ANZ Credit Card Insurance
Claim Form for Disability Benefit

STATEMENT FROM PERSON INSURED

Claim number

Please send your completed form and attachments to OnePath General Insurance Pty Limited, GPO Box 4028, Sydney NSW 2001.

If there is insufficient space to provide information, attach additional sheets to this form.

For further information, call 13 16 14.

1. DETAILS OF THE INSURED

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Family name

Given names

Date of birth (dd/mm/yyyy) / / Gender ☐ Male ☐ Female Age

Are you ☐ an Australian Citizen? ☐ a New Zealand citizen? ☐ a permanent resident of Australia?

☐ a holder of a temporary visa? Visa Class

Address

State Postcode

Phone Home Work

Mobile

Email

Note: Provide your email address to receive information on the progress of your claim by email.

Occupation prior to injury or illness*

* If not employed for a minimum of 10 hours per week, state 'Not employed'.

Credit card number

2. INJURY OR ILLNESS DETAILS

Which event are you claiming for? (Please tick the relevant box) ☐ Injury ☐ Illness

Describe the injury or illness. If an injury, state when, where and how it happened.

Exact date your injury or illness began (dd/mm/yyyy) / /

Details of the person who witnessed the accident/injury

Name

Address

Phone number

Did the injury or accident occur at work? ☐ Yes ☐ No

After the injury or accident were you required to undergo a breath analysis or blood test? ☐ Yes ☐ No (If yes, please attach a copy of the analysis results)

Date you first received advice or treatment for the injury or illness (dd/mm/yyyy) / /

Your first day absent from work (dd/mm/yyyy) / /

Have you ever had this, or a similar injury or illness in the past? ☐ Yes ☐ No ☐ N/A

If yes, please provide details of the nature of the injury or illness and when it occurred

Please advise who treated you and the date that treatment occurred / /

Have you returned to work after the injury or illness? ☐ Yes ☐ No ☐ N/A

If yes, date you returned to work (dd/mm/yyyy) / /

If still totally disabled, when do you expect your disability to end? (dd/mm/yyyy) / /

Name and address of doctors or other health professional who first treated/are treating you for this injury or illness

Provider 1

Name

Address

Date consulted / / Type of treatment

Provider 2

Name

Address

Date consulted / / Type of treatment

If you were admitted to hospital, or treated as an outpatient, please give details below.

Provider 1

Name of hospital

Address

Date admitted / / Type of treatment

Provider 2

Name

Address

Date consulted / / Type of treatment

Details of usual general 'practitioner ('family doctor')

Name

Address

Phone number

Length of time you have been attending this doctor ☐☐ years ☐☐ months

3. DECLARATION

I authorise any hospital, physician, previous employer, accountant or other person who has attended me or has information relevant to my claim to supply OnePath General Insurance Pty Limited or its representatives, with any and all information that it may require in the consideration of this claim. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I declare that the information supplied on this form and in any attached documentation is correct and that I have not withheld anything material from OnePath General Insurance Pty Limited. I understand that if I do not give full particulars or provide incorrect information, my rights to obtain benefits under the policy may be prejudiced.

Full name | Signature ✗ | Date (dd/mm/yyyy) / /

4. FURTHER INFORMATION

If you have any questions, please call 13 16 14.

The completed form should be mailed to:

OnePath General Insurance Pty Limited
GPO Box 4028
Sydney NSW 2001

Or emailed to:

DIClaims@onepath.com.au

or faxed to

02 9234 5015

After reviewing this completed claim form, the Claims Department will contact you to advise if any further information is needed. You may be required to arrange a report from your doctor.

Please ensure you provide all the requirements listed in our letter in order to avoid any delays with the assessment of the claim

5. THIS SECTION TO BE COMPLETED BY YOUR EMPLOYER

(If you are self-employed you can complete this section yourself. If you are not working, proceed to section 6)

Name of employee

Position held

Company name

ABN

Is this person still employed? ☐ Yes ☐ No If no, please provide last date of employment (dd/mm/yyyy) / /

Date employment commenced (dd/mm/yyyy) / /

Last date employee worked (dd/mm/yyyy) / /

Basis under which this person is or was employed. Please tick (✔) ☐ Permanent (part time or full time) ☐ Casual ☐ Temporary/Contract ☐ Self-employed

Average number of hours per week the employee worked in the 90 days prior to the injury or illness ☐☐ Hours

Name of the employer or authorised representative

Position held

Telephone number

Email

Name of employer

Signature of employer ✗

Date (dd/mm/yy) / /

6. THIS SECTION TO BE COMPLETED BY YOUR MEDICAL PRACTITIONER

This is to certify that _____ as a result of an injury or illness that occurred on / /

Please state fully the nature of the injury or illness.

_____

_____

(Please note: any fees charged by the medical practitioner for completion of this certificate are the patient's responsibility)

Please only select either **A** or **B** or **C** then proceed with completing the remaining part of the form

A ☐ **Unable to resume employment** (If you patient was engaged in an occupation at the time of injury/illness)

Is unable to attend their usual occupation of _____

from (dd/mm/yyyy) / / to (dd/mm/yyyy) / /

or

B ☐ **Loss of independent existence** (If you patient was NOT engaged in an occupation at the time of injury/illness)

Is totally unable to perform at least two of the five activities listed below of daily living without the assistance of another adult person.

Please indicate ✓ the activities of daily living that the insured is totally unable to perform because of injury or illness

☐ bathing and/or showering

☐ dressing and undressing

☐ eating and drinking

☐ using a toilet to maintain personal hygiene

☐ getting in and out of bed, a chair or wheelchair, or moving from place to place by walking, wheelchair or with the assistance of a walking aid

from (dd/mm/yyyy) / / to (dd/mm/yyyy) / /

or

C ☐ **Cognitive loss**

is suffering from total deterioration or loss of intellectual capacity that requires him/her to be under continuous care and supervision by another adult person

from (dd/mm/yyyy) / / to (dd/mm/yyyy) / /

Is this illness or injury a result of a work place accident? ☐ Yes ☐ No

Is this illness or injury in any way associated with:

Pregnancy	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No
Drugs	☐ Yes	☐ No

If 'yes', any remarks:

_____

Date this patient first consulted you for this condition (dd/mm/yyyy) / /

Date of first attendance at this surgery (for any condition) (dd/mm/yyyy) / /

Has the patient been hospitalised at any time for this illness or injury? ☐ Yes ☐ No If 'yes', please provide details below

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Hospitalisation 1

Name of hospital

Address

From (dd/mm/yyyy) / /

To (dd/mm/yyyy) / /

In/Out patient

Hospitalisation 2

Name of hospital

Address

From (dd/mm/yyyy) / /

To (dd/mm/yyyy) / /

In/Out patient

Was this patient referred to you? ☐ Yes ☐ No

If 'yes', please give name and address of referring doctor

Name

Address

Has this patient ever suffered a previous or similar illness or injury in the past? ☐ Yes ☐ No

If 'yes', when?

Remarks

In your opinion would the symptoms of the illness have been evident to the patient? ☐ Yes ☐ No

If 'yes', approximately how long?

Remarks

To your knowledge has the patient consulted any other doctor(s) in relation to this illness or injury? ☐ Yes ☐ No

If 'yes', please provide doctor(s) name(s)?

When do you estimate this patient's disability to end?

Remarks

Name of medical practioner

Signature of medical practioner ✗

Date (dd/mm/yy) / /

Address of practice

Telephone

Email

A3171/0312