Total and Permanent Disability

Illness or Injury Claim Form

Complete this form if you want to make a Total and Permanent Disability claim for Illness or Injury.

- This form is to be completed by the person who is making the claim.
- Please answer all questions to the best of your ability to ensure that your claim is assessed as quickly as possible.

BEFORE YOU RETURN THIS FORM YOU WILL NEED TO COMPLETE THE FOLLOWING

☐ Answer all questions fully

☐ Sign and date the Information Authority

☐ Sign and date the Privacy Disclosure

☐ Sign and date the Declaration

☐ Certified copy of proof of age (copy of birth certificate, passport or driver's licence)
To find out who can certify documents, please go to https://www.comlaw.gov.au/Details/F2006C00248.

☐ Copy of your resume

☐ Attach copies of reports received from specialists, other treating doctors and health professionals you may have

☐ Provide any other information we have specifically requested

1. YOUR POLICY

Policy number/ Member number

Fund name (if applicable)

2. PERSONAL DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Given name(s)

Surname

Date of birth DD / MM / YYYY

3. CONTACTING YOU

Street address

Suburb State Postcode

Best contact phone number (Mobile phone preferred)

Email address

4. YOUR CLAIM

a) What is the nature of your illness or injury (including diagnosis)?
Please only give a brief description e.g. fractured left wrist, repetitive strain injury in right hand, acute migraines.

b) Are you receiving or eligible to receive any benefits from any other organisation, insurer or government body?
(e.g. Centrelink, DVA, CTP, workers compensation)

☐ Yes ☐ No

c) If yes, please provide their name and contact details.

ORGANISATION	REFERENCE/CLAIM NUMBER	CONTACT DETAILS

5. YOUR DOCTOR

a) What was the first date on which you stopped working due to your illness or injury?
(This refers to the first date you stopped working entirely.) DD / MM / YYYY

b) What is the name of the doctor who advised you to stop working as a result of your illness or injury?

Type of doctor (e.g. psychiatrist, cardiologist, orthopaedic surgeon. If it was your general practitioner (GP), then please write GP in this section.)

Street address

Suburb State Postcode

Phone number

c) How long have you been a patient of this doctor? (If you do not know the exact period, an approximation is sufficient.)

Years Months

d) Date of the last visit to this doctor DD / MM / YYYY

e) What treatment are you receiving?

f) Have any other doctors, specialist or healthcare providers been consulted?

☐ Yes ☐ No

g) If yes, please provide details including contact information and type of doctor/healthcare provider.

NAME OF PRACTITIONER	TREATMENT	LOCATION	DATE
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

6. YOUR JOB

a) Are you self employed?

☐ Yes → Please provide the name of your business

☐ No → Please provide the name of the company you worked for prior to stopping work

Company name

Contact name of employer (e.g. your manager, team leader or HR contact)

Contact phone number of employer

b) What was your job title immediately prior to stopping work due to your illness or injury?

c) How many hours did you work each week in your job prior to your illness or injury? HOURS

d) i. What duties were you performing in your job? (Manual and/or non-manual duties) (e.g. managing employees, quoting, computer work, bricklaying, checking and repairing equipment, driving, operating machinery, preparing orders)

e) Please list all of the duties that you are now able to perform in your job because of your illness or injury

f) Please list all of the duties that you are now unable to perform in your job because of your illness or injury

g) Have you returned to work in any capacity since the date you stopped all work due to your illness or injury?

☐ Yes ☐ No

h) If yes, what date did you first return to work? DD / MM / YYYY

i) In what capacity have you returned to work?

7. ADDITIONAL INFORMATION

8. PRIVACY DISCLOSURE

The privacy of TAL customers is important and TAL is bound by obligations imposed by current privacy laws including the Australian Privacy Principles. The way in which TAL collects, uses, secures and discloses your personal information is set out in the TAL Privacy Policy available at http://www.tal.com.au/Privacy-Policy or free of charge on request to TAL using the contact details below.

GPO Box 5380, Sydney NSW 2001
Telephone: 1300 209 088
Fax: 1800 300 072
Email: customerservice@tal.com.au

Collection and use of personal information

We are bound by relevant legislation including the Privacy Act 1988 (Cth) and the 13 Australian Privacy Principles when we collect, store, use and disclose your personal and sensitive information ("personal information").

During your claim we may collect personal information, including your name, age, gender, contact details, health information, lifestyle information, financial information, and employment information. If you do not supply the information that is required, we may not be able to provide our services to you and this may result in us being unable to continue to assess or pay a claim. In some circumstances we may take steps to verify the information we collect about you from independent sources to ensure the information is correct, up to date and complete.

Disclosure of personal information

Where we consider it appropriate during your claim, we may disclose relevant personal information to related bodies corporate and external individuals and organisations and entities including but not limited to:

- providers of medical and health services;
- reinsurers, other insurers and their administrators;
- any person acting on your behalf, including your financial adviser, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- for members of superannuation funds where TAL is the insurer, to the trustee, or administrator of the superannuation fund as the superannuation fund owns the life insurance policy on your behalf and where appropriate to your employer for the purposes of rehabilitation assistance for return to work; and
- providers of services to whom TAL outsources certain functions such as medical providers, rehabilitation providers and surveillance/investigation providers.

Where it is required or authorised by law we may also need to disclose information about you to Government agencies and Courts and enforcement bodies (e.g. under Court Orders or Statutory Notices).

Generally you have a right to access information we hold about you with limited exceptions and if you wish to access information we hold about you please contact us.

We are legally required to send all communications about your policy to the policy owner. However, where the policy owner is different from the life insured, we will not communicate personal medical information about a life insured to a policy owner unless the life insured has consented or there is other lawful authority.

By signing this form you consent to us collecting, using and disclosing your personal and sensitive information as detailed in our Privacy Policy at www.tal.com.au and as summarised above.

Please note that this authority remains valid for the duration of your claim.

Name

Signature ✗

Date DD / MM / YYYY

9. INFORMATION AUTHORITY

I hereby authorise any doctor, hospital, therapist or other medical professional who has attended me, to release to TAL Life Limited (TAL), its related bodies corporate, its agents or its representatives and to my superannuation fund or its administrator, information relevant to my policy and/or claim, with respect to any illness or injury, medical history, consultations, medications or treatment, received by me together with copies of any and all medical records. I consent to TAL and my superannuation fund collecting this sensitive information.

I authorise any insurer (including workers compensation/CTP insurer), government agency or body (including Centrelink/ Department of Veterans' Affairs), employer, accountant or other relevant holder of information, to release to TAL Life Limited, its related bodies corporate, its agents or its representatives and my superannuation fund or its administrator, information which they require for the purpose of assessing or investigating my claim.

A copy of this authority is to be regarded as if it were the original signed authority.

Name

Signature ✗

Date DD / MM / YYYY

10. DECLARATION

I hereby declare that the information in this claim form is true, complete and correct.

I understand and agree that if I make any false or fraudulent statements or fail to advise TAL Life Limited of any relevant information regarding my claim, TAL Life Limited may refuse to pay this claim or cancel my policy.

Name

Signature ✗

Date DD / MM / YYYY

SUBMITTING THIS FORM

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

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