NRMA Income Protection
Sickness or Injury Initial Claim Form

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Please answer **ALL** questions. Use black/blue ink and ensure answers are clear and legible.

Any fee for the completion of the Initial Medical Certificate by your Medical Practitioner is your responsibility.

In addition to this form, please provide:

- ☐ An 'Authority to release personal Medicare claims information to a third party' form.
  (We also recommend that you obtain the last 3 years of your Medicare records from the Medicare website to speed up the claims process).
- ☐ Initial Medical Report (to be completed by your Medical Practitioner).
- ☐ A copy of your resume or a document detailing your education, training and work experience.

A: Self-Assessment

1. Have you been off work or unable to perform Regular Daily Activities for longer than the waiting period? ☐ Yes – Complete and Submit this form ☐ No – Answer Q2
2. Has a medical practitioner confirmed that you are likely to be off work for longer than the waiting period? ☐ Yes – Complete and Submit this form ☐ No – Please wait before claiming.
3. Have you experienced this condition, or a related condition, in the past? ☐ Yes – Please check your policy exclusions ☐ No

B: Personal Details - Claimant

Policy number:____________________

Policy Type (Income Protection Cover or Essentials Cover):____________________

Date of birth:____________________

First Name:____________________ Surname:____________________

Current residential address (not a P.O. Box):____________________

____

Postal address (if different from above):____________________

____

Email address:____________________

Phone numbers: Home ____________________ Work ____________________ Mobile____________________

C: Banking Details

Please provide bank account details for the claim benefit payments to be paid to upon approval:

BSB:____________________ Account number:____________________

Name of account holder:____________________

D: Occupational/Daily Activity Details

1. What occupation or daily activities were you performing prior to your sickness or accident?

____

2. Please provide details of ALL the duties that you performed in your occupation/daily activity during an average day, the approximate time spent performing those duties, and if and why you can no longer do those duties:

Duties Performed:	% of working day	Please explain if/how/why you are currently restricted from performing these duties?
e.g. Driving	e.g. 25%	e.g. Broken leg prevents ability to use brakes

3. If employed, how long had you been in this occupation and performing these duties?_______________

4. What is the average number of hours you spent per week over the last 12 months in the occupation?_______________

5. Do you do any unpaid work? ☐ Yes ☐ No

6. Have you returned to work/your daily activity yet? ☐ Yes ☐ No

7. If "yes", on what date did you return to work/your daily activity? DD / MM / YYYY

If "no": a. what currently prevents you from returning to work/your daily activity?_______________

____

b. when do you expect to be able to do so? ☐ Full-time: DD / MM / YYYY

☐ Part-time: DD / MM / YYYY

8. If you are an employee, is your job currently being held open? ☐ Yes ☐ No

9. Is it your intention to return to work with the same employer? ☐ Yes ☐ No

If not, please explain why?_______________

____

E: Income Details

1. What was your annual income in the last financial year?_______________

2. What was your average monthly income in the 12 months before you became unable to work?_______________

3. What income have you received since you became unable to work?_______________

4. Do you have any other source of income? (e.g. Worker's Compensation, government benefits) ☐ Yes ☐ No

If "yes", please provide the details of the amount you are receiving and when these payments commenced:_______________

____

E: Income Details continued

This section is to be completed if you are **EMPLOYED**

IMPORTANT!

If you are **employed** please ATTACH all of the following:

☐ a. Your income tax return for the last financial year.

☐ b. Your Notice of Assessment from the Tax Office for the last financial year.

☐ c. A copy of your pay-slips for the 12 months prior to your sickness or injury. (If you are unable to supply any of these, please call us on 1300 996 143 to discuss.)

5. Company name of employer:____________________

6. Employer's address:____________________

7. Employer's phone number:____________________

8. Manager/HR Representative's name:____________________

This section is to be completed if you are **SELF-EMPLOYED**. Please complete the appropriate questions

IMPORTANT!

If you are **self-employed** please ATTACH all of the following:

☐ a. Your personal Tax Return and Business Tax return (if applicable).

☐ b. Your Notice of Assessment from the Tax Office.

☐ c. A Profit and Loss Statement and a Balance Sheet for the 12 months prior to your sickness or injury.

(if you are unable to provide documentation for the 12 months prior to your accident or illness, please provide documentation for the last financial year)

9. What is the name of your business entity?____________________

10. What is your trading name?____________________

11. What is your business structure (please tick appropriate boxes)?

    ☐ Sole Trader ☐ Partnership ☐ Trust ☐ Company

    Company ACN____________________ ABN____________________

12. What is your % of ownership of the business?____________________

13. Is your business continuing in your absence? ☐ Yes ☐ No

14. If yes, who is completing your role/duties?____________________

F: Other Claims Income

1. Have you made, or do you intend to make, a sickness or injury claim with any of the following?

   If so, please tick the appropriate answer and provide details:

a. Any insurers	☐ Yes	☐ No	Name of company:__________
b. Centrelink / Social Security	☐ Yes	☐ No	Branch:__________
c. Workers' Compensation	☐ Yes	☐ No	Organisation:__________
d. Common Law Claim	☐ Yes	☐ No	Details:__________
e. Department of Veteran's Affairs	☐ Yes	☐ No	Details:__________
f. Any other organisation	☐ Yes	☐ No	Organisation:__________
g. CTP insurer	☐ Yes	☐ No	Name of company:__________

2. What is the total benefit you have received, or are entitled to, from the above?____________________

3. Please provide the date you first started receiving this benefit: DD / MM / YYYY

G: Sickness Claim

Please complete either G: Sickness Claim or H: Injury Claim

1. Nature of sickness: ____________________

2. Date the symptoms began: Date Doctor first consulted: DD / MM / YYYY

3. Date ceased work/regular activity: DD / MM / YYYY

4. What are your current symptoms? ____________________

5. Have you previously had the same or similar condition or symptoms? ☐ Yes ☐ No

   If 'yes', please provide full details: ____________________

6. Details of all the Doctors/Medical Practitioners you have seen about your condition:

   Name: ____________________

   Address: ____________________

   Phone number: ____________________

   Name: ____________________

   Address: ____________________

   Phone number: ____________________

   Name: ____________________

   Address: ____________________

   Phone number: ____________________

7. What treatments are you currently receiving (e.g. physiotherapy) and how frequently? ____________________

8. What medications, if any, are you taking at present? Please provide the names and dosages of each medication?

Medication:	Dosage / frequency per day	Recent changes / side effects

9. How are you responding to the treatment and medication that you are receiving? ____________________

IMPORTANT!
Please attach copies of reports received from Specialists, other Treating Doctors and Health Professionals

H: Injury Claim

1. Nature of injury:
2. How did the injury occur?
3. Location where the Incident/Accident occurred:
4. Date of injury: DD / MM / YYYY
5. Date Doctor first consulted for this condition: DD / MM / YYYY
6. Date ceased work/regular activity: DD / MM / YYYY
7. Details of all the Doctors/Medical Practitioners you have seen about your condition:

   Name:

   Address:

   Phone number:

   Name:

   Address:

   Phone number:

   Name:

   Address:

   Phone number:

8. What treatments are you currently receiving (e.g. physiotherapy) and how frequently?
9. What medications, if any, are you taking at present? Please provide the names and dosages of each medication?

Medication:	Dosage / frequency per day	Recent changes / side effects

10. How are you responding to the treatment and medication that you are receiving?

IMPORTANT!
Please attach copies of reports received from Specialists, other Treating Doctors and Health Professionals

I: Authorities

Medical Authority

I,____(full name) hereby authorise any doctor, hospital, therapist or other medical professional who has attended me, to release to TAL Direct Pty Limited, or its representatives, information relevant to my policy and/or claim, with respect to any sickness or injury, medical history, consultations, medications or treatment, received by me, together with copies of any and all medical records.

I consent to TAL Direct Pty Limited collecting this sensitive information. A copy of this authority is to be regarded as if it were the original signed authority. This medical authority will only be used for the purpose of assessing initial and ongoing entitlements to a claim.

Signature:____Date:____________________

Information Authority

I,____(full name) hereby authorise any insurer, employer, accountant or other relevant holder of information, to release to TAL Direct Pty Limited, or its representatives, information which TAL Direct Pty Limited requires for the purpose of assessing my claim for benefits. A copy of this authority is to be regarded as if it were the original signed authority.

Signature:____Date:____________________

J: Declarations

Claim Declaration

I hereby declare that the information provided 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 TAL Direct Pty limited of any material information regarding my claim, the insurer may refuse to pay or cancel my claim.

Signature:____Date:____________________

Privacy Declaration

Personal and sensitive information is collected from you to enable TAL Direct Pty Limited to provide the product or service you request. Without this information, We cannot provide this product or service. Your personal information may be disclosed to TAL Direct Pty Limited and any relevant bodies corporate including the following third parties, where necessary: Health Professionals; your (or your employer's, if relevant) Adviser or Financial Planner, the insurer TAL Life Limited; organisations to whom we outsource our mailing, administration and information technologies; the Insurance Reference Service; Investigators; the Trustee (if relevant); the administrator of the product or fund; reinsurers; government regulatory bodies; lawyers; accountants. By signing this form you consent to TAL and these organisations collecting your personal and sensitive information. In accordance with Privacy legislation, you can also obtain access to your information. A photocopy of this declaration is as valid as the original.

Signature:____Date:____________________

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Please return your documents: **e-mail:** contact@nrmalife.com.au | **Fax:** 1800 731 122
Mail: Reply Paid 72, Carlton South VIC 3053 | **Need Help:** Call 1300 996 143

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