

Macquarie Life

Blood Borne Disease: Claimant's Statement



Filling in this statement

Please complete all sections, use black ink and mark boxes like this with an X.

- 1 May we disclose information included in this claim form to your adviser?
No
Yes

2 Claimant's details

Policy number(s)

Mr Mrs Miss Ms Dr Other

First given name

Other given name(s)

Surname

Date of birth

Occupation

Email address

3 Postal address

Suburb/Town

State

Postcode

- 4 Residential address (if different to postal address)
Street number and name

Suburb/Town

State

Postcode

- 5 What is the cause of your Blood Borne Disease?

- 6 How and when did the incident occur?

- 7 Has this incident been officially reported to the appropriate authorities?

No *Go to next question*

Yes *Provide details below*

- 8 Did you undergo a HIV/Hepatitis test within 24 hours of the incident?

No *Go to 10*

Yes *Go to next question*

- 9 Was this test negative or positive?

Negative

Positive

Provide copies of these tests.

Go to 12

- 10 Why did you not undergo a HIV/Hepatitis test within 24 hours of the incident?

- 11 When were the first HIV/Hepatitis tests done?

12 Were antiretrovirals prescribed and/or taken within the first 24 hours of the incident?

No Go to next question

Yes Provide details below

13 Have you previously undergone a Hepatitis vaccination prior to this incident?

No Go to next question

Yes Provide the date this was completed below

14 What treatment have you had and for how long have you had this treatment?

15 Are you claiming, intending to claim or have you submitted a claim for Blood Borne Disease from any other insurance or workers compensation company?

No Go to next question

Yes Provide details of the company/ies below

16 Give the name and contact details of the doctor who is currently treating you.

Current treating doctor

Initials Surname

Practice name and address

Phone number

17 Give the name and contact details of any doctor that you have consulted in the past 5 years.

Doctor 1

Initials Surname

Practice name and address

Reason

Phone number

Initial date consulted

Last date consulted

Doctor 2

Initials Surname

Practice name and address

Reason

Phone number

Initial date consulted

Last date consulted

Doctor 3

Initials Surname

Practice name and address

Reason

Phone number

Initial date consulted

Last date consulted

17 continued

Doctor 4

Initials Surname

Practice name and address

Reason

Phone number
 ()

Initial date consulted Last date consulted
 / / /

Doctor 5

Initials Surname

Practice name and address

Reason

Phone number
 ()

Initial date consulted Last date consulted
 / / /

18 Are you a member of a private health fund?

No *Go to next question*

Yes Provide the name of the private health fund below

19 What is the occupation you have last been involved in prior to this claim?

20 Are you still working?

No *Go to next question*

Yes **Go to 22**

21 What was your last day at work?

 / /

22 What percentage amount of time is spent in each of the following areas?

Administration—% of time

Supervision—% of time

Manual—% of time

Travel—% of time

Total duties (must add up to 100%) %

23 Provide a description of the key areas of skill relating to your occupation and percentage of time spent with each key area of skill.

Key areas of skill	Percentage

24 How long have you been in your current occupation?

25 What is your highest educational qualification?

- Less than year 12
- Year 12 or equivalent/IB Diploma
- Tertiary degree
- Professional
- Trade qualified
- Other Provide details below

29 Blood Borne Disease claim declaration

I

the claimant:

- now wish to claim to the Blood Borne Disease benefits of the Macquarie Life Limited policy; and
- declare that my answers to the claims questions on pages 1-5 of this form and the statements and representations I make on pages 1-5 [and otherwise in my discussions with Macquarie on the phone] are complete and true to the best of my knowledge and belief, and that I have not withheld any relevant information from Macquarie Life Limited ("**Macquarie**");
- authorise any medical practitioner, hospital or any other person to furnish Macquarie, or any of its representatives, any details relating to illness or injury of the insured person(s) or such other information as may be necessary to consider this claim;
- authorise Macquarie to disclose my personal information (which may include sensitive or health information) to the following parties:
 - Any physician, hospital or any other healthcare provider who has attended or examined me in order for them to supply Macquarie with full particulars of my medical history including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.
 - Any claims assessor, investigator, medical professional, healthcare provider, insurance reference service, credit reference service, legal or accounting firm, auditor, employer, consultant or reinsurer for the purposes of producing a report concerning my claim.
 - Any benefit provider such as other insurers or Government departments (including for the purposes of Workers Compensation, other insurers, Centrelink or similar benefit providers) that provides benefits in the event of my sickness and/or injury.
 - And I further consent to those parties collecting information about me and releasing to Macquarie their report, including any information they may hold about me as relates to Macquarie's administration of the policy, including this claim.

29 continued

I acknowledge and agree that:

- any written statements (including affidavits) of all the doctors or other physicians who attended or treated me and all other papers submitted in support of this claim, form part of this claim;
- the supply to me of this form or any other forms related to my claim does not constitute an admission of my claim by Macquarie;
- any benefits payable in respect of this claim shall be forfeited if I, or anyone acting on my behalf or with my knowledge and consent, have knowingly withheld any relevant information or submitted any false information in respect of the claim;
- upon payment by Macquarie of the benefits hereby claimed, Macquarie is wholly discharged from all liability in respect of such benefits.

Claimant's name

Claimant's signature (Please sign in black ink)


Date signed

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Macquarie Life

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