Initial Information Form for Income Protection Insurance Claim

We want to make this process as easy as possible, so please:

- **Complete in full all sections of the form.** An incomplete form will delay our review as we may need to contact you for further information or return the form to you to complete in full. Use the 'Additional comments' section if you need more space to answer a question.
- **Review the checklist below** and ensure all supplementary information is provided. If you don't send this information, we will not be able to complete our review. Before you start we recommend you gather the documents on the checklist to assist you with completing this form.
- It is important that you answer the questions below honestly, completely and to the best of your ability. If you are unclear on any question, please contact us. Providing misleading or incomplete answers could lead to your claim being delayed or declined.
- If you **require assistance** or further information please call 1300 555 625 or go to www.metlife.com.au and a claims expert will be made available to talk you through completion and answer questions on why the information is required and how it may be used.

Please note that issuing this form is not an admission of liability.

Claim checklist and mandatory requirements

Please complete the following checklist before forwarding this form to us. Additional information specific to your claim circumstances may also be requested and detailed under the attached correspondence.

We will need the following information before we start our review:

- ☐ **I have completed all sections of this form.**
- ☐ **Proof of identification -** A certified copy of your passport or driver's licence.
- ☐ **Any other documents -** Provide any additional documents you think might assist with your claim such as insurance or compensation reports.
- ☐ **Medical reports -** Please provide copies of any medical reports, scans, referral letters or any other medical information that you have available.
  Important: Please note that we cannot start the assessment of your claim until we are provided with medical information in support of your claim.
- ☐ **Completed Authority** to release health information and other information from third parties - This provides us with authority to collect and use information to assess and manage your claim.
- ☐ **Tax File Number Declaration** - If your income policy is held under superannuation, the benefits paid will be taxed before payment. For further information on your tax liability please speak with a financial advisor or tax agent.
- ☐ **Australian Business Number (ABN)** - If you are self-employed or own part or all of the business you work for.

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide you with the products and services you have requested from MetLife, and to manage your claim. You do not have to provide MetLife with your personal information, but if you do not do so MetLife may not be able to provide you with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of your personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

Section 1. Declaration and authority

I declare that the answers and statements made on this claim form are true and complete. I have not made any false or misleading statements and have included all information relevant to the assessment of my claim. I understand that making false or misleading statements to claim insurance benefit is fraud and is a criminal offence.

In the event of a fraudulent claim MetLife reserves the right to: decline the claim, and/or cancel all cover held by the Life Insured with MetLife in accordance with the Insurance Contracts Act.

Where I have completed this declaration and authority as the Guardian/Attorney, I have attached a certified copy of the relevant legal documents (e.g. Power of Attorney). If any of the answers have not been completed by myself, I certify that I have checked them and they are correct.

I have read and understood the Privacy Disclosure Statement entitled 'Privacy - Use and Disclosure of personal information'. I consent to the collection, use and disclosure of my personal (including sensitive) information in accordance with the terms of these documents.

I understand and agree that if I do not give the information requested by MetLife or its representative, MetLife may not be able to assess, investigate or pay my claim.

Signature ▶	Date *(dd/mm/yyyy)*

Full name (please print)

Section 2. Personal details

Policy number/fund member number (*if applicable*)

Title	Given name(s)

Surname	Previous name(s)

Address	Suburb	State	Postcode

Preferred contact number	Email

Gender	Date of birth *(dd/mm/yyyy)*
☐ Male ☐ Female ☐ Indeterminate, Intersex, Unspecified	

Section 3. Details of medical condition

Benefits under your policy are paid based on your inability to work due to a medical condition. Please detail all your medical conditions below, we will use this information to assist us in understanding how your condition is impacting you.

1. Please detail all medical conditions impacting your ability to function.

What is the medical condition(s) that caused you to be unfit for work?	Date symptoms commenced	Date you first consulted a medical practitioner	Date of disability (the date your doctor first certified you as medically unfit for work)
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /

Section 3. Details of medical condition (continued)

2. Is your condition caused by or related to an accident? ☐ Yes ☐ No

If Yes, please provide details of the accident including date, location and activity performed.

3. What was the date you were last at work performing any work duties (*dd/mm/yyyy*)? / /

4. Have you ever had this/these medical condition(s) or similar before? ☐ Yes ☐ No

If Yes, please provide details.

5. What usual daily activities are you unable to do as a result of your medical condition(s)? e.g. home duties, social activities, etc.

6. Have you had any treatment for your condition? ☐ Yes ☐ No

If Yes, please provide details of treatment that has been prescribed.

7. Please detail all home-based exercises or activities that have been recommended or instructed by your treatment providers. Please include; nature of activity, frequency of activity, your level of success in completing the activity, how the activity is impacting your recovery.

8. Provide the details of all medical practitioners, including allied health professionals, treating you for this/these condition(s). Please attach copies of any letters or referrals you have available.

Doctor's name	Doctor's address, phone number and email	Specialty	Date first consulted	Date last consulted	Usual Doctor (Yes/No)
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

Section 4. Employment and return to work

We will use this information to assist us in understanding how your condition has impacted on your ability to work.

9. Have you returned to work in any capacity, whether paid or unpaid (e.g. voluntary work), since you first ceased work? ☐ Yes ☐ No

If Yes, please provide details.

Start date	End date	Duties and hours performed
/ /	/ /	
/ /	/ /	
/ /	/ /	

10. Is your job available to return to? ☐ Yes ☐ No

If No, please tell us why it is unavailable.

11. If you have not yet returned to work, when do you hope or expect to return to work (*dd/mm/yyyy*)? / /

12. If you can perform all of your usual duties but are only able to work reduced hours, please specify the hours and days.

How many hours per day could you work?

How many days per week could you work?

13. If you could safely perform your role with reduced or modified duties, please detail what duties you remain capable of performing.

14. Are there any other challenges or issues that may prevent you from returning to work?

Section 5. Income details

15. Have you received any income since ceasing work? ☐ Yes ☐ No

16. Please provide details of any money or income you have received since ceasing work from any sources such as superannuation benefits, Workers' Compensation, sick or annual leave, ongoing business income, other insurance payments or Centrelink benefits.

If available, you can provide copies of payment letters or schedules in place of completing the below table.

Type of payment	Payment start date	Payment end date	Amount per week	Expected to continue?
	/ /	/ /		☐ Yes ☐ No
	/ /	/ /		☐ Yes ☐ No
	/ /	/ /		☐ Yes ☐ No

Section 6. Occupation and duties

17. Please detail your most recent occupation/role.

Occupation/Job title	Industry	Date started (*dd/mm/yyyy*)	Date finished (*dd/mm/yyyy*)
		/ /	/ /

18. Please include any specific work skills as a part of main duties, e.g. supervise others, telephone or face-to-face customer service, cash handling, equipment/tools used, etc.
Please include detail of your employment status (full-time, part-time, etc.) and the hours and days worked per week.

Main duties

19. Were you employed or self-employed in your most recent occupation? ☐ Self-employed ☐ Employed

20. If you were employed, please provide the name and contact details of your supervisor or HR contact.

Name	Role	Contact number	Email

21. If you were self-employed in your prior occupation, please include the business trading name, ABN, % of business owned by you, if the business is still trading and if not, when did it stop?

Business trading name	ABN	% Owned by you

22. If self-employed, is your business still trading? ☐ Yes ☐ No

If Yes, please provide detail in relation to your ongoing involvement in the business.

If No, when did it stop trading (*dd/mm/yyyy*)? / /

Section 7. Tasks and duties

23. Please complete the following table on how physical your role was, detailing the time per day required of each physical task.
If your role varied day to day, please provide in comments on an 'average' day.

a) Sitting ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments

b) Standing ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments

c) Walking ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments

Section 7. Tasks and duties (continued)

d) Lifting	☐ Over 20kg	☐ Up to 20kg	☐ Up to 15kg	☐ Up to 10kg	☐ Up to 5kg	☐ Minimal (1 - 2kg)
Provide detail on lifting position e.g. from floor/ bench, one/two arms						
e) Driving	☐ Over 4 hours	☐ 4 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ Nil
Additional comments						
f) Travelling by other means e.g. public transport						
g) Pushing/pulling						
h) Bending/twisting/ squatting						
i) Reaching						
j) Fine motor e.g. computer use, gripping						
k) Other (please specify)						

Section 8. Hobbies, pursuits, volunteer work and pastimes

24. What were your regular hobbies, pursuits and pastimes prior to your disablement?

25. Within the last 5 years, have you regularly performed volunteer work activities? ☐ Yes ☐ No

If Yes, please provide details.

Section 9. Language

26. Please indicate your level of English skills.

	Below average	Average	Above average
Speaking	☐	☐	☐
Writing	☐	☐	☐
Reading	☐	☐	☐

27. Is English your first language? ☐ Yes ☐ No

28. Are you interested in re-training? ☐ Yes ☐ No

If Yes, please provide details.

Section 10. Other insurance or claims

29. Have you currently lodged or might you lodge a claim under Workers' Compensation or under any other superannuation or insurance policies? ☐ Yes ☐ No

If Yes, please provide details below.

Name of fund/insurer	Address, phone number and email	Claim number	Payment amount	Benefit type

30. In addition to the above, have you ever had any previous Workers' Compensation, Disability Insurance, TPD, Trauma Insurance claim paid or declined? ☐ Yes ☐ No

If Yes, please provide details including insurer and what was claimed.
If available, please provide copies of any letter or other correspondence that outlines the claim.

Section 11. Claim payment (EFT)

Full name of account holder/payee

Name of bank	BSB number	Account number

NOTE: Payment direct to you is only available if the policyholder has given permission for this. If your policy is under superannuation, the policyholder is the Trustee of the Superannuation Fund.

Additional comments

Releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, MetLife, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Information from other parties or MetLife

Supporting information from other entities, third parties or MetLife, includes any information held about you, including reports, that relates to MetLife's administration of the policy/plan, including your claim. This information is required to enable MetLife to assess and manage your claim in accordance with the Terms and Conditions of your policy/group life cover.

Authority 3 explanatory notes – through this authority, you are consenting to the parties listed in the authority releasing a copy of any information they may hold about you concerning your claim, for example:

- producing a report;
- supplying MetLife with full particulars of any and all claims you have made for benefits in the event of your sickness and/or injury including copies of evidence they hold; and
- releasing your correspondence with MetLife to your accountant, financial adviser/planner, fund trustee/fund administrator, in order for them to supply MetLife with the requested particulars.

Any information released to MetLife as a result of this authority will be used to assess and manage your claim(s) with MetLife, and we will tell you each time we use your consent.

If you choose to withhold your consent to this authority, we may not be able to process your application for a claim.

A photocopy of this authority is as valid as the original.

Authority 1 - to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **MetLife**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **MetLife** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **MetLife** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MetLife** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Authority 2 - to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **MetLife**, or to third parties they engage, only if **MetLife** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to the following:

- **MetLife** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MetLife** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Authority 3 - to release other information

I authorise the parties listed below to release to **MetLife** any information held about me (including their reports) which relates to the administration of my **MetLife** policy/plan, including this claim.

- Any claims assessor, investigator, insurance reference service, credit reference service, financial institution, legal or accounting firm, auditor, employer, consultant or reinsurer.
- Any benefit provider such as other insurers or Government Departments (including Workers' Compensation, Centrelink or similar benefit providers) that provide benefits in the event of my sickness and/or injury.
- My accountant, financial adviser/planner, fund trustee/fund administrator including but not limited to providing my accountant, financial adviser/planner, fund trustee/fund administrator with copies of all correspondence (which may include personal and sensitive information) between **MetLife** and myself in respect of the claim in order for the nominated party to supply **MetLife** with the requested particulars.

I agree to the following:

- My information can be released in the form **MetLife** asks for, such as a general report, correspondence, full particulars of any and all claims I have made for benefits in the event of my sickness and/or injury including copies of evidence they hold.
- My Financial Adviser/Fund Trustee/Fund Administrator can make enquires regarding the progress of the claim for the purpose of providing me with ongoing service.
- **MetLife** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MetLife** is assessing my claim or is verifying disclosures I made in connection with the cover.
- Any information released to **MetLife** under this Authority, or any previous authorities I have signed, will be used in assessing my claim(s) with **MetLife**.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Please return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auservices@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

MetLife

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