Income Protection

Attending Doctor's Statement

This form is to be completed by the attending medical doctor and relates to a claim for Income Protection.

If there is a charge for completing this form, the payment is the responsibility of your patient.

TAL Life Limited will not be responsible for any costs associated with the completion of this form.

1. PATIENT'S DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Given name(s)

Surname

Date of birth DD / MM / YYYY Height CM Weight KG

2. MEDICAL – DIAGNOSIS

a) Are you the patient's usual doctor? ☐ Yes ☐ No

b) When did your patient first consult you? DD / MM / YYYY

c) What is your diagnosis impacting your patient's work capacity.

CONDITION	SYMPTOMS	DATE COMMENCED
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY

d) Please list any other active medical condition(s).

CONDITION	DATE COMMENCED
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY

e) What are the clinical signs your patient is currently presenting with?

f) Please list relevant investigations including imaging studies used to diagnose and manage the disabling condition(s). (Please attach copies.)

3. MEDICAL - TREATMENT

a) What treatment (including medication) has your patient received from yourself and other practitioners since the condition(s) was diagnosed for the condition(s)?

b) Response to date with treatment intervention

c) Details of any proposed treatment

d) Please list practitioners involved in your patient's management.

NAME	SPECIALITY	Telephone Number

e) Please provide the patient's prior medical history?

4. MEDICAL

a) What is your understanding of your patient's occupation and the duties involved?

b) From what date do you consider your patient totally unfit for work? DD / MM / YYYY

c) Please provide your reasoning.

d) Since becoming unfit for work, has your patient been able to perform suitable duties?

☐ No ☐ Yes → From when? DD / MM / YYYY Hours PER WEEK

e) Specify suitable duties

f) What restrictions does your patient experience as a result of their condition(s)?

g) Are you aware of any other occupational factors that may delay your patient's recovery?

h) When is your patient likely to be certified fit to return to work?

Part-time DD / MM / YYYY Full-time DD / MM / YYYY

i) Have you considered or are you considering a return to work plan or rehabilitation for your patient?

☐ Yes → Please provide details of the plan ☐ No → Please explain why this has not been considered

5. OTHER

Have medical certificates been provided in respect of your patient's condition to any other organisation, insurer or government body?
(eg Centrelink, DVA, workers compensation insurer)

☐ No ☐ Yes → Please provide details

ORGANISATION	REFERENCE/CLAIM NUMBER	CONTACT DETAILS

6. ADDITIONAL INFORMATION

A TAL representative may contact you to better understand your patient's needs. Please advise what days/times suit you.

DAY	TIME										
	:	AM ☐	PM ☐	to	:	AM ☐	PM ☐				
	:	AM ☐	PM ☐	to	:	AM ☐	PM ☐				

7. PRIVACY STATEMENT

TAL Life Limited is bound by obligations imposed by current privacy legislation. Information received or requested from you is handled in accordance with these obligations. TAL Life Limited requires that all entities adhere to relevant privacy obligations when dealing with personal and sensitive information about our customers.

Name of Medical Attendant

Medical Attendant's stamp

Specialist ☐ Yes ☐ No

Specialty

Work phone number

Email address

Street address

Suburb State Postcode

I certify that I have examined the patient and that all information provided in this form is correct.

Signature ✗ Date DD / MM / YYYY

SUBMITTING THIS FORM

GPO Box 4974
Melbourne VIC 3001

super@vissf.com.au

If you have any questions, please contact us on 1300 660 027.