

Statement of Claim

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

Statement of Claim relating to:

Plan Name

Policy No.

Section 1. Personal details

Title

Surname

Given names

Address

Suburb

State

Postcode

Phone No. (h)

Phone No. (w)

Mobile No.

Date of birth

Email

Date joined company

Date last worked

Date of Disability

Annual Salary at the date last worked (excluding overtime, bonus allowances etc.)
(please provide copies of pay slips in support of your Annual Salary)



Section 2. Occupation details

Job title and duties performed including percentage of time spent in each duty: (or attach a copy of your role description).

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

Hours of work to No. of days per week

Please list below any machines or special equipment used and whether these were operated manually or automatically:

Machine Manual Automatic

Machine Manual Automatic

Were you employed in a supervisory capacity? Yes No

If 'YES', how many staff did you supervise?



In what area did you work (e.g. office/loading dock etc.)?

| |
|--|
| |
| |

Is there any other information you wish to provide which may be relevant to the assessment of this claim?

| |
|--|
| |
| |

Please confirm the physical requirement of the role where applicable by completing the following:

| Percentage of time spent in task | | | | Percentage of time spent in task | |
|----------------------------------|------|--------|------|--------------------------------------|-----------|
| Task | <30% | 31–70% | >71% | Task | % per day |
| Lifting, 20kg & over | | | | Walking | |
| Lifting, 7–19kg | | | | Standing | |
| Lifting, under 7kg | | | | Climbing – ladders, scaffolding etc. | |
| Carrying, 20kg & over | | | | Crawling | |
| Carrying, 7–19kg | | | | Kneeling | |
| Carrying, under 7kg | | | | Climbing – ramps, steps etc. | |
| Reaching above shoulders | | | | Sitting | |

What qualifications, training and experience do you have?

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

190102

Section 2. Occupation details (continued)

Did you travel on the job?

Yes No

If 'YES', No. kilometres per month

Type of Vehicle

How far from home was your place of work?

How did you get to work (e.g. drive/walk/public transport etc.)?

Please list all previous jobs you have had and indicate the period spent in each job:

| Employer | Job Title | Duties | Period |
|----------|-----------|--------|--------|
| | | | |
| | | | |
| | | | |

Section 3. Details of disability



1 What is the nature of the illness or injury?

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

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| | | / | | | | / | | | |
|--|--|---|--|--|--|---|--|--|--|

3 When did you first consult a doctor for this medical condition?

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| | | / | | | | / | | | |
|--|--|---|--|--|--|---|--|--|--|

4 When was your last day at work?

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| | | / | | | | / | | | |
|--|--|---|--|--|--|---|--|--|--|

5 Did you stop work because of your medical condition?

Yes No

If 'YES', please give details:

6 Is your condition the result of an accident?

Yes No

If 'YES', how, where and when did the accident occur?

7 Was the accident reported (e.g. to employer, police, etc.)?

Yes No

If 'YES', please give details:

190103

Section 3. Details of disability (continued)

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

| Name | Address and phone number | Date last seen |
|------|--------------------------|----------------|
| | | |
| | | |

9 How long have you been attending this doctor and/or surgery? Months Years

10 Please state the names and addresses of medical practitioners attending to you for this condition: +

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

(please attach a separate list if insufficient space)

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

If 'YES', please give details:

| Name | Address and phone number | Treatment |
|------|--------------------------|-----------|
| | | |
| | | |

12 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:

Claim No.

| Name | Address and phone number | Payment details |
|------|--------------------------|-----------------|
| | | |
| | | |
| | | |

190104

Section 4. 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.
- 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 also authorise my Financial Adviser/Fund Trustee/Fund Administrator to make inquiries regarding the progress of the claim for the purpose of providing me with ongoing service. I understand that this information is required to enable MetLife to assess and manage my claim in accordance with the Terms and Conditions of my policy/group life cover.

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 | <input type="text" value="x"/> |
| Name | <input type="text"/> |
| Date | <input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/> |



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

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

Level 9, 2 Park Street, Sydney NSW 2000

ABN 75 004 274 882

AFSL No. 238096

www.metlife.com.au

CIT3064 07/05

Products are offered by MetLife Insurance Limited (MetLife), which is an affiliate of MetLife, Inc. and operates under the "MetLife" brand. None of the obligations of MetLife are guaranteed by MetLife, Inc. (Incorporated in the USA) or any other member of the MetLife group.

190106