/illness? Can do all work Can do some work Can do no work

If still disabled, when will you be able to return to work?

If no longer disabled, when did you resume work? Part-time Full-time

In what areas did you work? (eg office, factory, building site, underground mine)

How long have you been in that role?

Did you supervise other employees? Yes No

Did you operate machines or use special equipment? Yes No If yes, provide details of the type of equipment.

Were you required to travel as part of your normal duties? Yes No

If yes, how many kilometres per week and in what type of vehicle did you travel?

Kilometres per week Type of vehicle

How far from home was your place of employment and how did you travel to work?

Distance from home Method of travel

Please attach a copy of your current driver licence

Please list insured income details:

Base annual salary ¹	Superannuation	Bonuses and guarantee (SG) contributions ²	Income from company commissions ³	Income from company profit distributions ⁴	Total other sources (please provide details below ⁵)
\$	\$	\$	\$	\$	\$

- 1 Include salary packaged items (eg motor vehicles, pre-tax [salary sacrificed] superannuation contributions etc).
- 2 Include only SG contributions if included as a feature of the policy.
- 3 Please note bonuses and commissions are only considered as insured income where the insurer has previously agreed in writing with the policy owner to include them as insured income.
- 4 Only applicable for a person insured who owns part, or all of the business.

5 Details of income from other sources
 (eg trusts, service companies, hobby farms etc).

Please provide your accountant's name and address:

Accountant's name Phone
 ()

Street number and name Town/Suburb State Postcode

Before your present occupation, did you work in any other full-time or part-time occupation? Yes No If yes, please give details.

Period		Occupation	Employer
From	/ /	To	/ /
From	/ /	To	/ /
From	/ /	To	/ /

What level of education or other qualifications and special courses did your job require?

Part D – Other insurances

Has a claim been made or do you intend to make a claim for any of the following: (please tick)

	Yes	No	Weekly benefit	Name and address of benefits provider (For social security benefits, show branch office and pension number)
Worker's compensation?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Motor vehicle?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Third party insurance?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Social security?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Unemployment benefits?	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Any other benefits or insurance?	<input type="checkbox"/>	<input type="checkbox"/>	\$	

Do you have any other sources of income? Yes No If yes, please provide details.

Have you previously made a claim against NMLA or Swann in respect of this or any other illness, injury or disability? Yes No
 If yes, give details and dates.

Are you insured against injury, illness, disability or trauma under any other insurance? Yes No Please provide details of insurer/s including benefit amounts and whether or not you have made or intend to make a claim.

Are you currently a member of a Health Insurance Fund for hospital cover? Yes No If yes, please give details including the name of the fund concerned.

Section B – Personal history (if space is insufficient, attach a separate sheet, which is to be signed and dated)

- 1 (a) At what age did you leave school?
- (b) What is your level of education – Primary, Secondary, Tertiary?
- (c) What qualifications do you have?
- 2 (a) Do you speak English fluently? Yes No (if No see (b))
- (b) Do you need an interpreter? If so, in which language?
- 3 (a) What is your height and weight? Height Weight
- (b) What is your dominant hand? Left-handed Right-handed
- 4 (a) Do you currently or have you in the past 12 months smoked tobacco? Yes No
If yes, state nature and quantity daily e.g. 40 cigarettes, 3 pipes, etc:
- (b) How many standard drinks containing alcohol do you consume per week on average? standard drinks per week

Section C – General (If space insufficient, please attach a separate sheet, which is to be signed and dated)

- 1 Please describe your sports, hobbies, interests and social activities:
- 2 What daily/weekly exercise do you undertake?
- 3 Any other comments that you consider may be relevant to your claim:

Section D – Privacy

Use and disclosure of personal information

The privacy of your personal information is important to you and also to NMLA and Swann. The purpose of collecting your information is to assess your claim. This includes information about health, financial situation, occupation and lifestyle. If the information you give is not complete or accurate, we may not be able to provide you with the full benefits of your Plan.

In assessing and managing your claim, we may need to disclose your personal information to other parties, such as claim assessors, loss assessors, reinsurers, medical and financial professionals, the trustee of your super fund (if this claim relates to cover provided to you as a superannuation fund member), government authorities, judicial or dispute resolution bodies and AXA Australia Group companies.

You are entitled to request reasonable access to information we have about you. We reserve the right to charge an administration fee for collating the information you request.

Please check the information you have provided in Sections A–C is true and correct.
Please complete Section E.

Section E – Declaration

You must fully complete the section below

Declaration

I hereby declare that the information in this statement is true, correct and complete. I acknowledge responsibility for its completeness and accuracy whether the answers have been written by myself or by any person on my behalf. I understand and agree that if I make any false or fraudulent statements or fail to advise NMLA of any relevant information regarding my claim, NMLA may refuse to pay and proceed to cancel my claim and/or my cover. I understand that I can be prosecuted if I make any fraudulent statement. I have read and understood the Privacy Disclosure Statement on the previous page. I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement.

Name

Signature

Date

Please return completed form to:

Swann Insurance (Aust) Pty Ltd
Locked Bag 3274
Melbourne, VIC 3001
Fax: 1300 657 370

Total and Permanent Disability Claim Medical Report

This form is to be completed by the Claimant's Medical Practitioner.

Date

If there is insufficient space for you to answer any questions please attach further details on a separate sheet.

	/		/	
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Dear doctor

Your patient is making a disablement claim and we write to you to obtain information concerning his/her history. Your report will be used by NMLA and Swann. You should be aware that your report may be provided to your patient should access be requested or otherwise thought to be desirable by NMLA and Swann as part of the claims process.

Please complete the report as fully as possible from your present knowledge, or from notes recorded by any colleagues in your practice regarding any relevant conditions. It is not necessary for you to specifically see or examine the person for the purpose of this report.

Please note if there is a charge for completion of this report, it is the responsibility of your patient.

The patient:

Surname

Given names

Maiden name (if applicable)

Occupation

Date of birth

	/		/	
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Yours faithfully,

Swann Insurance (Aust) Pty Ltd
Locked Bag 3274
Melbourne, VIC 3001

Section A – Patient details

1 Are you the patient's regular doctor? Yes No

(a) If 'No', please advise the name and address of his/her regular doctor.

(b) Please also provide details of other doctors seen by the patient in connection with this injury/sickness.

Date of visit(s)	Name and address of doctor	Qualifications
/ /		
/ /		
/ /		

(c) How long have you known the patient personally? professionally?

2 What is the principal diagnosis of the current injury/sickness?

3 When was the patient first aware of the condition?

Date

4 On what date did the patient:

(a) First attend you for any reason?

Date

(b) First attend you for the current injury/sickness?

Date

5 On what date did the current injury/sickness first occur?

Date

6 List all dates the patient has attended you for this injury/sickness.

Section B – Medical details

1 (a) Please state the history of the injury/sickness, including the exact nature and severity of the condition and give particulars of any treatment which has been or may be necessary.

(b) Please also provide full details and results of any tests performed (please include copies).

(c) What medical, surgical, rehabilitation or other treatments has the patient undergone?

(d) What is the current treatment plan?

(e) What is the future/anticipated treatment plan?

(f) What is the prognosis?

2 Has hospital admission been necessary? Yes No

If 'Yes', please provide the name of the hospital(s) and relevant dates.

Name of hospital	Reasons for admission	Date of admission	Date of discharge
		/ /	/ /
		/ /	/ /
		/ /	/ /

3 Has the patient suffered previously from the same or a related condition? Yes No

If 'Yes', please provide details.

4 In respect of the patient's current injury/sickness, have you given any certificate to another insurance company, or in connection with workers compensation, social security, sick leave benefits from the patient's employer or for any other reason? Yes No

If 'Yes', please provide details.

5 Are there any concurrent conditions? Yes No

If 'Yes', please provide details.

Section C – Occupation details

1 What were the usual duties of the patient's normal occupation?

2 Did the patient work: Full time Part time Casual

3 In your opinion on what date was the patient first unable to perform all the usual duties of his/her normal occupation as a result of the injury/sickness? Date

(a) In your opinion, do the limitations and restrictions that you have outlined above totally prevent the patient working in his/her usual occupation? Yes No

(b) Indicate the date the incapacity to work (if any) began. Date or Not applicable

(c) If the patient is currently unable to work, when do you expect that these restrictions/limitations will improve to enable a return to work:

- On a part time basis? Date or Not applicable
- On a full time basis? Date or Not applicable
- On a full time but restricted basis? Date or Not applicable

Please provide additional information if applicable.

4 In your opinion, at the current time, can the patient perform any duties of his/her normal occupation? Yes No

If 'Yes':

(a) Which work duties is the patient able to perform and from what date?

Duties

Date

[Text input box for duties and date]

(b) Which work duties is the patient unable to perform?

[Text input box for duties unable to perform]

5 Is the patient able to perform any kind of work? Yes No

If 'Yes', please provide details.

[Text input box for work details]

6 (a) Do you expect the patient to ever fully return to the usual duties of his/her normal occupation? Yes No

(b) If 'No', do you think the patient will ever be able to do a job for which he/she is reasonably suited by education, training or experience?

Yes No

(c) If 'Yes', please list examples of jobs which in your opinion would be appropriate.

[Text input box for job examples]

7 Has any rehabilitation been considered for the patient? Yes No

(a) If 'No', please outline why this has not been considered.

[Text input box for rehabilitation reasons]

(b) If 'Yes', please provide details.

[Text input box for rehabilitation details]

8 If you think the patient will never return to any type of work, please give detailed reasons for this.

[Text input box for reasons for no return]

Section D – Physician's details

Name (please print)

[Text input box for name]

Qualifications

Speciality

[Text input boxes for qualifications and speciality]

Telephone

Facsimile

Provider number

[Text input boxes for telephone, facsimile, and provider number]

Practice name and address

Town/Suburb

State

Postcode

[Text input boxes for practice name, town, state, and postcode]

I/We certify that the information provided in this medical report is true and correct.

Signature

Date

[Text input boxes for signature and date, with 'X' in the signature box]

Medical authority

I hereby authorise Medicare or any doctor, hospital, dentist or other person who has attended me, to release to NMLA or Swann, all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Name

Member's signature Date

Accountant authority

I hereby authorise my accountant/financial adviser to release to Swann or its representatives, all information which NMLA requests for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Name

Insured's signature Date

Authority to release information

I Born on the day of 19

(Name)

Residing at

Postcode In the state of

(Name of work comp/work care/disability insurer)

Hereby authorise and direct

Claim number:

(Postal address of work comp/work care/disability insurer)

Of

To release:

To NMLA or Swann, any medical or other information to which I would be entitled under the freedom of information act, any other acts of parliament and under general law, in relation to any claims I have made to the insurer; and to me a complete copy of all the medical information you have released to NMLA or Swann. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

This request is made to enable NMLA to fully assess a claim made by me in relation to Total and Permanent Disablement Cover under the

Policy number:

Dated on this day of Year

Insured's signature Date

Please return completed form to:

Swann Insurance (Aust) Pty Ltd
Locked Bag 3274
Melbourne, VIC 3001
Fax: 1300 657 370

Third Person Authority to make and receive claims enquiries in relation to my claim

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the following authorisation and return with your completed claim form.

I, _____ (name) of
_____ (address),

freely give permission for:

Name: _____

Address: _____

Contact Ph. No.: _____

to contact and be contacted by Swann Insurance (Aust) Pty Ltd to discuss information relating to and about my disablement claim, (number _____).

I know that I may request a copy of this authorisation. I agree that a copy of this authorisation shall be as valid as the original.

I understand that this authorisation shall be valid until my claim is processed and finalised, and that I have a right to revoke this authorisation by written notification to Swann Insurance.

Signed by

Print name

Dated

Witness signature

Print name

Dated