Cash Assist Insurance Claim Form

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.

Please complete

Section 1 For ALL claims

Section 2 For Disability Claims (and have medical statement completed on page 5)

Section 3 For Rehabilitation Expense Claims

Section 4 For Unemployment Claims

Section 5 For Death Claims

Section 6 Declaration and authority – For ALL claims

Mark boxes with X where appropriate and use BLOCK letters.

If you have any questions about how to complete this form, please call 1300 555 625.

Cash Assist Insurance Claim Form

Policy/Card no.

Section 1. Policyholder personal details

Title | Given name(s)

Surname | Date of birth *(dd/mm/yyyy)*

Residential address | Suburb | State | Postcode

Phone no. (H) | Mobile no. | Gender ☐ Male ☐ Female

Occupation

Please confirm in what capacity you are completing this claim form.

☐ Policyholder | ☐ Executor of Estate or Legal Personal Representative

☐ Other (please explain)

What is the condition under which you are lodging this claim?

☐ Disability | ☐ Rehabilitation expense | ☐ Unemployment | ☐ Death

☐ Other (please explain)

Section 2. Disability claims

Were you in paid employment for at least 15 hours per week during the 12 consecutive months preceding the incapacity? ☐ Yes ☐ No

If Yes, please complete Section 2(a) over page. Otherwise please proceed to Section 2(b).

Section 2a. Complete this section if you were in paid employment for at least 15 hours per week

(Please provide proof of income, including individual tax returns and tax assessment notice from the Australian Tax Office. If you are self-employed, tax returns for your business are also required).

Please provide details of your current employer.

Employer name	Address

Suburb	State	Postcode

Contact name	Contact number	Period of employment

Please describe the usual duties of your occupation.

Please describe your present medical condition.

How did the condition occur?

When did you first experience difficulty as a result of the above illness or injury *(dd/mm/yyyy)*? / /

When did you first seek medical advice/treatment for this condition *(dd/mm/yyyy)*? / /

Have you ever suffered from the same or a similar condition before? ☐ Yes ☐ No

If Yes, please provide details.

Have you been working or receiving any income since the disability started? ☐ Yes ☐ No

(Income includes sick leave, Workers' Compensation or income replacement insurance)

If Yes, please provide details.

What period have you been unable to perform your usual occupation?

From / / To / /

Please proceed to Section 2(c).

Section 2b. Complete this section if you were not in paid employment for at least 15 hours per week

Please describe the present condition.

How did the condition occur?

When did you first experience difficulty as a result of the above illness or injury *(dd/mm/yyyy)*?	/ /
When did you first seek medical advice/treatment for this condition *(dd/mm/yyyy)*?	/ /
Have you ever suffered from the same or a similar condition before?	☐ Yes ☐ No

If Yes, please provide details.

Please state how your illness or injury affects your ability to perform the following daily activities.

	Able to perform	Partially able to perform	Unable to perform
Bathing or showering	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Toileting – including getting on and off	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Eating and drinking	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Moving about – getting in and out of bed, chair or wheelchair	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Controlling bowel or bladder function	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	

Please state how your illness or injury affects your ability to perform the following regular home duties.

	Able to perform	Partially able to perform	Unable to perform
Cooking meals	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Cleaning the home	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Doing the laundry	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Shopping for food	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	
Providing care for children and/or dependent adults, if applicable	☐	☐	☐
What period were you partially or unable to perform this function?	From / /	To / /	

Please proceed to Section 2(c).

Section 2c. All Disability Claims

1. Please state the name and address of your usual medical practitioner.

Name	Address	Date first consulted
		/ /
		/ /

2. Please state the names and addresses of other medical practitioners attending to you for this condition.

Name	Address	Date first consulted
		/ /
		/ /
		/ /
		/ /

(Please attach a separate list if insufficient space)

3. For motor accidents only

Were you driving? ☐ Yes ☐ No	Vehicle registration no.	
Date of accident *(dd/mm/yyyy)* / /	Time	Location
Did police attend? ☐ Yes ☐ No	From what police station?	
Was a breathalyser or blood alcohol test taken? ☐ Yes ☐ No	If Yes, what was the reading?	

Section 3. Rehabilitation Expense Claims

All Rehabilitation Expense Claims are subject to MetLife's written approval **before** the expense is incurred.

1. Please describe the nature of the expense

2. Why was the expense required?

3. When did you first seek medical advice/treatment for this condition *(dd/mm/yyyy)*? / /

Please use this space if required.

4. What is the expected cost of this expense (please provide a quote if available)?

5. What person/organisation will be providing the service required for this expense?

Name	Address

Section 4. Unemployment Claims

(Please attach a certified copy of the Termination of Employment Notice, proof that you are actively seeking employment and a copy of your last Tax Return and Tax Assessment Notice)

1. Please describe the circumstances of your unemployment.

2. When did you last work *(dd/mm/yyyy)*? / /

3. Are you actively seeking work? ☐ Yes ☐ No

If Yes, please provide details of your searches for work, including contact details of prospective employers.

If No, please explain the circumstances.

Section 5. Death Claims

(Please attach a certified copy of the Death and Birth Certificate)

1. Date of death *(dd/mm/yyyy)* / /

2. Cause of death

3. Please describe the circumstances of the illness or injury which caused the death.

Other Information (please use this space if needed).

Section 6. Electronic Funds Transfer

To enable the processing of your payment in a timely and efficient manner, we would like to offer payment to you via Electronic Funds Transfer. Payments using EFT will be deposited into your nominated bank account and a remittance advice mailed to you. Please note we are unable to offer this service to a credit card account.

Full name of account (account holder)

Name of bank

BSB	Or Building Society no.	Account no.

Account type

☐ Cheque ☐ Non-passbook Savings

I/we understand and acknowledge that

1. The bank/financial institution may in its absolute discretion determine the order or priority of payment by it of any monies pursuant to this request or any authority or mandate.

2. The bank/financial institution may in its absolute discretion at any time by notice in writing to me/us terminate this request as to future debits.

Account holder(s') signature(s) Date *(dd/mm/yyyy)*

Signature 1

▶

Signature 2

▶

If you do not complete this section, payments will be issued to you via cheque.

Section 7. Declaration and authority

I declare that to the best of my knowledge, all the statements made on this Claim Form are true and correct. I have not made any false or misleading statements and I have included all information relevant to the assessment of my claim.

If any of the answers are not in my handwriting, I certify that I have checked them and they are correct.

I hereby authorise MetLife Insurance Limited (MetLife), or any person duly authorised by MetLife, to disclose my personal information (which may include sensitive or health information) to the following nominated parties. I further consent to the nominated parties collecting information about me and releasing to MetLife any information they may hold about me (including their report) which relates to MetLife's administration of the policy/plan, including this claim; and

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.

- Any physical, hospital or any other healthcare provided who has attended or examined me in order for them to supply MetLife with full particulars of my medical history including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made
- Any claims assessor, investigator, medical professional, healthcare provider, insurance reference service, credit reference service, financial institution, legal or accounting firm, auditor, employer, consultant or reinsurer in order for the nominated party to produce a report concerning my claim
- Any benefit provided such as other insurers or Government Departments (including Workers' Compensation, Centrelink or similar benefit providers) that provide benefits in the event of my injury. I authorise for the nominated party to supply MetLife with full particulars of any and all claims made for benefits in the event of my injury including copies of evidence they hold.

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.

A photocopy of this declaration shall be as valid an authority as the original.

Signature

Date *(dd/mm/yyyy)*

▶ _____ _____

Name

_____

Please attach to this claim form copies of medical reports/medical certificates/test results you have in your possession that are relevant to this claim.

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

Medical statement

Privacy Information
The personal information you provide in the form is necessary for MetLife to provide your patient with the products and services they have requested from MetLife, and to manage their claim. You do not have to provide MetLife with this personal information, but if you do not do so MetLife may not be able to provide your patient 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 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.

To be completed by a registered medical practitioner. The patient will incur any charge for this service.

Mark boxes with X where appropriate, otherwise use BLOCK letters.

Patient/claimant details

Title	Given name(s)

Surname

Address	Suburb	State	Postcode

Occupation	Date of birth *(dd/mm/yyyy)*

Patient history

1. Are you the patient's usual medical practitioner? ☐ Yes ☐ No — If Yes, how long have you known the patient?
2. When did the patient first consult you for the present condition *(dd/mm/yyyy)*?
3. When did the present condition commence *(dd/mm/yyyy)*?
4. When would the condition have caused the patient to cease work *(dd/mm/yyyy)*?
5. Please provide a summary of the patient's present condition including cause, symptoms and diagnosis.
6. Please detail a history of this condition, including all dates of consultation (attach separate list if required).

Date of consultation	Reasons, including symptoms, diagnosis and test results	Treatment prescribed	Results	Progress of patient's condition (recovered, improved, static, deteriorated)
/ /				
/ /				
/ /				
/ /				

Patient history (continued)

7. Does the patient have a prior medical history related to the present condition? ☐ Yes ☐ No

If Yes, please provide details below.

8. Please provide details of other medical practitioners the patient has consulted for this condition.

Name	Address and phone number	Qualifications	Date(s) consulted
			/ /
			/ /
			/ /

Medical certification

Please complete either

Section 1. If patient was unable to work; or
Section 2. If patient was able to work on a partial/restricted basis; or
Section 3. If patient has recovered.

Section 1. Inability to work

i. For what period was the patient unable to perform any of the duties of his/her occupation *(dd/mm/yyyy)*?

From / / To / /

ii. What are the patient's capabilities and limitations with respect to the above period?

Capabilities

Limitations

iii. When do you consider that the patient may return to work on a partial/restricted or full-time basis?

Date *(dd/mm/yyyy)* / /

Basis of return to work

Section 2. Partial/restricted ability to work

i. When did the patient return to work on a partial or restricted basis *(dd/mm/yyyy)*? / /

ii. What are the patient's capabilities and limitations with respect to the period of partial/restricted disability?

Capabilities

Limitations

iii. When do you believe that the patient will return to work on a full-time basis *(dd/mm/yyyy)*? / /

Section 3. Clearance to return to work

i. When was the patient able to return to work on a full-time basis *(dd/mm/yyyy)*? / /

ii. What were the patient's capabilities and limitations with respect to the period of disability?

Capabilities

Limitations

Section 4. Other information

Are you completing claim forms on behalf of the patient for any other company in respect of this condition? ☐ Yes ☐ No

If Yes, please provide details.

Other comments (please use this space if required)

Section 5. Your details

Title	Given name(s)

Surname

Address	Suburb	State	Postcode

Phone no.	Qualifications

Signature of medical practitioner	Date *(dd/mm/yyyy)*
▶	

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

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ABN 75 004 274 882 AFSL NO. 238 096