Intent to Claim Life Insurance

Attending Doctor's Statement

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

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

2. MEDICAL DETAILS

a) Are you the patient's usual general practitioner?

☐ Yes → What date did you begin treating your patient? DD / MM / YYYY

☐ No → Who referred your patient to you?

b) On what date did you first see them? DD / MM / YYYY

c) What is the current diagnosis?

d) Please provide relevant diagnostic evidence confirming the diagnosis

e) Who made the initial diagnosis and on what date?

DOCTOR'S NAME	SPECIALITY	DATE
		DD / MM / YYYY

f) Has your patient ever experienced these, or similar, symptoms previously?

☐ No ☐ Yes → Please provide the date DD / MM / YYYY

g) Based on diagnostic criteria, is your patient suffering from a terminal illness?

☐ No ☐ Yes → Please provide the date your patient was diagnosed as terminally ill DD / MM / YYYY

h) Please confirm your patient's life expectancy. MONTHS

Is it expected to result in their death within 12 months ? ☐ Yes ☐ No

Is it expected to result in their death within 24 months ? ☐ Yes ☐ No

3. 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.