Corporate Progress Claim Form
Salary Continuance Insurance/Income Protection
Supplementary Report Form for Continuing Disablement

Statement by CLAIMANT. Please answer ALL relevant questions fully, not doing so could result in delays in processing your claim.

Plan Name	Member No. (if superannuation owned)	Policy No.
		MP

SECTION A – Personal Details

Claimant Name | Date of Birth / /

Residential Address | Postcode

Telephone (home) | (work) | (mobile)

E-mail *(for correspondence)*

This form covers the claim period / / **to** / / **inclusive.**

Please attach payslips for this period (if applicable).

SECTION B – Medical Treatment

1. (a) Please provide details of all medical providers you have seen during this claim period (please attach a separate sheet if required).

Date	Name of medical provider and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
/ /		Tel:
/ /		Tel:
/ /		Tel:

(b) When is your next scheduled consultation? / / Please provide details.

2. (a) Please list all your current symptoms and their severity.

(b) How are the current symptoms preventing your return to work?

(c) Please list all the duties of your usual occupation you were **UNABLE** to perform in this claim period, including the reasons why.

Work duties	Reason you were **unable** to perform the work duty

SECTION B – Medical Treatment (continued)

3. Please list all your current medication/s including dosages.

SECTION C – Work Activities

4. Have you worked in any capacity, either paid or unpaid since your last progress claim form?

☐ Yes – **Please continue to question 5 below.**

☐ No – **Please continue to Section D, question 6.**

5. (a) What period did you work? / / to / /

(b) Name of the employer.

(c) Please provide details of work you have carried out (paid or unpaid) during this claim period.
(This is a diary to record all work you have done during this current claim period.
To ensure accuracy, we suggest that you fill in the details daily.)

Date	Hours worked	Duties performed
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(d) (i) If **Employed**, what is your **TOTAL GROSS MONTHLY INCOME** for this claim period (i.e. before tax)? $
Please provide a copy of your payslip(s) for the claim period.

(ii) If **Self Employed**, what is your **TOTAL GROSS MONTHLY INCOME** for this claim period? $
(Gross income is the income derived from your personal exertion after deducting your share of the business expenses.)
Please provide a copy of your Profit and Loss Statement for the claim period. If you have employed or engaged any staff to perform some of your usual duties, please provide details including name, employment type, income generated and associated costs.

SECTION D – Daily Activities

6. Please provide details of your daily activities during this period.

SECTION E – Other Benefits

7. (a) As a result of your injury/sickness, are you currently receiving or entitled to receive/claim any benefits from:

- ☐ Workers' Compensation
- ☐ Common Law
- ☐ TAC
- ☐ Centrelink (Please ask Centrelink to provide you with an income statement/break-down of payment.)
- ☐ Another Insurer (eg. for another Income Protection policy)
- ☐ Any other source. Please state:

(b) If you are receiving or have received any benefits, please provide full details of each benefit including:

Type of claim | Claim/Ref No.

Insurer (if applicable) | Gross amount of claim $ per week

Contact person | Contact number

Type of claim | Claim/Ref No.

Insurer (if applicable) | Gross amount of claim $ per week

Contact person | Contact number

SECTION F – Work Confirmation

8. Have you been involved in any rehabilitation for your injury/sickness,
eg. graduated return to work program, studying, re-training,up-skilling, etc.? ☐ Yes ☐ No
If '**Yes**', please provide the name, address and telephone details of the rehabilitation provider and the name of your case manager.
If '**No**', do you believe occupational rehabilitation could assist you? Please provide your detailed reasons.

9. If you have not already done so, when do you expect to resume your usual duties?

Full-time / / Part-time / /

SECTION G – Checklist

10. ☐ I have attached payslips for this period (if applicable) and provided any other information that may assist my claim.

11. ☐ I have provided my Doctor with my Plan Name and Member Number (if applicable) so he/she can complete the Medical Attendant's Statement for my claim.

12. ☐ I have fully completed this form, to ensure my claim is assessed promptly.

SECTION H – Declarations and Authorities

DECLARATION AND CONSENT

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

I understand and agree that if I make any false or fraudulent statements, or fail to advise the insurer, AIA Australia Limited, of any relevant information regarding my claim, AIA Australia Limited may refuse to pay benefits and proceed to cancel my claim and/or my insurance cover.

I declare that I have read and understood the Privacy Statement attached to the initial claim form and I consent to the collection, use and disclosure of my personal and sensitive information in the manner described in that Privacy Statement.

I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the AIA Australia Privacy Policy available on the AIA Australia website at www.aia.com.au as updated from time to time or by calling AIA Australia on 1800 333 613, including the exchange with third parties located in Australia and overseas.

AUTHORITY TO OBTAIN INFORMATION

I hereby authorise any individual, organisation or entity within any of the above categories (a to h) that holds my personal and sensitive information to release that information to AIA Australia Limited on request, for the purpose of investigating, assessing and managing my claim.

I hereby authorise any medical practitioner, medical provider, health professional, hospital, dentist or other person who has attended me, to release to AIA Australia Limited or its representatives all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records.

I authorise any previous and my current employer to provide AIA Australia Limited with details of my employment and pay history.

I agree that a copy of this authorisation shall be considered as effective and valid as the original.

Name *(please print)*	Claimant's signature	Date
	✗	/ /

Medical Attendant's Statement
(Corporate Progress Claim)
Forming part of the Supplementary Report Form for Continuing Disablement

This Medical Attendant's Statement is to be completed by your usual doctor.
If there is a charge for completing this form, the payment is the responsibility of the patient.

Privacy
In completing this form you may be providing AIA Australia Limited with personal information (including sensitive information). This information must be handled, collected, used and disclosed in accordance with the Privacy Act 1988 (Cth) and the AIA Australia Privacy Policy as updated from time to time. For more information about the AIA Australia Privacy Policy (including notification) please refer to www.aia.com.au or contact 1800 333 613 to request a copy. AIA Australia may, if requested by the patient, require that you consider a request for personal and sensitive information and act accordingly.

Plan Name

Member No. (if applicable)

Patient's Name

Occupation

1. What is your current diagnosis and the patient's level of disability?

2. What is the objective clinical evidence to support your diagnosis?

3. Please provide details of the treatment plan currently prescribed (including the names and dosages of any medication/s).

4. To the best of your knowledge is the patient following the treatment plan prescribed? ☐ Yes ☐ No If '**No**', please comment.

5. Do you consider any other treatment plan necessary and/or beneficial for recovery and return to work in their usual occupation? ☐ Yes ☐ No If '**Yes**', please comment.

6. Would the patient benefit from Occupational Rehabilitation, eg. graduated RTW program, studying, re-training, up-skilling, etc.? ☐ Yes ☐ No If '**Yes**' or '**No**', please comment.

7. What is your short term and long term prognosis?

8. Has the patient been referred to any other doctor/s, or medical provider/s, or rehabilitation provider/s or other health professionals for treatment or consultation? ☐ Yes ☐ No If '**Yes**', please state:

Date of referral	Name and field of practice (eg. oncologist, cardiologist, etc.)	Address and telephone contact details
/ /		Tel:
/ /		Tel:

9. Is the patient, in your view, **able** to perform any duties of their **usual** occupation?

☐ Yes – **Please continue to question 10.**

☐ No – **Please continue to question 11.**

10. (a) If the patient is **able** to perform some duties and/or responsibilities of their **usual** occupation, please list the date from which the patient became capable of resuming at least some duties they can perform and to what capacity (i.e. 50%, etc.)

Work duty **able** to be performed	Date **able** to perform work duty	% capacity
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

(b) How many hours per week can the patient perform these duties?

(c) When do you consider the patient will be able to perform all of their **usual** occupation duties? / /

(d) Please continue to question 12.

11. (a) What are the reasons why the patient is **unable** to perform the full duties of their **usual** occupation?

Work duty **unable** to perform	Reason they are **unable** to perform this duty

(b) While under your care, how long was, or will the patient be:

(i) **unable** to perform **all** of the duties of their **usual** occupation? / / to / /

(ii) **able** to perform **some** of the duties of their **usual** occupation? / / to / /

(c) When do you consider the patient will be:

(i) **able** to perform **some** of the duties of their **usual** occupation? / /

(ii) **able** to perform **all** of the duties of their **usual** occupation? / /

(d) If you consider the patient will never be able to perform their usual occupation, will they be able to perform any work/duties within their education/training or experience? ☐ Yes ☐ No
If '**Yes**', please give details.

12. Is the patient **currently performing** any **alternative** duties? ☐ Yes ☐ No

If '**Yes**', please state: From / / to / /

If '**Yes**', please provide full details including the duties the patient is currently performing and the number of hours per week these duties are being performed.

Duties	No. of hours duties are being performed

ADDITIONAL INFORMATION

13. Please provide any additional information or comments you feel are relevant to this claim.

DECLARATION

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true, correct and complete.

I confirm that I have handled, collected, used and disclosed the patient's personal and sensitive information provided with this form in accordance with privacy law.

I understand that AIA Australia may be entitled or required to provide access or a copy of my report to the patient, the patient's representatives, a conciliator, mediator, tribunal or court, or to medical specialists and other third parties, under privacy law and the AIA Australia Privacy Policy, and authorise AIA Australia to do so.

Name *(please print)* Qualification(s)

Signature Date / /

Address Postcode

E-mail

Telephone Facsimile