

**THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE SUBMITTING THE CLAIM**  
 IF INSUFFICIENT SPACE IS PROVIDED ON THIS FORM, PLEASE ATTACH YOUR ANSWERS ON A SEPARATE SHEET

This claim is made for:

**Total and Permanent Disablement Claim (TPD)**

**Group Salary Continuance Claim (GSC)**

or

**Both TPD & GSC**

Title	Given Name		
-------	------------	--	--

Surname	Date of Birth	DD/MM/YY	
---------	---------------	----------	--

Address	Unit No.	Street No.	Street Name.
---------	----------	------------	--------------

Suburb	State	Postcode
--------	-------	----------

*(We do not accept PO Box)*

Phone No.	Home	Mobile	Fax
-----------	------	--------	-----

Email Address
---------------

Policy Number	Policy Name
---------------	-------------

Current Employer's Name	Phone No.
-------------------------	-----------

**Current Employer's Address:**

Address	Unit No.	Street No.	Street Name.
---------	----------	------------	--------------

Suburb	State	Postcode
--------	-------	----------

Date commenced employment

**DO YOU REQUIRE AN INTERPRETER FOR MEDICAL APPOINTMENTS?**

If so, please advise your usual language:

**A. THIS SECTION TO BE COMPLETED FOR ACCIDENT CLAIMS ONLY**

IF INSUFFICIENT SPACE IS PROVIDED ON THIS FORM, PLEASE ATTACH YOUR ANSWERS ON A SEPARATE SHEET

1. Date and time of accident/injury
2. Where did the accident/injury happen?
3. How did the accident/injury happen?
4. Details of any witnesses
5. Nature of the accident/injuries suffered
6. Are you right or left handed

**B. THIS SECTION TO BE COMPLETED FOR ILLNESS CLAIMS ONLY**

IF INSUFFICIENT SPACE IS PROVIDED ON THIS FORM, PLEASE ATTACH YOUR ANSWERS ON A SEPARATE SHEET

- 1. The nature of the illness
- 2. Date the symptoms began
- 3. If a limb has been affected, advise whether right or left
- 4. Are you right or left handed?
- 5. Date treatment first sought
- 6. Details of current treatment

**C. THIS SECTION TO BE COMPLETED FOR ALL CLAIMS**

IF INSUFFICIENT SPACE IS PROVIDED ON THIS FORM, PLEASE ATTACH YOUR ANSWERS ON A SEPARATE SHEET

- 1. Date you ceased work due to the illness or accident/injury   
 If the date ceased work is more than six (6) months ago, please give detailed reasons for late submission of this claim

- 2. Are you currently completely unable to work?

Yes  go to **question 3**

No  please provide:

- (a) the first date you returned to full-time or normal duties
- (b) the date you returned to any partial or restricted duties
- (c) the duties of your job that you are **unable** to perform
- (d) how many hours are you working per day or per week performing the above duties Please provide a copy of your pay slips for details of income earned

- 3. At the time you ceased work because of the illness or accident/injury

- (a) What was your occupation
- (b) How long had you been in that employment or business?
- (c) Were you working full- time or part time?  
Please specify no of hours worked per week

- 4. Have you received any income from your employer or made any drawings from your business since ceasing work as a result of your disability?

Yes  please advise Amount \$  per week/per month

No

- 5. Has the disability caused you a loss of income?

Yes

No

- (a) If Yes, what is the amount of loss per month?
- (b) If No, why has there been no loss

6. Have you applied for any jobs since ceasing work?

- Yes
- No

If Yes, please provide details


7. Please advise the following details:

- (a) Your education level (i.e. secondary, tertiary etc)
- (b) Any trade apprenticeship, licensing certificates, or qualifications held or currently being studied
- (c) Any other training or skills acquired


8. Please advise the following details in relation to the illness/injury

- (a) All general practitioners consulted

	Dr's Name e.g Dr Thomas	Dr's Name	Dr's Name
<b>Address &amp; Ph no</b>			
<b>Date first seen</b>	1/1/2000		
<b>Frequency of attendance</b>	every week		
<b>Date last seen</b>	1/12/2002		

- (b) Name and address of your usual general practitioner

--

- (c) Name of all specialists consulted

	Dr's Name	Dr's Name	Dr's Name
<b>Address &amp; Ph no</b>			
<b>Specialty</b>			
<b>Date first seen</b>			
<b>Frequency of attendance</b>			
<b>Date last seen</b>			

- (d) Were you referred to any of the above specialists by Workers Compensation/other Insurer?

- Yes
- No

If yes, which specialist(s)?


e) Any other health professional (e.g. physiotherapist, chiropractor)

	Name	Name	Name
Address & Ph no			
Specialty			
Date first seen			
Frequency of attendance			
Date last seen			

(f) Any hospital admission

Yes

No

If yes,  
Name of Hospital

Date of Admission

Date of Discharge

*Please attach a copy of the hospital discharge*

9. Have you previously suffered from the same or similar complaint?

Yes

No

If Yes,

a) Date of episode/s

b) Name & Address of doctor/s consulted

  


c) Details of any hospital treatment

d) Details of any time off work

10. Do you have any insurance Policy including those that provide similar benefits? If yes, please provide

Name of the Company	Ph no & Contact person	Address

11. Can compensation for this illness/injury be claimed under any of the following?

Yes

No

	Yes	No
a) Workers Compensation	<input type="checkbox"/>	<input type="checkbox"/>
b) Third Party Compensation	<input type="checkbox"/>	<input type="checkbox"/>
c) Another Superannuation Fund	<input type="checkbox"/>	<input type="checkbox"/>
d) Transport/Motor Accident Board Payments	<input type="checkbox"/>	<input type="checkbox"/>

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| e) Centrelink payments e.g sickness or unemployment benefits | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Dept of Veterans Affairs                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| g) other   | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above:

Name & Address of organisation/company	<input style="width: 100%;" type="text"/>
Contact name and phone number	<input style="width: 100%;" type="text"/>
Policy number	<input style="width: 100%;" type="text"/>
Claim number	<input style="width: 100%;" type="text"/>
If the claim has been accepted, from what date	<input style="width: 100%; text-align: center;" type="text" value="DD/MM/YY"/>
Amount of benefit entitled/receivable	<input style="width: 100%;" type="text"/>

12. Have you ever received, or been declined benefits under any disability policy or Workers Compensation?

Yes

No

If yes, please provide:

Nature of illness/injury	<input style="width: 100%;" type="text"/>
Date/s involved	<input style="width: 100%;" type="text"/>
Name of organisation/company	<input style="width: 100%;" type="text"/>

**D THIS SECTION TO BE COMPLETED FOR TPD CLAIM ONLY**

**a) Employment history**

Please list all of the positions you've held in the past


Please complete the following sections for each position you have held including your part-time work. If insufficient space has been provided, please attach answers on a separate sheet. If there are any periods of time of greater than 1 month in which you were not in employment, please also specify each of these and the reason.

Employment period from:  to

Name of Employer

Self-employed:

Yes

No

Position title:

Industry worked in:

No of Hours worked:  hours/week

Detailed description of duties performed:


**b) Employment *prior to disability***

Please complete the following sections in relation to the position held **prior to disability**. If insufficient space has been provided, please attach additional information. If there are any periods of time of greater than 1 month in which you were not in employment, please also specify each of these and the reason.

Employment period from:  to

Name of Employer

Self-employed:

Yes

No

Position title:

Industry worked in:

Hours worked:  hours/week

Detailed description of duties performed. For each duty, please advise the percentage of time spent performing each duty.


Did you supervise any staff?

Yes

No

If yes, how many people did you supervise?

**c) Work activities of position prior to disability**

Please advise the time spent performing the following tasks in your position prior to disability

Time spent walking  %

Time spent sitting  %

Time spent lifting  %

Time spent standing  %

Other  %

Please specify nature of other

Please advise the time spent performing the following tasks in your position prior to disability

Manual duties

	%
--	---

Supervisory duties

	%
--	---

If required to lift, please list typical weights required to lift and frequency

--

Please list any tools or special equipment you were required to use and frequency of use.

--

Please provide any additional information that you believe would assist us in the assessment of your claim


I hereby declare that I am the person referred to in the above, and the answers are complete and true in every particular.

SIGNATURE	<input type="text" value="X"/>	DATE	<input type="text" value="DD/MM/YY"/>
NAME (Please Print):	<input type="text"/>		

Personal and sensitive information is collected from you to enable TOWER to provide the product or service you request. Without this information, TOWER cannot provide this product or service. Your personal information may be disclosed to TOWER and any relevant bodies corporate including the following 3rd parties, where necessary: your employer; health professionals; your (or your employer's Adviser or Financial Planner (if applicable); other companies within the TOWER Group; organisations to whom we outsource our mailing, administration and information technologies; the Insurance Reference Service; investigators; the Trustee (if applicable); the administrator of the product or fund; reinsurers; government regulatory bodies; lawyers; accountants (if applicable). By signing this form you consent to TOWER and these organisations collecting and disclosing your personal and sensitive information. In accordance with Privacy legislation, you can also obtain access to your information.

SIGNATURE	<input type="text" value="X"/>	DATE	<input type="text" value="DD/MM/YY"/>
NAME (Please Print):	<input type="text"/>		

I hereby authorise and direct any Medical Attendant, Hospital, or Insurance Company to divulge to TOWER Australia Limited, and the trustee of the Superannuation Fund (where applicable) or any legal tribunal any information which they hold or are able to acquire about myself.

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

SIGNATURE	<input type="text" value="X"/>	DATE	<input type="text" value="DD/MM/YY"/>
NAME (Please Print):	<input type="text"/>		

