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

The way we handle your personal information

You agree that, by submitting this claim, the personal information you provide to Swann Insurance for the purposes of making this claim, may be collected, held, used and disclosed in the manner set out in the Swann Insurance Privacy Policy found at www.swanninsurance.com.au/privacy, including for the purposes of the determination and / or settlement of, this claim.

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Total and Permanent Disability Claim

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? / /

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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? (e.g. 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 (e.g. 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 (e.g. 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?	☐	☐	$	
Motor vehicle?	☐	☐	$	
Third party insurance?	☐	☐	$	
Social security?	☐	☐	$	
Unemployment benefits?	☐	☐	$	
Any other benefits or insurance?	☐	☐	$	

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

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

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 AMP Life and Swann Insurance (We). 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.

For more details on how We collect, store, use and disclose your personal information, please read our respective Privacy policies:

Swann Insurance:
www.swanninsurance.com.au/privacy or contact 1300 307 926 for a copy of the Swann Insurance Privacy Policy.

AMP Life: www.amp.com.au/privacy.

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 AMP Life of any relevant information regarding my claim, AMP Life 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

X

Date

/ /

Please return completed form to:

Swann Insurance
Locked Bag 3274
Melbourne, VIC 3001
Fax: 1300 657 370

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Total and Permanent Disability Claim Medical Report

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

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

Date / /

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 AMP Life and Swann Insurance. You should be aware that your report may be provided to your patient should access be requested or otherwise thought to be desirable by AMP Life and Swann Insurance 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
	/ /

Yours faithfully,

Swann Insurance
Locked Bag 3274
Melbourne, VIC 3001

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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
	/ /

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

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

If 'Yes', please provide 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.

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

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

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

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

Section D – Physician's details

Name (please print)

Qualifications	Speciality

Telephone	Facsimile	Provider number
( )	( )	

Practice name and address	Town/Suburb	State	Postcode

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

Signature	Date
X	/ /

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Authorities

Medical authority

I hereby authorise Medicare or any doctor, hospital, dentist or other person who has attended me, to release to AMP Life or Swann Insurance, 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

X

Date

/ /

Accountant authority

I hereby authorise my accountant/financial adviser to release to Swann Insurance or its representatives, all information which AMP Life 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

X

Date

/ /

Authority to release information

I (Name) Born on the day of 19

Residingat

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 AMP Life or Swann Insurance, 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 AMP Life or Swann Insurance. 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 AMP Life 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

X

Date

/ /

Please return completed form to:

Swann Insurance
Locked Bag 3274
Melbourne, VIC 3001
Fax: 1300 657 370

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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 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 ……