Rest Easy Plan 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.

Claim Form Instructions

For us to process your claim promptly please:

1. Complete all relevant sections of the claim form.
2. For a Rest Easy Benefit and/or Permanent Disability Benefit claim, have your doctor complete the Medical Statement. Please attach copies of any medical reports, medical certificates or test results you may have in your possession.
3. For a death claim include a certified copy of the Death Certificate and the Birth Certificate. and mail it to: Insurance Claims - MetLife GPO Box 3319, Sydney NSW 2001

Please complete:

Section 1 For ALL claims

Section 2 For Rest Easy Benefit claims (and have the Medical Statement completed on pages 12 to 14)

Section 3 For Rest Easy Overseas claims

Section 4 For Permanent Disability claims (and have the Medical Statement completed on pages 12 to 14)

Section 5 For Death Claims

Section 6 Declaration and authority – For ALL claims

Mark boxes with X where appropriate and complete in BLOCK letters.

Section 1. Personal details of life insured

Title	Given name(s)

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

Address	Suburb	State	Postcode

Phone no. (H)	Phone no. (W)	Mobile no.

Employment details at the date you last worked

Employer name	Date joined company *(dd/mm/yyyy)*

Employer address	Suburb	State	Postcode

Occupation

Employer phone no.	Date last worked

Section 2. Rest Easy Benefit Claims

The Rest Easy Benefit is payable if, as the direct result of an *Accidental Injury*, you are unable to perform without the assistance of another person at least three (3) Activities of Daily Living for 24 consecutive hours.

Accidental Injury means you suffer a bodily injury caused directly by a sudden and unforeseeable event that occurs purely by chance.

Activities of Daily Living are:

- Bathing – to shower or bathe
- Dressing – to dress or undress
- Toileting – to use the toilet, including getting on and off the toilet
- Feeding – to eat and drink
- Mobility – to get into and out of a bed, chair or wheelchair
- Continence – to control bladder and bowel function

1. Are you claiming the Rest Easy Benefit?
   ☐ Yes ☐ No

   If No, please go to Section 4.

   If Yes, please continue.

2. What *Accidental Injury* did you suffer and what were you doing at the time?
   Please continue your description in the 'Other Comments' section if there is insufficient space here.

3. What part/s of your body is/are affected and how is/are they affected? Please continue your description in the 'Other Comments' section if there is insufficient space here.

Section 2. Rest Easy Benefit Claims (continued)

4. When did the *Accidental Injury* occur *(dd/mm/yyyy)*? / /

5. How and where did the *Accidental Injury* occur?

6. Was the accident reported (e.g. to employer, police, etc)? ☐ Yes ☐ No

If Yes, please provide details.

7. **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 which police station?	
Was a breathalyser or blood alcohol test taken? ☐ Yes ☐ No	If Yes, what was the reading?	

8. Did anyone witness the accident? ☐ Yes ☐ No

If Yes, please give names and their relation to you.

9. Please complete the table below for those *Activities of Daily Living* you are unable to perform.

Activity	% of inability (e.g. 50%, 80%)	Can you perform the activity with the assistance of another?	How long were you continuously unable to perform the activity?
Bathing			From To
Dressing			From To
Toileting			From To
Feeding			From To
Mobility			From To
Continence			From To

10. When did you first consult a doctor about your *Accidental Injury (dd/mm/yyyy)*? / /

Section 2. Rest Easy Benefit Claims (continued)

11. Name and address of doctor consulted.

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

If Yes, please provide details.

13. Provide the name and address of your usual doctor and/or surgery and the date of your most recent consultation.

Name	Medical practitioner address and phone number	Date last seen

14. How long have you been attending this medical practitioner and/or surgery? Years Months

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

Name	Address and phone number	Qualifications	Date last seen

(please attach a separate list if insufficient space)

16. Are you required to attend any surgery, hospital, clinic or health worker for continuing treatment? ☐ Yes ☐ No

If Yes, please provide details.

Name	Address and phone number	Treatment

17. Have you lodged a claim under Workers' Compensation, sickness/accident benefit or any other insurance policy? ☐ Yes ☐ No

If Yes, please provide details including claim number, name and address of insurer, and details of payments made to date.

Name	Claim no.	Address and phone number	Payment details

Section 2. Rest Easy Benefit Claims (continued)

18. Have you performed your usual work or performed any other work since your condition commenced? ☐ Yes ☐ No

If Yes, please provide details below

Employer	Duties

Period from | to

Basis of employment for this period ☐ Full-time ☐ Part-time

Other comments (please use this space if required)

Section 3. Rest Easy Overseas Option Claims

The Rest Easy Overseas option applies only if it is shown in your Plan Schedule. Double the Rest Easy Benefit is payable if your *Accidental Injury* occurred overseas (i.e. outside the Commonwealth of Australia).

1. Are you claiming the Rest Easy Overseas option?

   ☐ Yes ☐ No

   If No, please go to Section 4.

   If Yes, please continue.

2. Where were you and in what country did the *Accidental Injury* occur?
   Please continue your description in the 'Other Comments' section if there is insufficient space here.

3. When did you leave Australia? Please attach proof.

Date of departure	Where departed from	Date of arrival	Where arrived
/ /		/ /	

4. When did you or when do you intend to return to Australia? Please attach proof.

Date of departure (or date of planned return)	Where departed from	Date of arrival
/ /		/ /

Other comments (please use this space if required)

Section 4. Permanent Disability Claims

The Permanent Disability Benefit applies only if it is shown in your Plan Schedule. The Permanent Disability Benefit is payable if, as the direct result of an *Accidental Injury*, you suffer the permanent loss of use of a part of your body, or sight, speech or hearing. The amount payable depends on the type of permanent disability suffered (as specified in the Product Disclosure Statement) and the type of cover shown in your Plan Schedule.

1. Are you claiming the Permanent Disability Benefit?

☐ Yes ☐ No

If No, please go to Section 5.

If Yes, please continue.

2. What permanent loss have you suffered as a result of your *Accidental Injury*?
Please indicate all losses that are the direct result of your *Accidental Injury*.

☐ Use of both feet	☐ Use of one hand	☐ Complete hearing in both ears
☐ Use of both hands	☐ Complete sight in one eye	☐ Complete hearing in one ear
☐ Use of one foot	☐ Complete sight in both eyes	☐ Complete loss of speech

Please answer the remainder of the questions in Section 4 only if you have not answered them elsewhere.

3. What *Accidental Injury* did you suffer and what were you doing at the time? Please continue your description in the 'Other Comments' section if there is insufficient space here.

4. What part/s of your body is/are affected and how is/are they affected? Please continue your description in the 'Other Comments' section if there is insufficient space here.

5. When did the *Accidental Injury* occur *(dd/mm/yyyy)*? / /

6. How and where did the *Accidental Injury* occur?

7. Was the accident reported (e.g. to employer, police, etc)? ☐ Yes ☐ No

If Yes, please provide details

Section 4. Permanent Disability Claims (continued)

8. 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 which police station?	
Was a breathalyser or blood alcohol test taken? ☐ Yes ☐ No	If Yes, what was the reading?	

9. Did anyone witness the accident? ☐ Yes ☐ No

If Yes, please give names and their relation to you.

10. When did you first consult a doctor about your *Accidental Injury (dd/mm/yyyy)*? / /

11. Name and address of doctor consulted.

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

If Yes, please provide details.

13. Provide the name and address of your usual medical practitioner and/or surgery and the date of your most recent consultation.

Name	Address and phone number	Date last seen

14. How long have you been attending this medical practitioner and/or surgery? Years Months

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

Name	Address and phone number	Qualifications	Date last seen

(please attach a separate list if insufficient space)

Section 4. Permanent Disability Claims (continued)

16. Are you required to attend any surgery, hospital, clinic or health worker for continuing treatment? ☐ Yes ☐ No

If Yes, please provide details.

Name	Address and phone number	Treatment

17. Have you lodged a claim under Workers' Compensation, sickness/accident benefit or any other insurance policy? ☐ Yes ☐ No

If Yes, please provide details including claim number, name and address of insurer, and details of payments made to date.

Insurer name	Claim no.	Address and phone number	Payment details

Other comments (please use this space if required)

Section 5. Death Claims

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

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

Cause of death/injury.

Duration of illness.

2. Name and address of medical practitioners who would be able to provide information regarding the insured's medical history.

Name	Address and phone number

3. Is the Estate being handled by: ☐ Solicitors ☐ Public Trustee ☐ Trustee Company ☐ Other

Provide name and address below.

Name	Address and phone number

Other comments (please use this space if required)

Section 6. Declaration and authority

I declare that the answers and statement made on this claim form are true and complete. I have not made any false or misleading statement and I have included all information relevant to the assessment of my claim.

Where I have completed this declaration and authority as the Executor / Administrator / Guardian, I have attached a certified copy of the relevant legal documents (eg. Will, Letter of Administration, Power of Attorney).

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 medical practitioner, hospital or any other healthcare provider 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 provider such as other insurers or Government departments (including Workers' Compensation, Centrelink or similar benefit providers) that provide benefits in the event of my unemployment, sickness and/or injury for the nominated party to supply MetLife with full particulars of any and all claims I have made for benefits in the event of my unemployment, sickness and/or 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 authority is as valid as the original.

Signature

Date *(dd/mm/yyyy)*

Name

Please return completed form to
Insurance Claims, MetLife GPO Box 3319 Sydney NSW 2001

Rest Easy Plan Disability Claim - Medical Statement

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

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.

Patient 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 did the *Accidental Injury* occur *(dd/mm/yyyy)*? / /

5. What *Accidental Injury* did the patient suffer and what was the patient doing at the time?

6. What part/s of the patient's body is/are affected and how is it/are they affected?

7. Your patient has a type of life insurance policy where a benefit is payable if, as the direct result of an *Accidental Injury*, he/she is unable to perform without the assistance of another person at least three (3) Activities of Daily Living, for 24 consecutive hours.
   Activities of Daily Living are:
   - Bathing – to shower or bathe
   - Dressing – to dress or undress
   - Toileting – to use the toilet, including getting on and off the toilet
   - Feeding – to eat and drink
   - Mobility – to get into and out of a bed, chair or wheelchair
   - Continence – to control bladder and bowel function

Patient history (continued)

Please complete the table below for those *Activities of Daily Living* your patient is unable to perform.

Activity	% of inability (e.g. 50%, 80%)	Can the activity be performed with the assistance of another?	How long were they continuously unable to perform the activity?	
Bathing			From	To
Dressing			From	To
Toileting			From	To
Feeding			From	To
Mobility			From	To
Continence			From	To

8. For how long do you anticipate the patient will be unable to perform the above Activities?
Please give reasons for any continuing disability.

9. **For Permanent Disability claims only**

A Permanent Disability benefit may be payable if the patient is covered for the benefit and if, as the direct result of *Accidental Injury*, the patient has suffered the permanent loss of the use of a hand, foot, complete sight in an eye, complete hearing in an ear or the complete loss of speech.

If such a permanent loss has occurred, please specify the type of loss and why you consider the loss to be permanent.

10. If not provided elsewhere, please provide a summary of the patient's present condition including the cause of the *Accidental Injury*, symptoms and diagnosis.

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

If Yes, please provide details including dates seen.

Patient history (continued)

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

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.

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

MetLife Insurance Limited | Level 9, 2 Park Street, Sydney | NSW 2000
ABN 75 004 274 882 AFSL NO. 238 096