

# Macquarie Life

## Disability Income: 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

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** Do you have a Business Expenses benefit with Macquarie Life?  
No   
Yes

- 6** Do you want to claim from this benefit as well?  
No   
Yes

- 7** What is the nature of your injury or sickness causing your disability income claim?

- 8** When did you first notice your symptoms?

- 9** When did you first consult the doctor who diagnosed your condition?

- 10** Have you been hospitalised?

No  *Go to next question*

Yes  Provide details below, including the name and address of the hospital and admission and discharge dates

- 11** Are you confined to a bed or wheelchair?

No  *Go to next question*

Yes  Which?

Bed

Wheelchair

- 12** What treatment have you received?

Please provide details

- 13** Has this condition ever resulted in you being off work before?

No

Yes

**14** Are you expecting to receive further treatment?

No  Go to next question

Yes  Provide details below


**15** Give the name and contact details of the doctor or treatment providers who are currently treating you.

**Current treating doctor or treatment provider 1**

Initials Surname

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Practice name and address


Phone number

( )
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**Current treating doctor or treatment provider 2**

Initials Surname

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Practice name and address


Phone number

( )
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**Current treating doctor or treatment provider 3**

Initials Surname

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Practice name and address


Phone number

( )
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**Current treating doctor or treatment provider 4**

Initials Surname

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Practice name and address


Phone number

( )
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**16** Give the name and contact details of any other doctors or treatment providers you may have consulted with regards to this condition.

**Doctor or treatment provider 1**

Initials Surname

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Practice name and address


Reason


Phone number

( )
-----

Initial date consulted

	/		/	
--	---	--	---	--

Last date consulted

	/		/	
--	---	--	---	--

**Doctor or treatment provider 2**

Initials Surname

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Practice name and address


Reason


Phone number

( )
-----

Initial date consulted

	/		/	
--	---	--	---	--

Last date consulted

	/		/	
--	---	--	---	--

**Doctor or treatment provider 3**

Initials Surname

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Practice name and address


Reason


Phone number

( )
-----

Initial date consulted

	/		/	
--	---	--	---	--

Last date consulted

	/		/	
--	---	--	---	--

**16 continued**

**Doctor or treatment provider 4**

Initials Surname

Practice name and address

Reason

Phone number  
 ( )

Initial date consulted Last date consulted  
 /  /  /  /

**Doctor or treatment provider 5**

Initials Surname

Practice name and address

Reason

Phone number  
 ( )

Initial date consulted Last date consulted  
 /  /  /  /

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

**18** Are you still working?  
 No  What date did you cease work?  
 /  /

Yes  How many hours per week are you working?

**19** What percentage of your work are you currently able to perform?  
 %

**20** What date do you expect to return to work or to resume some of your occupational duties?

Date of return to work Date to resume some occupational duties  
 /  /  /  /

**21** 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%)  %

**22** Please 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
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**23** How long have you been in your current occupation?

**24** 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

**25** Are you currently claiming or do you intend to claim Disability Income from any of the following?

No  **Go to 27**

Yes  Provide details below

**Mark ALL that apply**

Worker's Compensation

Centrelink

Third Party insurance

Any other insurance policy

Any other Government department

*Go to next question*





**40 Please read this before answering the question about payment details**

It is important that the account information requested below is correct as Macquarie Life Limited will not be held responsible for delays or other damage due to incorrect details being provided.

- To ensure faster payment and for your protection, payment will only be effected by Electronic Fund Transfer.
- Payment will only be made to the policy owner or nominated beneficiary.
- No payment to a third party will be allowed.
- We will require proof of the account (cancelled cheque, bank statement with account number and name of account holder shown).

Name of account holder	
<input type="text"/>	
Bank name	
<input type="text"/>	
Account type	
<input type="text"/>	
Bank account BSB	Bank account number
<input type="text"/>	<input type="text"/>

**41 Please provide the marked documents together with this statement.**

Certified copy of birth certificate

Withdrawal form - attached

Certified copy of passport or drivers licence

PBS authority - attached

Medicare authority - attached

Activities of Daily Living form

Any medical reports

Income tax returns  Years

Company/Partnership/Trust tax returns  Years

Notice of assessment  Years

Audited financial records

Up to date financial statement   
*(if you answered Yes at **Question 38**)*

Other  Provide details below

## 42 Disability income claim declaration

I

the claimant:

- now wish to claim to the Disability Income benefits of the Macquarie Life Limited policy(ies); and
- declare that my answers to the claims questions on pages 1-7 of this form and the statements and representations I make on pages 1-7 [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.

## 42 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

This document is current as at 1 April 2010 and is issued by Macquarie Life Limited (Macquarie Life) ABN 56 003 963 773 AFSL 237 497 (“we”, “us”, “our” or “Macquarie” as the context requires). MML is not an authorised deposit-taking institution for the purposes of the Banking Act (Cth) 1959, and its obligations do not represent deposits or other liabilities of Macquarie Bank Limited ABN 46 008 583 542(MBL). MBL does not guarantee or otherwise provide assurance in respect of the obligations of MML.

### Macquarie Life



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### Claims



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