Total and Permanent Disability

Attending Doctor's Statement

This form is to be completed by the attending medical doctor and relates to a claim for Total and Permanent Disability (TPD).

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? ☐ No ☐ Yes

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

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

DIAGNOSIS	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 conditions.

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

e) What are current symptoms your patient is presenting with?

____

____

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 treatment intervention

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

d) Please list practitioners or any rehabilitation interventions involved in your patient's management.

NAME	SPECIALITY	LOCATION

4. MEDICAL – CAPACITY FOR WORK

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

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

c) What job duties can your patient currently perform?

d) Do you believe your patient is ever likely to resume in his/her own or any other occupation in the future?

☐ Yes → Please provide duties/occupation they could perform now or in the future and indicate whether rehabilitation would assist in a return to work.

☐ No → Please provide reasons for your opinion and the date from which this applies. DD / MM / YYYY

5. ACTIVITIES OF DAILY LIVING

1. Does your patient require assistance from another person with any of the following activities of daily living?

Activity	**Yes/No**	**If yes, please describe the type of assistance required and their limitations in performing these activities.**
Dressing (i.e. putting on and taking off clothes)	Yes ☐ No ☐	
Bathing (i.e. washing and showering)	Yes ☐ No ☐	
Toileting (i.e. using the toilet including getting on and off)	Yes ☐ No ☐	
Mobility (i.e. walking, and getting in and out of a chair and bed)	Yes ☐ No ☐	
Feeding (i.e. getting food from a plate to mouth)	Yes ☐ No ☐	
Domestic duties (i.e. cooking and cleaning)	Yes ☐ No ☐	

6. 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

7. ADDITIONAL INFORMATION

8. 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

9. 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.