

Helpful tips when lodging a claim

Claimant – superannuation fund



AIA.COM.AU

Making a claim can be difficult, particularly when you also have to deal with stressful life events. That's why we try to make the process as easy as possible. AIA Australia is the insurer for your life insurance policy and will be processing your claim. To help you, we have provided some tips below.

What happens when you make a claim?

When you make a claim your fund will check your details and write to you. If your claim form is completed correctly, your fund will send it to us and we will start processing your claim. If your form is incomplete, or does not include all necessary information, your fund will contact you and wait until it has received the information before sending it to us.

Once we have your claim form we will go through it and make a decision about your claim. Sometimes we will need to request information from third party providers (e.g. your doctor, employer, workers' compensation) and this may slow the process down. We will not be able to process your claim until we have this information, but once we have it, we'll do so as quickly as possible.

How can you speed up your claim?

1. Give as much information as possible upfront

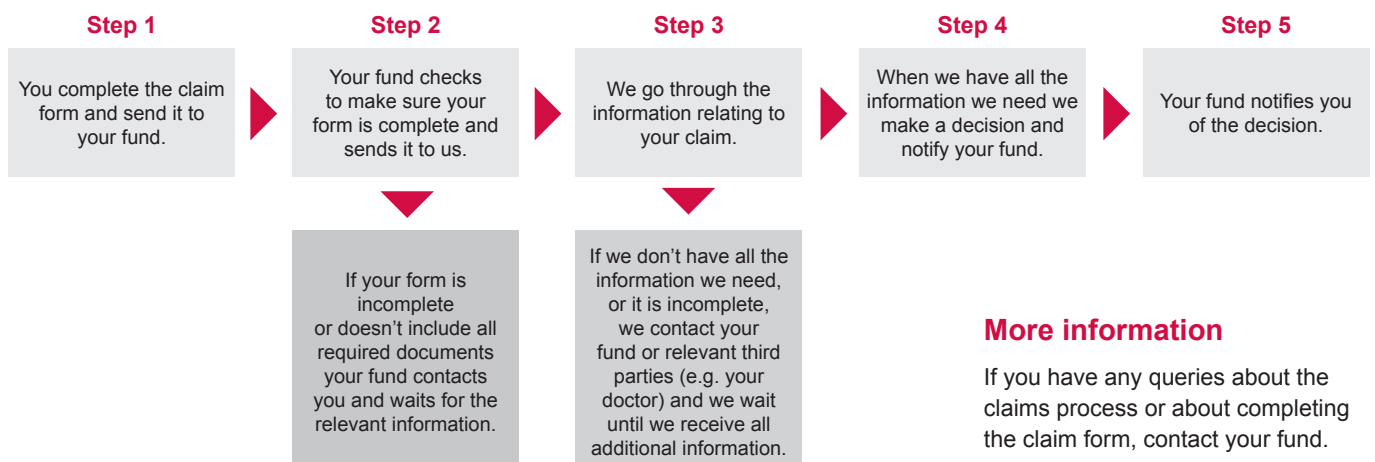
As we don't know about your circumstances, we need to ask for a lot of information to be able to make a decision about your claim. So it's important to provide as much information as possible upfront. Most delays happen when we don't get all the information we need. You can help speed up the process by providing all relevant information when you first complete your form.

2. Check the information you provide is correct and complete

Before sending in your form and any other documents, read through the form and check that all information is correct and that you haven't missed anything.

3. Follow-up promptly

If for any reason you are asked to provide further information, please respond quickly so we can process your claim.



Frequently asked questions about lodging a claim

Why do I have to provide information to support my claim?

We need this information to understand your circumstances and decide whether your claim is covered by the insurance policy.

How long will it take to assess my claim?

The time it takes to assess your claim varies as we assess each claim on its merits. It will depend on whether we have all the information we need upfront and whether we need to request additional information.

How can I speed up the process of assessing my claim?

You can speed up the process by providing as much information as you can upfront, ensuring that your form is fully complete, and following up with third parties (e.g. doctor and employer) to ensure they provide any information requested from them.

Why does the insurer need a Medical Attendant's Statement?

The Medical Attendant's Statement gives information about the diagnosis, treatment and current status of your condition. We use this information to assist us in assessing your claim.

Why does the insurer need an Employer Statement?

The Employer Statement helps us understand your work environment and the impact your condition has on your ability to perform your work.

What is a certified copy?

A 'certified copy' of a document such as your Driver's Licence or Passport means the document must be certified 'as a true copy of the original document'. The person who certifies must be either a:

- magistrate, or a CEO of a Commonwealth Court
- registrar or deputy registrar of a court
- JP or notary public
- police officer
- person in charge of a post office agency or an Australia Post employee of two or more years service
- Australian Consular or diplomatic officer
- officer of a financial institution or finance company of at least two years service
- officer of an AFSL holder, or an authorised representative of an AFSL holder, of at least two years continuous service
- CPA or chartered accountant of at least two years standing.

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The information contained in this document is for general reference and guidance purposes only. While AIA Australia has made all reasonable efforts to ensure the information is up-to-date and accurate, the information may be subject to change from time to time. The information should not be construed as advice of any type. AIA Australia treats and assesses all claims it receives on a case by case basis taking into account the individual circumstances applying to each particular claim. As such, AIA Australia reserves the right at all times to deviate from the standard processes and procedures described in this document if required.



Member Initial Claim Form

Salary Continuance Insurance/ Income Protection

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

Fund Name	Fund Member No.	Policy No.
<input type="text"/>	<input type="text"/>	MP

SECTION A – Personal Details

Member Name	<input type="text"/>	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Residential Address	<input type="text"/>		
		Postcode	<input type="text"/>
Telephone (home)	<input type="text"/>	(work)	<input type="text"/>
		(mobile)	<input type="text"/>
Your last physical day at work?	<input type="text"/> / <input type="text"/> / <input type="text"/>	E-mail (for correspondence)	<input type="text"/>

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
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>

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
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/> Tel: <input type="text"/>

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
<input type="text"/>	<input type="text"/> Tel: <input type="text"/>
<input type="text"/>	<input type="text"/> Tel: <input type="text"/>

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:	
		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. Name of Current or Last Employer

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift/Carry, 5 to 19 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift/Carry, under 5 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

Only complete questions 13 to 21 if you are SELF EMPLOYED

13. Are you a Sole trader Partnership Company Trust

14. What is the name of your business?

15. (a) If a partnership, what is your share of partnership (income and expenses) distribution? %

(b) How many partners are there?

16. How many employees does your business have?

SECTION E – Occupation Details (continued)

17. What are their work responsibilities?

18. Since you ceased all work, has your business continued to operate in any way? Yes No
 If 'Yes', please detail what activities have continued.

19. If your business has continued, what impact has your disability had on the business?

20. Who has been operating your business in your absence?

21. How long will your business continue to operate during your absence?

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 work? Yes – If 'Yes', please continue to question 3.
 No – If 'No', please continue to question 4.

3. (a) If you are working, when did you return to work and in what capacity (full-time, part-time or casual and paid or unpaid)?

Full-time / / Part-time / / Casual / / Paid Unpaid

(b) How many hours a week are you working?

(c) If you have returned to work with a different employer, please provide the following information:

Other employer name/s and contact details (if different to Section E, question 1)	Job title	Duties	Gross monthly income
			\$
			\$

4. If you have not returned to work, when do you think you will be able to return to work?

Full-time / / Part-time / / Casual / /

5. (a) If you are currently not working, have you applied for any jobs since ceasing work? Yes No
 If 'Yes', please provide details (including dates, employer and job title).

(b) If successful please provide details of your new employer, job title and your expected start date.

SECTION F – Level of Disability (continued)

6. What jobs do you think you may be able to do in the future?

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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 / /			

SECTION H – Activities and Restrictions

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

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(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?

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SECTION I – Financial Information

1. What was your total gross income for the last 12 months prior to disablement? \$

--

If you are an **Employee**, provide a breakdown of regular bonuses, overtime earnings etc.

If you are **Self Employed**, income is the gross income derived from your personal exertion after deducting your share of the business expenses.

--

During your period of disability, we may ask you to provide other documentation to support your claim including future Tax Returns and other financial evidence to confirm these figures.

2. If you are **Self Employed**, please provide a copy of your most recent Tax Return submitted to the Australian Taxation Office for the financial year **prior** to you becoming Totally Disabled.

SECTION J – Other Benefits

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

<p>.....</p> <p>.....</p>

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

<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Centrelink (Please ask Centrelink to provide you with an income statement/break-down of payment.)
<input type="checkbox"/> Common Law	<input type="checkbox"/> Another Insurer (eg. for another Income Protection policy)
<input type="checkbox"/> TAC	<input type="checkbox"/> Any other source. Please state: <input style="width: 150px;" type="text"/>

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

Type of claim	<input style="width: 95%;" type="text"/>	Claim/Ref No.	<input style="width: 95%;" type="text"/>
Insurer (if applicable)	<input style="width: 95%;" type="text"/>	Gross amount of claim	\$ <input style="width: 60px;" type="text"/> per week
Contact person	<input style="width: 95%;" type="text"/>		
Contact number	<input style="width: 95%;" type="text"/>		
Type of claim	<input style="width: 95%;" type="text"/>	Claim/Ref No.	<input style="width: 95%;" type="text"/>
Insurer (if applicable)	<input style="width: 95%;" type="text"/>	Gross amount of claim	\$ <input style="width: 60px;" type="text"/> per week
Contact person	<input style="width: 95%;" type="text"/>		
Contact number	<input style="width: 95%;" type="text"/>		

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

<p>.....</p> <p>.....</p>

SECTION K – 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 Fund Name and Fund Member Number 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 L – 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 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)

Member'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 (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 Salary Continuance Insurance/
Income Protection Member Initial 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.

Fund Name Fund Member No.

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 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 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?

months

(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
/ /	/ /		
/ /	/ /		
/ /	/ /		

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) Is the patient **currently performing** any **alternative** duties? Yes No If 'No', please go to question 12(g)

If 'Yes', please state: From to

Please provide full details including which duties the patient is **currently performing** and the number of hours per week these duties can be performed.

Duties	No. of hours duties can be performed

(g) If still **unable** to work, when do you expect that your patient will be:

(i) **able** to perform **some** of the duties of their **usual** occupation?

(ii) **able** to perform **all** of the duties of their **usual** occupation?

(h) Will the patient be able to perform any work/duties within their education/training or experience in the future? Yes No
Please give details.

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, Complaints Resolution Tribunal, 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 Government Privacy Legislation.

Name (please print) Qualification(s)

Signature Date

Address Postcode

E-mail

Telephone Facsimile