

### 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** What is the cause of your TPD?

**6** When did you first notice your symptoms?

**7** When was your condition first diagnosed?

**8** What investigations have you undergone (include dates)?

**9** What treatment, including surgery, have you had and for how long have you had this treatment?

**10** Are you still receiving treatment?

No  *Go to next question*

Yes  *Provide details below*

**11** Have you previously suffered from or received treatment for a similar or related illness?

No  *Go to next question*

Yes  *Provide details below*

**12** In the case of injury, give details of how the injury occurred.

- 13** 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

Practice name and address

Phone number  
 (  )

**Current treating doctor or treatment provider 2**

Initials Surname

Practice name and address

Phone number  
 (  )

**Current treating doctor or treatment provider 3**

Initials Surname

Practice name and address

Phone number  
 (  )

- 14** Give the name and contact details of any other doctors or treatment providers you may have consulted within the past 5 years.

**Doctor or treatment provider 1**

Initials Surname

Practice name and address

Reason

Phone number  
 (  )

Initial date consulted Last date consulted  
 /  /   /  /

- 14 Continued**

**Doctor or treatment provider 2**

Initials Surname

Practice name and address

Reason

Phone number  
 (  )

Initial date consulted Last date consulted  
 /  /   /  /

**Doctor or treatment provider 3**

Initials Surname

Practice name and address

Reason

Phone number  
 (  )

Initial date consulted Last date consulted  
 /  /   /  /

- 15** Are you claiming or have you submitted a claim for TPD from any other company?

No  [Go to next question](#)

Yes  Provide details below


- 16** Are you a member of a private health fund?

No  [Go to next question](#)

Yes  Provide the name and medical fund below


- 17** What was your occupation prior to this claim?

18 Are you still working?

No  What was your last day at work?

/ /

Yes

19 Are you an employee or self employed?

Employee  Go to next question

Self employed  Go to 21

20 Provide the details of your employer below

Employer's business name

Employer's address — street number and name

Suburb/Town

State

Postcode

Work phone number

( )

21 Provide the following details ONLY if you are self employed.

Your business name

Your address — street number and name

Suburb/Town

State

Postcode

Work phone number

( )

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 occupational duty.

Key areas of skill	Percentage

24 Do you anticipate that you will be able to do any of these key duties in the foreseeable future?

No  Go to next question

Yes  Provide details below

25 Have you attempted or do you intend to undergo any form of rehabilitation or retraining?

No  Go to next question

Yes  Provide details below

26 How long have you been in your current occupation?

27 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

28 Has your employer offered you alternative employment or if self employed do you have alternative employment?

No  Go to next question

Yes  Provide details below

**29** Are you currently engaged in any other employment or activity for which you receive income?

No  Go to next question

Yes  Provide details below

**30** Are you receiving a pension?

No  Go to next question

Yes  Provide details below

**31** Are you receiving or are you entitled to receive benefits from any other source?

No  **Go to 33**

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*

**32** Provide the details of benefits received, including name and address of TPD income source, claim number, frequency of payments and amount received.

**33** Please provide any additional information or comments that will help assess this claim.

**34 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 life insured.
- 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

Bank name

Account type

Bank account BSB

Bank account number

**35 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

Other  Provide details below

### 36 TPD claim declaration

I

the claimant:

- now wish to claim to the TPD benefits of the Macquarie Life Limited policy(ies); and
- declare that my answers to the claims questions on pages 1-6 of this form and the statements and representations I make on pages 1-6 [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.

### 36 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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