TOWER

TelstraSuper

MEMBER'S CLAIM STATEMENT-GROUP FUND

TOWER Australia Limited ABN 70 050 109 450
80 Alfred Street, Milsons Point NSW 2061
PO Box 142, Milsons Point NSW 1565

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) ☐

Income Protection Claim (GSC) ☐

or

Both TPD & GSC ☐

Please address correspondence to:
Telstra Super Insured Benefits Group
PO Box 14309 Melbourne VIC 8001

Title	Given Name

Surname	Date of Birth / /

Address	Unit No.	Street No.	Street Name.

Suburb	State	Postcode

(We do not accept PO Box)

Phone No.	Home	Mobile	Fax

Email Address

Telstra Super Member 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

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

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B. THIS SECTION TO BE COMPLETED FOR ILLNESS CLAIMS ONLY

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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?

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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
Address & Phone Number			
Date first seen	1/1/2000		
Frequency of attendance	every week		
Date last seen	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
Address & Phone Number			
Specialty			
Date first seen			
Frequency of attendance			
Date last seen			

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

Yes ☐

No ☐

If yes, which specialist(s)?

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

	Name	Name	Name
Address & Phone Number			
Speciality			
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	Phone Numbers & Contact person	Address

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

Yes ☐

No ☐

	Yes	No
a) Workers Compensation	☐	☐
b) Third Party Compensation	☐	☐
c) Another Superannuation Fund	☐	☐
d) Transport/Motor Accident Board Payments	☐	☐

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	Yes	No
e) Centrelink payments e.g sickness or unemployment benefits	☐	☐
f) Dept of Veterans Affairs	☐	☐
g) other	☐	☐

If yes to any of the above:
Name & Address of organisation/company

Contact name and phone number

Policy number

Claim number

If the claim has been accepted, from what date / /

Amount of benefit entitled/receivable

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

Date(s) involved

Name of organisation/company

D. THIS SECTION TO BE COMPLETED FOR ALL CLAIMS

1.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 ☐

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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:

No of 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

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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

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

Signature ✗ Date / /

Name (Please Print):

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 ✗ Date / /

Name (Please Print):

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 ✗ Date / /

Name (Please Print):

Please address correspondence to:
Telstra Super Insured Benefits Group
PO Box 14309 Melbourne VIC 8001