# NRG Income Protection Claim Form

## INCOME PROTECTION CLAIMS

In order to alleviate any delay in the processing time of your claim, please ensure the following:

- The claim form is returned with all fields completed. Incomplete forms will be returned to obtain missing information. Please also provide a signed photocopy of your current driver's license or passport to verify your identification.
- It is essential that you provide us with the name and address of your Medical Practitioner(s) for the past 5 years, as requested in SECTION A – Claimants Statement.
- A wage report is to be provided from your employer detailing each weekly/fortnightly wage for the 12 months prior to the date of your total disablement, as requested in Section C – Employment.
- If your claim is for a psychiatric condition, we require a report from a psychiatrist supporting your claim.
- Medical certificates need to be original and must state the condition for which you are claiming.
- In relation to Workers Compensation/Compulsary Third Party claims, please provide an Acceptance/Decline letter and if liability has been accepted please provide copies of all benefits.
- If you are in receipt of Centrelink or any other benefits as a result of your condition, please provide copies of all benefits paid.

# NRG Income Protection Claim Form

**Please do not complete this form unless you have been or will be off work for at least 90 days.**

**Instructions**:

1. **Section A** is to be completed by you, the claimant.
2. **Section B** is to be completed by your treating doctor.
3. **Section C** is to be completed by your employer.
4. Please enclose original medical certificates. If your condtition is in anyway related to a psychological illness, we require a supporting medical report to be provided from your treating Psychiatrist/Psychologist.
5. Please provide a signed photocopy of your current drivers license or passport to verify your identification.
6. Mail completed form to: **Australian Income Protection Pty Ltd**
   PO Box R1196, Royal Exchange, NSW 1225.
7. If have any enquiries please call **Australian Income Protection™ Pty Ltd** on (02) 8252 7900 or 1300 559 362 (only from landline)

**IMPORTANT NOTICE**
Any fraud, misstatement or concealment by you in relation to any matter affecting this insurance in connection with making of any claim under it, will give us the rights provided for in the Insurance Contract Act, including where appropriate the right to reduce or refuse payment of any claim.

## Section A - Claimant's Section - To be completed by claimant

**All questions must be completed and claim form signed before claim will be processed. (Please print)**

| | | | | | |
|---|---|---|---|---|---|
| Title: | | First name(s): | | | |
| Last name: | | | | | |
| Address: | | | | | |
| Suburb | | State: | | Postcode: | |
| Phone: | ( ) | Mobile: | | | |
| Fax: | ( ) | | | | |
| Email: | | | | | |
| Date of birth: | / / | Gender: | Male □ | Female □ | |

## Employment details:

Employer:

Address:

Suburb: State: Postcode:

Work ph: ( ) Work fax: ( )

Email:

Length of employment: Years: Months:

Occupation:

Usual duties:

## Medical Information:

Is your condition: Injury: Yes □ No □

Sickness: Yes □ No □

Date of injury or first symptoms of sickness: / / Time occured: **am/pm**

Name and extent of injury/sickness:

If injured, please state what you were doing and how it happened:

Have you suffered from this injury/sickness before?: Yes □ No □

Date previous injury/sickness occured: / /

If Yes, please provide details:

Was surgery required?: Yes □ No □

If Yes, when was the surgery?: / /

Date you first sought medical attention for current condition: / /

## Name and address of your medical Practitioner(s) for the past 5 years:

**You must fully complete your medical practitioner's information below or your claim may be delayed up to 10 weeks while we obtain a full Medicare history report.**

Name:

Address:

Suburb: State: Postcode:

Ph: ( ) Fax: ( )

Date first attended: / / Date last consulted: / /

Years attended:

Name:

Address:

Suburb: State: Postcode:

Ph: ( ) Fax: ( )

Date first attended: / / Date last consulted: / /

Years attended:

**(If you have visited more than 2 medical practitioners over the last 5 years provide the information attached to this claim form.)**

## Additional Benefits Checklist: (please tick either Yes or No to each question)

**If you answer Yes to any of the below, please provide proof of claim / benefit. For example: provide acceptance letter, decline letter and copies of benefits paid.**

Have you or will you lodge a motor accident claim?: Yes □ No □

Was your injury/sickness work related?: Yes □ No □

If Yes, have you or are you going to lodge a claim for Workers Compensation?: Yes □ No □

Insurance Co for Workers Comp:

Are you receiving any additional benefits from your employer ?:

Sick leave: Yes □ No □

Annual/holiday leave: Yes □ No □

Long service leave: Yes □ No □

Other: Yes □ No □

Have you or will you lodge a claim with Centrelink?: Yes □ No □

Have you or will you lodge a claim for any sports insurance benefit?: Yes □ No □

Have you or will you lodge any other type of insurance claim?: Yes □ No □

If Yes, please provide details below:

Insurance company:

Policy number:

Contact details:

Type of policy:

# Australian Income Protection

## Authority

I hereby authorise any hospital, physician, employer, insurer, Health Insurance Commission or other person who have attended me to furnish to Australian Income Protection Pty Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Worker's Compensation claims or claims with any other insurer to be released to Australian Income Protection Pty Ltd. I agree that a photo stat or fax copy of this authorisation shall be considered as effective and valid as the original.

I also authorise Australian Income Protection to release any and all information to NRG Gladstone or its representatives in relation to my Income Protection claim.

## Declaration

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recovery there under or in respect of past or future claims shall be forfeited.

| | |
|---|---|
| Signature of Claimant: | |
| Name of Claimant: | |
| Date: | / / |

## Claim form check list:

- Have all sections been completed?
- Have you provided a signed photocopy of your current drivers license or passport?
- Have you supplied a list of all treating doctors over the last 5 years?
- Has your employer supplied a report showing a breakdown of weekly wages for the 12 months preceding the date of incapacity?

**Your claim will be delayed unless all sections are complete. Send the completed form to:**

Australian Income Protection Pty Ltd
Attn: Claims department
PO Box R1196, Royal Exchange, NSW 1225

# Section B - Doctor's Section - To be completed by the Doctor

**Please have this section completed by your regular treating doctor that you have seen for this condition.**

## Patients Details: (Please print)

Title: First name(s):

Last name:

Address:

Suburb: State: Postcode:

Age: Date of birth: / /

Is the claimant's condition: Injury: Yes □ No □

Sickness: Yes □ No □

Date of injury or onset of sickness: / /

Date you were first consulted: / /

Date diagnosed: / /

Date incapacity commenced: / /

Date claimant was first aware of symptoms: / /

Are you the claimant's usual doctor: Yes □ No □

If yes, how long have they been attending your practice: Years: Months:

Please list dates of all consultations in relation to the patient's condition:

| | | | |
|---|---|---|---|
| 1. / / | 2. / / | 3. / / | 4. / / |
| 5. / / | 6. / / | 7. / / | 8. / / |

## Injury/sickness details:

Please provide your diagnosis of their condition:

Please provide an outline of their symptoms:

In your opinion, what caused the current condition:

Please provide an outline of past treatment :

Please outline your recovery/treatment plan:

History:

| | |
|---|---|
| In your opinion, is the injury or sickness work related? : | Yes □ No □ |
| Estimated date of return to work on restricted duties: | / / |
| Estimated date of return to work on normal duties: | / / |
| Is the patient's current condition related to any previous injury/sickness? | Yes □ No □ |
| If so, did you treat the patient for the injury/sickness? | Yes □ No □ |
| Has the claimant been referred to a specialist for his/her problems?: | Yes □ No □ |

If Yes, could you please supply the contact details?

| | | | | | |
|---|---|---|---|---|---|
| Name: | | | | | |
| Address: | | | | | |
| Suburb: | | State: | | Postcode: | |
| Ph: | ( ) | Fax: | ( ) | | |

| | |
|---|---|
| In your opinion, does the patient require surgery for the condition?: | Yes □ No □ |
| If yes, has the patient already undertaken the surgery?: | Yes □ No □ |
| Date surgery was undertaken: | / / |

**Medication/Treatment:**

| | |
|---|---|
| Has the claimant been taking medication for their condition?: | Yes □ No □ |

If yes, please state the medication and the date prescribed:

| | | | |
|---|---|---|---|
| Date: | / / | Medication: | |
| Date: | / / | Medication: | |
| Date: | / / | Medication: | |
| Date: | / / | Medication: | |

| | |
|---|---|
| Have you advised the patient, that their condition no longer requires any treatment or ongoing medical supervision, including the use of any prescribed medication? | Yes □ No □ |
| If Yes, on what date was that advice given?: | / / |
| What is your prognosis? | |

## Doctor's Authority

**I,** Title: First name(s):

Last name:

**Of**, Practice:

In the state of: being a registered medical practitioner, have examined the above named patient and certify the following to be a true description of his/her condition:

And I further certify that the patient was totally disabled from following his/her usual duties:

From: / / To: / / (inclusive)

Signed:

Date: / /

Qualifications:

Address:

Suburb State: Postcode:

Phone: ( ) Fax: ( )

Email:

**Please note: Australian Income Protection is not liable for the costs associated in the completion of this section.**

# Section C - Employer's Section - To be completed by your Employer

## Employee details: (Please print)

Employee name:

Employee number:

Employed since: / /

Date of injury or onset of sickness: / /

Has been incapacitated since: / /

To the best of your knowledge, describe where and how the incapacity occurred:

Date employee is expected to resume duties: / /

| Employed type: | Full-time □ | Part-time □ | Casual □ | Contractor □ |
|---|---|---|---|---|
| Work status: | Employed □ | Terminated □ / / | Resigned □ / / | Ceased work □ / / |

If he/she is fit to return to work on alternative/restricted duties, we are:

Prepared to take employee back on alternative/restricted duties: Yes □ No □

## Job description:

Please advise the normal aspects of employee's role:

## Wage Report

**To calculate the weekly benefit, we require a wage report showing a weekly breakdown for the 12 months preceding the date of incapacity.**

12-month weekly wage report supplied: Yes □ No □

Has he/she salary sacrificed wages within those 12 months?: Yes □ No □

Average per week gross: $

During the period of incapacity he/she received:

| | | | | | | |
|---|---|---|---|---|---|---|
| $ | | Normal Pay | from | / / | to | / / |
| $ | | Sick Pay | from | / / | to | / / |
| $ | | Workers Compensation | from | / / | to | / / |
| $ | | Other | from | / / | to | / / |

If other, please specify:

**Workers Compensation Information**
This section MUST be completed even if the claim is not work related:

Are you self insured for Workers Compensation: Yes ☐ No ☐

Name of current Workers Compensation Insurer:

Policy number:

Is the employee's condition work related: Yes ☐ No ☐

Is the employee on a current Workers Compensation claim: Yes ☐ No ☐

If yes, does your company have an agreement to top-up the Workers Compensation benefits: Yes ☐ No ☐

**Company representative's details:**

Signature:

Title: First name(s):

Last name:

Position:

Company name:

Address:

Suburb State: Postcode:

Phone: ( ) Fax: ( )

Mobile:

Email:

Date: / /

**Employer check list:**

- Have all questions of Section C been completed?
- Have you supplied a wage report showing a weekly breakdown for the 12 months preceding the date of incapacity?
- Have you completed the Workers Compensation details?

## THIRD PARTY AUTHORITY (optional – complete only if required)

**If you require us to release or discuss information regarding your claim with another person, please complete and sign the following authority form and return it to our office with your fully completed claim form and any additional information required for the assessment of your claim.**

## To be completed by the claimant

Title: First name(s):

Last name:

**I hereby authorise:**

Title: First name(s):

Last name:

Address:

Suburb State: Postcode:

Phone: ( ) Mobile:

Fax: ( )

Email:

Date of birth: / /

Relationship to claimant:

**to liaise with Australian Income Protection in respect to my claim. If in future I no longer require the above mentioned person to act as a third party, I will notify Australian Income Protection in writing.**

Signature of Claimant:

Name of Claimant:

Date: / /