NRMA Income Protection
Sickness or Injury Initial Medical Report

(To be completed by your Medical Practitioner)

Please ensure that:

☐ ALL questions are completely answered to avoid any undue delays to this claim.

☐ You complete this form in black/blue ink and ensure that answers are clear and legible.

☐ The Insured is aware that any fee for the completion of this report is their responsibility.

Part A – Medical Practitioner's Details

Name:_____

Qualifications:_____

Email:_____

Address:_____

_____

Phone number:_____ Fax number:_____

Are you the Insured's usual treating doctor? ☐ Yes ☐ No

How long has the Insured been consulting with you?_____

If the Insured was referred to you, please advise by whom and the date of referral:_____

Part B – Insured's Details

Policy number:_____ Claim number:_____

First Name:_____ Surname:_____

Date of birth:_____ Height:_____ Weight:_____

Occupation or job title:_____

Hours worked per week:_____

Employment status prior to the Sickness or Injury: ☐ Full-time ☐ Part-time ☐ Casual ☐ Other

Part C – Medical Details - Diagnosis

1. What is the current diagnosis?_____

   Date of diagnosis: DD / MM / YYYY

2. On what objective findings is this diagnosis based? (Please attach copies of test results where possible)_____

   _____

3. What are the Insured's current signs and symptoms?_____

4. First consultation in regards to this condition: DD / MM / YYYY

   Most recent consultation for this condition: DD / MM / YYYY

5. When are you next scheduled to consult with the Insured?_____

Part C – Medical Details - Diagnosis continued

6. Has the Insured seen any other Doctors in relation to this condition? ☐ Yes ☐ No

If yes, please provide details (attach an additional list if necessay):

Name:_____

Address:_____

_____

Date(s) seen:_____ Speciality:_____

Name:_____

Address:_____

_____

Date(s) seen:_____ Speciality:_____

Part D – Medical Details - Treatment

1. Please describe the Insured's treatment plan, including surgery (either performed or being considered):

_____

_____

_____

2. Is the Insured taking prescribed medication? ☐ Yes ☐ No

Medication	Dosage / frequency

3. Has the Insured been following the treatment prescribed? ☐ Yes ☐ No

Part E – Medical Details - Regular Daily Activities

PLEASE ANSWER ONLY FOR WORKING PATIENTS AGED 18 – 64

1. Which specific work duties are affected by the Insured's current Sickness / Illness and to what degree:

Work duties performed pre-sickness or pre-injury:	Insured's current ability - Select one of the options below					Reason
	Able to with some difficulty	100% able	Able to in a limited capacity	Completely unable to do	Able to only with the assistance of another person or special equipment	
e.g. Driving				e.g. ✓		e.g. Fractured leg – unable to use brakes

Part E – Medical Details - Regular Daily Activities continued

2. Please advise from what date the Insured has been/will be:

   a. Totally unable to perform the duties of their usual occupation: DD / MM / YYYY

   b. Able to return to work full time: DD / MM / YYYY

   c. Able to return to partial duties: DD / MM / YYYY

   Please provide details of any applicable restrictions:_____

   _____

PLEASE ANSWER ONLY FOR NON-WORKING PATIENTS AGED 18 – 64

Activity	Was the Insured able to perform activity prior to the injury or illness?	Insured's current ability - Select one of the options below					Reason
		Able to with some difficulty	100% able	Able to in a limited capacity	Completely unable to do	Able to only with the assistance of another person or special equipment	
Cooking meals Use kitchen and cooking utensils, appliances and equipment to prepare a basic meal for oneself and/or others.	Yes / No						
Cleaning the home Use domestic appliances and equipment to clean and maintain a home and do laundry to basic standards.	Yes / No						
Shopping for food Physical ability to purchase every day household grocery items, with the use of a shopping basket or trolley.	Yes / No						
Providing care for children and/or dependent adults, if applicable	Yes / No						
Driving a car or using public transport Physical ability to drive a car for any distance, or catch a bus, train or ferry.	Yes / No						

3. Please advise from what date the Insured has been/will be:

   a. Totally unable to perform their regular daily activities: DD / MM / YYYY

   b. Partially able to return to their regular daily activities: DD / MM / YYYY

   c. Able to return to their regular daily activities: DD / MM / YYYY

   Please provide details of any applicable restrictions:_____

   _____

4. What is the current prognosis for recovery?_____

   _____

Part E – Medical Details - Regular Daily Activities continued

PLEASE ANSWER ONLY FOR PATIENTS AGED 65 – 75

Activity	Was the Insured able to perform activity prior to the injury or illness?	Patients current ability - Select one of the options below					Reason
		Able to with some difficulty	100% able	Able to in a limited capacity	Completely unable to do	Able to only with the assistance of another person or special equipment	
Bathing – the ability to shower or bathe.	Yes / No						
Dressing – the ability to put on and take off clothing.	Yes / No						
Toileting – the ability to get on and off and use a toilet.	Yes / No						
Mobility – the ability to get in and out of bed and a chair.	Yes / No						
Feeding – the ability to get food from a plate into the mouth.	Yes / No						

5. What is the current prognosis for recovery?_____

_____

Part F – Medical Details - Insured History

1. Please detail any past or ongoing medical conditions that have/are contributing to the claimed condition:

_____

_____

_____

2. Has the Insured ever consulted you, or any other medical practitioner previously for a similar or related condition or symptoms? ☐ Yes ☐ No

   If yes, please provide details of these conditions or symptoms along with the date of referral and doctors consulted:_____

_____

_____

_____

Part G – Other

In respect of the Insured's present condition, have you given any certificate or report to:

- Another Insurance Company ☐ Yes ☐ No
- Third Party Insurer ☐ Yes ☐ No
- Workers Compensation Insurer ☐ Yes ☐ No
- Solicitor ☐ Yes ☐ No
- Centrelink Office ☐ Yes ☐ No
- Other:_____

If yes, please provide details of who reports have been sent to:_____

_____

_____

Part H – Signature

By providing you with this Initial Medical Report to complete the Insured consents to the release of their personal and sensitive information and its collection by TAL.

I hereby declare that the above statements are true and correct:

Signature:_____ Date:_____

Qualification:_____ Address:_____

_____

Your Privacy

The way in which TAL, NRMA Insurance & St Andrew's collect, use, disclose and secure your personal information is set out in their respective Privacy Policies available at www.tal.com.au, www.nrma.com.au and www.standrews.com.au

Please return this form
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