Risk Only Super Solution (ROSS) Claim Form

Total and Permanent Disablement

STATEMENT BY CLAIMANT. Please answer ALL relevant questions fully, not doing so could result in delays in processing your claim.

Plan Name	Policy Owner	Master Policy No.	ROSS Employer No.
	CCSL Limited	MP7000	MP7

SECTION A – Personal Details

Claimant Name ______ Date of Birth / /

Residential Address ______ Postcode

Postal Address ______ Postcode

Telephone (home) ______ (work) ______ (mobile) ______

Your last physical day at work? / / E-mail *(for correspondence)* ______

SECTION B – Claim Details

1. What is the nature of your injury/sickness?
(If an injury, please provide full details of the extent of your injuries. If to a limb, specify whether left or right.)

2. When did the injury or symptoms of your sickness first occur? Date / / Time am/pm

If your claim is for an injury – please answer question 3
If your claim is for sickness – please answer question 4

3. If your claim is for an injury, please advise:

(a) How did the injury occur (including what caused it and the events leading up to the injury)?

(b) Where did the injury occur? (Please provide the full address details of the place where the injury occurred.)

(c) Were there any witnesses to the injury? ☐ Yes ☐ No If '**Yes**', please provide their names and telephone contact details (if known).

4. (a) If your claim is for sickness, on what date was the diagnosis made? Date / /

(b) Please describe your current symptoms and their severity.

SECTION C – Treatment for this Condition

1. (a) When did you first consult a doctor or medical provider for your injury/sickness? / /

Name of doctor/medical provider who made the diagnosis

Field of Practice (i.e. GP, cardiologist, etc.) Telephone

Address

(b) When did you last consult this doctor or medical provider? / /

(c) Is this your usual doctor or medical provider? ☐ Yes ☐ No
If '**No**', please provide the name, address and telephone number of your usual doctor or medical provider.

Name Telephone

Address

(d) How long have you attended your usual doctor or medical provider?

(e) Have you consulted any other doctors and/or medical providers for your condition? ☐ Yes ☐ No
If '**Yes**', please provide details below (attach a separate sheet if required).

Date first consulted	Date last consulted	Name of medical provider and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
/ /	/ /		Tel:
/ /	/ /		Tel:
/ /	/ /		Tel:

2. Were you hospitalised for this condition? ☐ Yes ☐ No
If '**Yes**', please provide details below and copies of your discharge summaries (attach a separate sheet if required).

Date admitted	Date discharged	Hospital name	Address and telephone contact details
/ /	/ /		Tel:
/ /	/ /		Tel:
/ /	/ /		Tel:

3. Have you ever had the same or similar injury or sickness before? ☐ Yes ☐ No If '**Yes**', please advise the following:

(a) the date the injury or sickness occurred. / /

(b) what was the nature of the injury or sickness?

(c) please provide the names and contact details of any doctors or medical providers you consulted (attach a separate sheet if required).

Name	Address and telephone contact details
	Tel:
	Tel:

SECTION C – Treatment for this Condition (continued)

4. Do you have a Return to Work Plan or have you discussed one with your doctor or employer? ☐ Yes ☐ No
If '**Yes**', please provide details (including the name of the rehabilitation provider and their contact details).
If '**No**', please provide the reason and whether you believe occupational rehabilitation (eg. Return to Work Plan, studying, re-training, up-skilling etc.) could assist you.

SECTION D – Medical History

1. Give the dates and reasons for all other consultations with your usual doctor or medical provider and medications taken during the last 3 years.

Date	Reason	Medications taken (other than for cold or influenza)

2. Have you attended any other doctor or medical provider (other than detailed in Section C question 1) during the last 3 years? ☐ Yes ☐ No
If '**Yes**', please give details below.

Date	Reason	Name, address and telephone contact number of doctor	Medications taken (other than for cold or influenza)
		Tel:	
		Tel:	
		Tel:	

3. Have you been disabled or incapacitated through any other injury or sickness in the last 12 months? ☐ Yes ☐ No
If '**Yes**', please advise the nature of the injury or sickness and how many days of sick leave you required.

SECTION E – Occupation Details

1. Employer Name

Street Address — Postcode

Contact Numbers (phone) — (facsimile)

2. What was your job title when you ceased work?

3. Please provide details of your usual work duties and % of time spent on those duties.

Work duties	% of time spent
1	
2	
3	
4	
5	
6	
	100%

4. (a) Was your employment ☐ Full-time ☐ Part-time ☐ Casual ☐ Contractor

(b) If contractor, please provide the term of contract? From / / To / /

5. Where did you work (eg. office, factory, building site)?

6. How long have you been in that job? Years Months

7. How many hours per week, on average, did you work in the last 3 months prior to ceasing work?

8. Did you supervise other employees? ☐ Yes ☐ No

9. Please indicate (✔) the following requirements of your usual job, where applicable.

	Never	Occasional (i.e. less than 33% of the time)	Frequent (i.e. approximately 50% of the time)	Continuous (i.e. more than 66% of the time)
Lift/Carry 20 kg and over	☐	☐	☐	☐
Lift/Carry, 5 to 19 kg	☐	☐	☐	☐
Lift/Carry, under 5 kg	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐

10. What percentage of time, on average, did you spend in the following activities while performing your usual job?

% Sitting % Standing % Walking % Bending % Lifting

% Driving % Climbing % Crawling % Kneeling

11. Were you required to travel as part of your usual occupation? ☐ Yes ☐ No
If '**Yes**', please state the following:

(a) how many kilometres per week did you travel? km

(b) please provide details (nature of travel and type of vehicle, eg. car, bus, train, plane, truck, ferry etc.)?

12. How far from home was your place of employment and how did you get there?

SECTION F – Level of Disability

1. Please list which of your usual occupation duties you **can** and **cannot** do solely due to your injury or sickness.

Work duties you **can** do	Work duties you **cannot** do

2. Have you returned to any form of work? ☐ Yes ☐ No
If '**Yes**', please provide details of employer name, hours worked, duties performed and period worked

Other employer name/s and contact details (if different to Section E, question 1)	Hours worked	Duties performed	Period worked

3. What jobs do you think you will be able to do in the future?
(Please ensure you provide full details, including whether you have applied for any of these jobs since ceasing work.)

4. Why do you think you are totally and permanently disabled and unable to perform any work/duties within your education/training or experience in the future?

SECTION G – Vocational History

1. What is your level of education? ☐ Primary ☐ Secondary ☐ TAFE ☐ Tertiary

2. Please provide a detailed education history of all secondary, tertiary, TAFE courses and any other job related training undertaken (attach a separate sheet if required or your resume).
If not in Australia, please advise which country the qualification was provided.

Course description/Qualification	Country	Date started	Date qualified
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Please provide a detailed work history for the last 10 years (please attach a separate sheet if required or your resume).
If not in Australia, please advise which country the work was performed.

Period of employment	Employer	Job title	Position description/Duties
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

SECTION H – Activities and Restrictions

1. (a) Please describe your hobbies, interests and social activities.

(b) Are you still able to pursue these? ☐ Yes ☐ No
If '**No**', please describe how long your condition has affected your hobbies, interests and social activities (eg. which activities can you no longer perform).

(c) What are your current daily activities?

SECTION I – Other Benefits

1. Have you previously made a claim against this policy? ☐ Yes ☐ No If '**Yes**', please provide details.

2. (a) As a result of your injury/sickness, have you received, or are you entitled to receive/claim any benefits from:

☐ Centrelink ☐ TAC ☐ Another Insurer (eg. for another policy providing disablement cover)

☐ Workers' Compensation ☐ Common Law ☐ Any other source. Please state:

(b) If you are receiving or have received any benefits, please provide full details of each benefit including:

Type of claim		Claim/Ref No.	
Insurer (if applicable)		Amount of claim	$
Contact person		Contact number	
Type of claim		Claim/Ref No.	
Insurer (if applicable)		Amount of claim	$
Contact person		Contact number	

3. Do you have any other sources of income? ☐ Yes ☐ No If '**Yes**', please provide details.

SECTION J – Checklist

1. ☐ I have attached a certified copy of my: ☐ Driver's Licence or ☐ Passport or ☐ Birth Certificate
2. ☐ I have provided any other information that was requested or that may assist my claim.
3. ☐ I have provided my Doctor with my Plan Name and Member Number (if applicable) so he/she can complete the Medical Attendant's Statement.
4. ☐ I have fully completed this form, to ensure my claim is assessed promptly.

SECTION K – Declarations and Authorities

DECLARATION AND CONSENT

I 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, AIA Australia Limited, of any relevant information regarding my claim, AIA Australia Limited may refuse to pay benefits and proceed to cancel my claim and/or my insurance cover.

I declare that I have read and understood the Privacy Statement attached to this claim form and I consent to the collection, use and disclosure of my personal and sensitive information in the manner described in that Privacy Statement.

I confirm my consent for AIA Australia Limited or its representatives to use my personal and sensitive information (whether received by AIA Australia Limited from me or a third party) to investigate, assess and manage my claim and to disclose that information to medical, or health professionals and institutions and:

a. other insurers (including Workers' Compensation insurers);
b. investigators;
c. the ambulance service;
d. AIA Australia Limited's service providers;
e. statutory bodies including law enforcement agencies;
f. insurance or credit reference agencies;
g. financial institutions; and
h. such other third parties as is necessary for that purpose.

AUTHORITY TO OBTAIN INFORMATION

I hereby authorise any individual, organisation or entity within any of the above categories (a to h) that holds my personal and sensitive information to release that information to AIA Australia Limited on request, for the purpose of investigating, assessing and managing my claim.

I hereby authorise any medical practitioner, medical provider, health professional, hospital, dentist or other person who has attended me, to release to AIA Australia Limited or its representatives all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records.

I authorise any previous and my current employer to provide AIA Australia Limited with details of my employment and pay history.

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

Name *(please print)*	Claimant's signature	Date
	✗	/ /

Privacy Statement

AIA Australia Limited ('AIA Australia') follows the National Privacy Principles of the Privacy Act 1988 (Cth) including the Privacy Amendment (Private Sector) Act 2000 (Cth).

AIA Australia provides you with the following information regarding its privacy procedures and your rights.

Purpose of Collection

AIA Australia collects personal information about you to:
a. process your application(s) for insurance cover; and
b. administer and manage your insurance cover under the policy including claims; and
c. facilitate AIA Australia's business operations.

If you do not wish to provide AIA Australia with all or part of the personal information it requests from you, AIA Australia may not be able to provide you with insurance cover or assess and manage your claim.

Access to Your Information

You are entitled at any time to request access to your personal information held by AIA Australia. All requests should be made in writing to:

The Group Administration Manager
PO Box 6111
St Kilda Road Central VIC 8008

You can ask AIA Australia to update your personal information at any time if it is inaccurate, incomplete or out of date. In some circumstances, AIA Australia may not permit access to your personal information. Circumstances where access may be denied include where access would be unlawful or denying access is authorised by law. In these cases, AIA Australia will provide you with written reasons for denial of access or a refusal to correct personal information.

Disclosure of Your Information

AIA Australia may disclose your personal information to:
a. the policy owner (including superannuation fund trustee or employer);
b. administrator of the policy;
c. another member of the AIA or AIG Group of companies (whether in Australia or overseas);
d. your adviser (if any);
e. AIA Group contractors and third party service providers, eg. medical practitioners and reinsurers;
f. your employer;
g. financial institutions you nominate; and
h. mail-houses and archive companies.

AIA Australia will only disclose your personal information to these parties for the primary purpose for which it was collected. In some circumstances, AIA Australia is entitled to disclose your personal information to third parties without your authorisation, such as law enforcement agencies or government authorities where disclosure is required by legislation, or to report illegal activities.

Any Questions or Concerns

If you have any questions or concerns about your personal information, please write to:

The Group Administration Manager
PO Box 6111
St Kilda Road Central VIC 8008

AIA Australia has established an internal dispute resolution process for handling customer complaints about company compliance with the National Privacy Principles. This dispute resolution mechanism is designed to be fair and timely to all parties and is free of charge.

If you have a complaint about AIA Australia's handling of your personal information, you should submit it in writing to the Group Administration Manager. You will receive a letter from AIA Australia within 5 working days which documents AIA Australia's complaints handling process. Your complaint will be referred to the Internal Dispute Resolution Committee at AIA Australia who will try to resolve your complaint within 45 days of receipt. Should your complaint not be resolved to your satisfaction by its internal dispute resolution process, you may take your complaint to the Privacy Commissioner. The Privacy Commissioner's contact details are:

Office of the Privacy Commissioner
PO Box 5218
Sydney NSW 2001

or call the Privacy Hotline on 1300 363 992.

For further information or to view AIA Australia's full privacy policy and procedures go to www.aia.com.au

Medical Attendant's Statement

Forming part of the Total and Permanent Disablement ROSS Claim Form

To be completed by the doctor or medical provider you have mainly consulted for this disability.
If there is a charge for completing this form, the payment is the responsibility of the patient.

Plan Name	Policy Owner	Master Policy No.	ROSS Employer No.
	CCSL Limited	MP7000	MP7

Patient's Name ______ Date of Birth / /

Patient's Address ______

Occupation ______

Patient's height ____ cm weight ____ kg Is your patient left or right handed? ☐ Left handed ☐ Right handed

Does your patient smoke? ☐ Yes ☐ No If '**Yes**', please state substance, quantity and how long they have smoked.

1. How long have you known this patient? Professionally ______ Personally ______

2. (a) Are you the patient's usual doctor? ☐ Yes ☐ No
If '**No**', please advise the name, address and telephone contact details of their usual doctor.

Name of usual doctor ______ Telephone ______

Address ______

(b) If the patient was referred to you, please advise name, address and contact number of referring doctor.

Name of referring doctor ______ Telephone ______

Address ______

3. (a) Please confirm whether the condition is an injury or sickness. ☐ Injury ☐ Sickness

(b) Please describe the nature and extent of the patient's condition, its probable cause (if known) and the level of disability.

(c) Is the injury/sickness consistent with the patient's description of cause? ☐ Yes ☐ No If '**No**', please provide details.

4. (a) (i) On what date did the condition first occur? Date / / Time ____ am/pm

(ii) **Please advise the date that total and permanent disablement commenced and caused the patient to become unfit for work.** / /

(iii) **Please attach a copy of your patient's clinical notes relevant to their condition, including medical evidence that supports your assessment date of total and permanent disability.**

(iv) Is the patient still receiving treatment? ☐ Yes ☐ No

(b) When were you first consulted for this condition? / /

(c) Please provide details of all subsequent consultations.

5. Are there any factors affecting or prolonging the condition? For example, does the patient have any contributing, concurrent or pre-existing conditions. ☐ Yes ☐ No If '**Yes**', please provide details.

6. If any tests or investigations have been performed (i.e. x-ray, CT Scans, MRI, blood tests, etc.) please provide results (or attach a copy of applicable reports if available).

7. (a) (i) What is the diagnosis and what are the objective clinical signs of the condition?

(ii) Date of diagnosis. / /

(b) What is your short term and long term prognosis?

(c) Please describe your patient's current symptoms.

(d) (i) Is your patient's illness considered terminal? ☐ Yes ☐ No

(ii) If '**Yes**', what is the patient's life expectancy?

(e) Has the patient suffered from this or a similar condition previously? ☐ Yes ☐ No If '**Yes**', please provide the following:

(i) date of previous injury/sickness / / (ii) period of disability

(iii) date of diagnosis / / (iv) prognosis

(f) Has the patient been referred to any other doctor/s, or medical provider/s, or rehabilitation provider/s or other health professionals for treatment or consultation? ☐ Yes ☐ No If '**Yes**', please state:

Date of referral	Name and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
/ /		Tel:
/ /		Tel:
/ /		Tel:

8. What is the current treatment plan (including names and dosages of any medication/s)?

9. (a) To the best of your knowledge is the patient following the treatment plan prescribed? ☐ Yes ☐ No If '**No**', please comment.

(b) Do you consider any other treatment plan necessary and/or beneficial for recovery and return to work in their usual capacity? ☐ Yes ☐ No If '**Yes**', please comment.

(c) Has the patient been involved in any other medical, surgical, rehabilitation or other treatment you have scheduled? ☐ Yes ☐ No
If '**Yes**', please provide full details.
If '**No**', would the patient benefit from such a program, including Occupational Rehabilitation, eg. graduated RTW program, studying, re-training, etc.?

10. Was the patient hospitalised? ☐ Yes ☐ No If '**Yes**', please provide details below (attach a separate sheet if required).

Date admitted	Date discharged	Hospital name/Address and telephone contact details	Condition/Procedure
/ /	/ /	Tel:	
/ /	/ /	Tel:	
/ /	/ /	Tel:	

11. Have you given any other certificates concerning the patient's disability? ☐ Yes ☐ No If '**Yes**', please provide details.

12. (a) To the best of your knowledge, what are the duties of the patient's usual occupation?

(b) Does your patient work ☐ Full-time ☐ Part-time ☐ Casual ☐ Contractor

(c) Please state the duties and/or responsibilities the patient is **unable** to perform of their usual occupation, including the reasons why they are **unable** to perform them.

Work duty **unable** to perform	Reason they are **unable** to perform this duty

(d) How long do you expect the patient to be **unable** to perform these duties? From / / to / /

(e) Is the patient **able** to perform any of their **usual** occupational duties? ☐ Yes ☐ No

If '**No**', please go to question 12(f)

If '**Yes**', please enter the date the patient returned to work (or will be able to return to work):............................ / /

Please provide full details including which duties the patient **can perform** and the number of hours per week these duties can be performed. (After detailing the duties below please go to question 13.)

Duties	No. of hours duties can be performed

(f) Will the patient be able to perform any work/duties within their education/training or experience in the future? ☐ Yes ☐ No

If '**Yes**', please give details below, including any **alternative** duties the patient is currently performing or will be able to perform in the future.

If '**No**', why do you think your patient is totally and permanently disabled?

ADDITIONAL INFORMATION

13. Please provide any additional information or comments you feel are relevant to this claim.

DECLARATION

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true, correct and complete.

I agree that AIA Australia may provide copies of this statement to any medical specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim.

I understand that AIA Australia may be required to submit a copy of my report to the patient for comment or to a mediator, solicitor, Superannuation Complaints Tribunal (SCT), court or to any other person necessary for determination of the claim.

I further understand that the patient may access a copy of my report from AIA Australia under Privacy Legislation.

Name *(please print)* Qualification(s)

Signature Date / /

Address Postcode

E-mail

Telephone Facsimile