TOWER

INITIAL DISABILITY CLAIM FORM

GUIDE TO COMPLETION OF INITIAL DISABILITY CLAIM FORM

- This form is for completion by the person who is sick or injured and who is making the claim.
- Please ensure that you fully and accurately answer all questions - this will avoid any undue delays.
- In this form you must tell us about all work that you do, whether the work you do is paid or unpaid, part-time or full-time.
- This form contains a number of authorities which we require you to complete so that we can collect information necessary to assess your claim
- With this form you will also receive a separate medical form which is for your treating doctor to complete – please note that if the treating doctor charges for completing the medical form this charge is your responsibility.
- If you have any questions about completing this form or about the assessment of your claim please contact us on TOWER's toll free telephone number 1800 226 364.

Policy Number ______________________________

1. Surname of Person Claiming ______________________ First Name ______________________
2. Date of Birth ______________
3. Occupation Immediately prior to the injury/illness______________________________
4. Current Residential Address (not post office box) ______________________________

   ______________________________ State ________ Postcode ________
5. Phone numbers (H) ______________ (W) ______________ (M) ______________

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PLEASE INDICATE HERE THE WORK THAT YOU ACTUALLY DO IN YOUR OCCUPATION

My job involves the following amount of manual labour (please tick)		I usually undertake the following duties, which I perform for the indicated percentage of my working hours.
Nil	( )	Duty ____________ for ______ % of working time
0 -10%	( )	Duty ____________ for ______ % of working time
10% - 20%	( )	Duty ____________ for ______ % of working time
20% - 30%	( )	Duty ____________ for ______ % of working time
30% - 40%	( )	Duty ____________ for ______ % of working time
40% - 50%	( )	Duty ____________ for ______ % of working time
50% - 60%	( )	Duty ____________ for ______ % of working time
60% - 70%	( )	Duty ____________ for ______ % of working time
70% or more	( )	Duty ____________ for ______ % of working time

6. For how long have you been undertaking the duties listed above? ____________

7. How many hours a week do you spend performing these duties? ____________

8. If not self employed, who is your employer? ____________

   Please provide employer's address and telephone number: ____________

   ____

9. What is the sickness or injury for which you are claiming benefits? ____________

   ____

10. On what date did you first have the symptoms of the sickness or injury? ____________

11. When did you first attend a doctor for the sickness or injury? ____________

12. Have you had this, or a similar sickness or injury, before? Yes ☐ No ☐

    If you have, please tell us the date and the circumstances Date ____________

    ____

13. What is the name, address and telephone number of the first doctor you saw for this sickness or injury?

    Name ____________

    Address ____________

    ____________Postcode ________ Telephone No: ____________

    How long have you known this doctor:____________ If less than 12 months, please provide the name and address of your previous doctor ____________

    ____

PLEASE COMPLETE THIS SECTION
IF, AS A RESULT OF SICKNESS OR INJURY, YOU HAD TO
STOP WORKING COMPLETELY.

14. On what date did you completely stop all paid work? ______________________

15. Do you do any unpaid work? Yes ☐ No ☐

16. Have you returned to work since the above date? Yes No If so, on what date? ________

17. On your return to work did you return to work on a full time or a part time basis? ________

18. What was the total length of time you were completely unable to work because of sickness or injury?
____

19. If you have not returned to work yet, what currently prevents you from doing so? ________
____

20. If you have not returned to work yet when do you expect to be able to return to work:
On a full-time basis ____________ On a part-time basis ____________

PLEASE COMPLETE THIS SECTION
IF, AS A RESULT OF SICKNESS OR INJURY, YOU HAD TO PARTIALLY STOP WORKING

21. On what date did you commence working in a partial capacity? ______________________

22. Has there been a reduction in your working hours? Yes ☐ No ☐ If Yes, how many hours a week have you been able to work during the period you were partially disabled ? ________

23. Has there been a reduction in the duties that you are able to perform? Yes ☐ No ☐
If Yes, please tell us which duties you have been unable to perform or have not been able to perform to your usual level. ______________________
____

24. Have you now fully returned to work? Yes ☐ No ☐ If Yes, on what date?________

25. If you have fully returned to work what was the total length of time you were only able to work in a partial capacity? ______________________

26. If you have not fully returned to work yet, when do you expect to be able to? ________

PLEASE COMPLETE THIS SECTION
IF YOU WERE HOSPITALISED FOR THIS SICKNESS OR INJURY

26. Which hospital were you admitted to? ______________________

27. On what date were you admitted to hospital? ____________

28. On what date did you leave hospital? ____________

29. If you had to have an operation, what type operation was it? ______________________

30. On what date did the operation occur? ____________

31. Who was the doctor who ordered or performed the operation: ______________________

32. If you were injured as the result of an accident, please tell us how the accident happened?

____

____

33. At what location did the accident happen? ______________________________

____

34. Are you currently receiving any medical treatment? Yes ☐ No ☐

35. What medical treatment are you receiving? ______________________________

36. What medication, if any, are you currently taking? ______________________________

37. What is the name, address and telephone number of the doctor from whom you are currently receiving medical treatment? Name ______________________________

Address ______________________________

______________________________Postcode ________ Telephone ________________

HAVE YOU LOST INCOME DURING THE PERIOD OF YOUR DISABILITY? PLEASE PROVIDE DETAILS

38. What was your average monthly income (net of business expenses but before tax) in the twelve months before your disability commenced? $________________ per month

39. To what amount has your monthly income reduced (net of business expenses but before taxation) during your period of disability? $ ________________ per month
(Please note that we may require verification of how you arrived at this amount)

40. What was your annual income (net of business expenses but before taxation) in the last financial year ended 30 June? $____________________

41. Do you have any other source of income? If so, please provide details. ____________________

____

ARE YOU SELF EMPLOYED? PLEASE COMPLETE BY TICKING APPROPRIATE ANSWER

42. Are you a sole trader? ☐ In a partnership? ☐ Trading as a company? ☐

43. Is your business continuing in your absence? Yes ☐ No ☐

44. If so, who is running the business and on what basis? (eg. Manager for wages) ________________

____

____

45. Have you made, or do you intend to make, a disability claim with any of the following? If so please tick the appropriate answer and provide details.

	Yes	No	
Any insurer	☐	☐	Name of company: ______________________
Social Security	☐	☐	Branch: ______________________
Workers Compensation	☐	☐	Organisation: ______________________
Common Law Claim	☐	☐	Details: ______________________
Any other organisation	☐	☐	Details: ______________________

What is the monthly benefit you have received, or are entitled to, from the above? $ ____________

Medical Authority

I, ______________________________ (full name) hereby authorise any doctor, hospital, therapist or other medical professional who has attended me, to release to TOWER Australia Limited, or its representatives, all information with respect to any sickness or injury, medical history, consultations, medications or treatment, received by me, together with copies of any and all medical records.

I consent to TOWER Australia Limited collecting this sensitive information. A copy of this authority is to be regarded as if it were the original signed authority.

Signed ______________________________ Dated ____________________

Authority to Health Insurance Commission

I, ______________________________ (full name), hereby authorise and request the Health Insurance Commission to provide direct to my insurer, TOWER Australia Limited,

I acknowledge and understand that in providing this authority TOWER Australia Limited will be provided my complete Medicare history, parts of which may not be relevant to my claim.

My Medicare number is: ______________________________

Signed ______________________________ Dated ____________________

Information Authority

I, ______________________________ hereby authorise any insurer, employer, accountant or other relevant holder of information, to release to TOWER Australia Limited, or its representatives, information which TOWER Australia Limited requires for the purpose of assessing my claim for benefits. A copy of this authority is to be regarded as if it were the original signed authority.

Signed ______________________________ Dated ____________________

Declaration

I hereby declare that the information provided 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 TOWER Australia Limited of any material information regarding my claim, TOWER Australia Limited may refuse to pay and cancel my claim.

Signed ______________________________ Dated ____________________

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: health professionals; your (or your employer's if relevant) Adviser or Financial Planner; 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 relevant); the administrator of the product or fund; reinsurers; government regulatory bodies; lawyers; accountants. By signing this form you consent to TOWER and these organisations collecting your personal and sensitive information. In accordance with Privacy legislation, you can also obtain access to your information

Signed ______________________________ Dated ____________________

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