

Loan Insurance Disability Claim Form

Mark boxes with where appropriate, otherwise use block letters. Leave a box between words.

Loan Insurance Disability Claim Form relating to:

Policy No.

Section 1. Personal details

Title Male Female Surname

Given names

Address

Suburb State Postcode

Phone No. () Mobile No. Date of birth / /

Section 2. Loan details

Loan account No. Monthly loan instalment \$. Due on / /

Financial institution

Financial institution address

Suburb State Postcode

Section 3. Employment details

Employer name

Employer address

Suburb State Postcode

Occupation

Section 3. Employment details (continued)

Employer phone No.

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|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

Date joined company

| | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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Section 4. Disability details

1 What is the nature of the illness or injury that caused you to cease work?

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|--|
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| |

2 When did you first experience difficulty arising out of the above illness or injury?

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|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

3 When did you physically cease work as a result of this illness or injury?

| | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

4 Please state the names and addresses of medical practitioners attending to you for this condition:
(please attach a separate list if insufficient space)

| Name | Address and phone number | Qualifications | Date first consulted |
|------|--------------------------|----------------|----------------------|
| | | | |
| | | | |
| | | | |

5 Are you required to attend any surgery, hospital, clinic or facility for continuing treatment?
If 'YES', please provide details:

Yes No

| Name | Address and phone number | Next appointment date |
|------|--------------------------|-----------------------|
| | | |
| | | |
| | | |

6 Have you lodged a claim under Workers Compensation, sickness/accident insurance policy or been in receipt of payments from your employer since you ceased work?

Yes No

If 'YES', please provide details including name and address of payee, claim number (if applicable) and details of payments made to date:

Claim No.



Section 5. 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.

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.

- Any physician, 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 sickness and/or injury I authorise 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 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 that MetLife may not be able to assess, investigate or pay my claim.

A photocopy of this authority is as valid as the original.

Signature

Name

Date

Please attach copies of any medical reports, medical certificates or test results you may have in your possession.

Please return this form and any attachments to:

Insurance Claims
GPO Box 3319
Sydney NSW 2001

have you met life today?

For Client Services call

1300 134 669

Monday to Friday 8.00am to 6.00pm EST

MetLife®

MetLife Insurance Limited

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AFSL No. 238096

www.metlife.com.au

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