Cash Assist Insurance Claim Form

Your Duty of Disclosure

Before you enter into a contract of insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, that is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you vary or reinstate a contract of life insurance.

Your duty however does not require disclosure of a matter:

- That diminishes the risk to be undertaken by the insurer;
- That is of common knowledge;
- That your insurer knows or, in the ordinary course of the insurer's business as an insurer, ought to know;
- Where compliance with your duty is waived by the insurer.

Privacy Infomation

MetLife in Australia is subject to the Australian Privacy Principles under the Privacy Act 1988 and has a Privacy Policy, which details information about 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. We may collect your personal information for a number of purposes, which may include:

- Providing you with a particular product or policy;
- Processing receipts and payments;
- Administering your product or policy;
- Assessing, processing and investigating insurance risks or claims;
- Producing statements and other mail related services;
- Meeting legal and regulatory requirements;
- Providing you with information about other products and services, with your consent.

We may also share your personal information with selected third parties for the purpose of administering your product or policy (some of whom may be situated outside Australia), and your information may be provided on a confidential basis for this purpose. We will not disclose your sensitive information (if applicable) for any purpose other than to underwrite or service your insurance cover or assess a claim. The organisations to whom we may disclose your personal information may include, among others:

To	For
Mailhouses	Statement production and other mail related services
Administration services and technology services	Data entry, data processing, continuity of business, account maintenance and documentation
Investigators, medical attendants, other insurers and reinsurers	Assessing your application, underwriting and claims assessment
Insurance Industry bodies	Claims matching and cross referencing
Professional and financial advisers	Administering your product or policy
Superannuation fund trustees	Administering your product or policy
Government or regulatory bodies	To comply with laws and regulation or for compliance related services
Organisation wishing to acquire an interest in any part of MetLife's business	Assessment of any proposed **acquisition**

Non Disclosure

If you fail to comply with your Duty of Disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurers may, within three years of entering into it, elect not to avoid it, but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

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. | Sex ☐ 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? / /

When did you first seek medical advice/treatment for this condition? / /

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? / /

When did you first seek medical advice/treatment for this condition? / /

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 / /	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? / /

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? / /

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 contained in the section entitled 'Privacy - Use and disclosure of personal information'. I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement above and MetLife's Privacy Policy.

- 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 completed form to
MetLife Insurance Limited, Cash Assist Claims, GPO Box 3319, Sydney NSW 2001 or email auservices@metlife.com

Medical statement

Privacy Information
MetLife recognises the importance of protecting you and your patient's personal information, and is committed to complying with its Privacy Law obligations. To find out more about how you may access or seek correction of your personal information, how we manage that information and our complaints process, please refer to the MetLife Privacy Statement, which 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?
3. When did the present condition commence?
4. When would the condition have caused the patient to cease work?
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?

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? / /

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? / /

Section 3. Clearance to return to work

i. When was the patient able to return to work on a full-time basis? / /

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)*
▶	

Please return completed form to
MetLife Insurance Limited, Cash Assist Claims, GPO Box 3319, Sydney NSW 2001 or email auservices@metlife.com **metlife.com.au**

MetLife

MetLife Insurance Limited | Level 9, 2 Park Street, Sydney | NSW 2000
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