NRMA Income Protection
Sickness or Injury Initial Claim Form

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

Any fee for the completion of the Initial Medical Report 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.

☐ Initial Medical Report (to be completed by your Medical Practitioner).

Part 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

Part B – Personal Details -

Policy number:____________________ Claim 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____________________

Part C – Banking Details

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

Name of Bank:____________________

BSB Number: ☐☐☐ - ☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐

Account Name:____________________

(For example: A & B Smith)

Part D – Occupational/Daily Activity Details

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

___

2. Please provide details of ALL the duties that you performed in your occupation/regular daily activities 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?___

___

Part 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:___

___

Part 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 individual 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 supply any of these, please call us on 1300 996 143 to discuss.)

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?____________________

Part 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

Part G – Sickness Claim

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

1. Nature of sickness:______________________________

____

2. Date the symptoms began DD / MM / YYYY
3. Date Doctor first consulted: DD / MM / YYYY
4. Date ceased work/regular daily activities: DD / MM / YYYY
5. What are your current symptoms?______________________________

____

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

   If 'yes', please provide full details:______________________________

____

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

Part 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 daily activities: 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

Part 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:____________________

Part J – Declaration

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:____________________

Your Privacy

The privacy of individuals is important and there are legal obligations imposed by current privacy laws including the Australian Privacy Principles.

The way in which your personal information is collected, used, secured and disclosed, as well as details about how to access or correct your personal information held by us, or make a complaint in relation to privacy is set out in the respective privacy policies of the providers of this product and / or related services and is available, free of charge, using the links and contact details below:

www.tal.com.au or call 1300 996 143

www.nrma.com.au or call 132 132

www.standrews.com.au

Collection and use of personal information

In order to provide this product to you (and to assess any claim made on this product) it may be necessary to collect your personal information, including your name, age, gender, contact details, health information, salary, and employment information. In certain circumstances, such as applications for life insurance products and claims, it may be necessary to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, then it may not be possible to provide the product to you or pay the claim.

Steps may be taken to verify the information that has been collected; for example, a birth certificate provided as identification may be verified with records held by the Registry of Births, Deaths and Marriages to protect against impersonation, or remuneration information may be verified with an employer in circumstances where there is a claim for income protection to ensure that it is accurate.

Disclosure of personal information

From time to time it may be necessary to disclose relevant personal information to external organisations and other parties in connection with providing this product, such as the following:

- Claims assessors and investigators, claims managers and reinsurers;
- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Other insurers;
- Other organisations to whom certain functions are outsourced during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where your personal information may be disclosed in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office); and
- Authorised by law (e.g. under Court Orders or Statutory Notices)

Please return this form
In the Reply Paid envelope provided,
or mail to the address here
(No postage stamp required)

Mail FREE Post
NRMA Insurance
Reply Paid 72
Carlton South, VIC 3053

How to contact us
Phone: **1300 996 143**
Email: contact@nrmalife.com.au
Fax: 1800 731 122

NRMA Income Protection is promoted by IAL Life Pty Limited ABN 15 137 509 936, Authorised Representative No 427847 of the distributor, TAL Direct Pty Limited ABN 39 084 666 017 AFSL 243260. Policies and claims administered under agreement with the insurers, TAL Life Limited ABN 70 050 109 450 AFSL 237848 and for Involuntary Unemployment Cover, St Andrew's Insurance (Australia) Pty Ltd ABN 89 075 044 656 AFSL 239649.

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