



TOTAL PERMANENT DISABLEMENT CLAIM FORM

TOWER Australia Limited ABN 70 050 109 450
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Disabled Employee's Name

Disabled Employee's Address

Policy Name Policy Number

QUESTIONS TO BE ANSWERED BY THE DISABLED EMPLOYEE

If the disabled employee is incapable of completing this form, it may be completed by another on the disabled employee's behalf. Incomplete answers or omissions may delay settlement. If insufficient space is provided, please attach a separate sheet.

A. SECTION TO BE COMPLETED FOR ACCIDENT CLAIMS ONLY

1. Time and date of accident am/pm/...../.....

2. Where did the accident happen?

3. State exactly how the accident happened

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4. State the nature of injuries suffered.

If a limb was involved, state whether left or right

B. SECTION TO BE COMPLETED FOR SICKNESS CLAIMS ONLY

1. What is the nature of the sickness?

If a limb was involved, state whether left or right

2. When did the symptoms become apparent?

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C. SECTION TO BE COMPLETED FOR ALL CLAIMS

1. Date the sickness or injury caused you to cease work **entirely**/...../.....

2. Have you been able to do any part of your work, supervisory or otherwise, since the above date?
If so, provide date and extent of work performed
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3. Are you still completely unable to work?

4. If you are still disabled, when do you expect to resume work?

5. If no longer disabled, on what date did you resume:
full time usual duties/...../.....
partial or restricted duties/...../.....

6. (a) Describe your usual occupational duties
(b) Do you perform any occupational duties which result in the receipt of income from any source other than your primary source of income?
(c) If the answer to 6(b) is Yes, give details

7. What level of education to you have (secondary, tertiary, etc.)? What other trade apprenticeship, qualifications or skills do you have?
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8. Please list all jobs you have had and occupational duties with both your present and past employers and indicate years spent on each job.
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9. Were you following your occupation on a full time basis immediately prior to the disability occurring?

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10. Have you received any income from your employer, business or occupation since ceasing work as a result of your disability? If yes, provide details

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11. Has the disability caused you a loss of income?

(a) if yes, what is the monthly amount of loss?

(b) if no, why has there been no loss?

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DOCTOR FIRST SEEN ON

12. State the names and addresses of **all doctors consulted** by you for this disability, including any to whom you were referred for further opinion or investigations and the **date of the first attendance** with each one

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Also provide names of physiotherapists, chiropractors, etc. consulted

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13. Have you ever in the past suffered from the same or similar complaint? If so,
- (a) approximate date of the episode(s)
- (b) name of attending doctor(s) at that time

14. Name and address of your usual Medical Attendant

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15. Can compensation (by way of regular payment, or lump sum settlement) be claimed for this disability from:
- (a) Workers' Compensation?
- (b) Third Party Compensation?
- (c) Motor Accident Board payments?
- (d) Social Security payments (sickness or unemployment benefits)
- (e) Any other insurance policy

If yes to any of the above, please state the:

- (i) Name of Organisation or Company
- (ii) Policy No. and Claim No.
- (iii) Amount of monthly compensation

16. Have you ever received, or been declined benefit under any disability policy or Workers Compensation? If so, provide full details

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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.

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

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

SIGNATURE DATED...../...../