

For further information contact International Underwriting Services Pty Ltd on:

Phone: 1300 651 450

ClaimsTrak
Group Income
Protection
claimants
[click here](#)
to monitor
your claim
Open 24 hours a day.
For you.
www.ius.com.au

INSTRUCTIONS

1. **YOU Fully** complete Part A of the claim form including either the sickness statement or the injury statement.
2. Have **YOUR DOCTOR Fully** complete Part B of the claim form.
3. **YOUR EMPLOYER Fully** completes Part C of the claim form.
4. Ensure all the details are correct and that each section is **signed**.
5. Send the claim form to;
International Underwriting Services Limited
Attention Claims Department
PO Box 6215
North Sydney NSW 2060
6. We will send confirmation to you within 24 hours that we have received your claim form.

**YOUR
CLAIM FORM
IS INSIDE**

Frequently Asked Questions

How long will it take to complete my section of the form?

We've tested it -- it takes about 20 minutes. We want to settle your claim for you just as quickly as we can, so please don't rush the completion of this form as delays will happen if corrections are needed or if insufficient information is provided.

What can delay my claim?

The most common causes of delay are:

- If a claim form isn't correctly completed or signed.
- When medical practitioners and medical specialists are too busy to get around to medical reports.

How can I check the progress of my claim?

We've developed ClaimsTrak, a new and simple to use web-based facility that will enable you to check the progress of your claim. We will provide you with a unique code and password to access ClaimsTrak when we receive your claim form. You can access ClaimsTrak by visiting the IUS website: www.ius.com.au and clicking on the ClaimsTrak icon on the home page. Alternatively, you can contact your personal claims consultant -- they will provide their name and contact phone number when they write to you to confirm receipt of this form.

I need help completing this form, what can I do?

We're here to help you, so just call us on 1300 651 450 and ask for claims.

To sum up: IUS has one of the best claims settlement rates in the country, so you can be sure we will do everything we can to process your claim promptly. You can play your part by double-checking that your claim form really has been accurately completed before you send it to us.

Thanks. The IUS Claims Team.

**International Underwriting Services Pty Limited (ACN 074 494 885 AFSL 237881)
is acting under the authority of the insurer and will be dealing
with this insurance claim as agent of the insurer and not the insured**

**International Underwriting Services Pty Limited (ACN 074 494 885 AFSL 237881)
Telephone: 1300 651 450 Facsimile: 02 9954 1750 Email: info@ius.com.au Web: www.ius.com.au
Postal: PO Box 6215 North Sydney NSW 2060**

Section A – To be completed by Claimant

All questions must be completed or claim form will be returned and assessment of your claim will be delayed

Print Super Membership Number:

Claimant's Surname: Given Names: Title:

Sex: Male Female Date of Birth: / / Height: cm Weight: kg

Street Address: Suburb: State: Postcode:

Postal Address: Suburb: State: Postcode:

Home Telephone: Mobile No: Work No:

Email: Union Name: Union No:

Name of Employer:

Site Name & Address:

Suburb: State: Postcode:

Employed Since: / / Occupation/Job Title:

Department: Department Manager/Supervisor:

Contact Phone Number (Manager/Supervisor):

Please list your Usual Duties and percentage of time spent on each task:

| Tasks | % Time spent on task |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

On average how many days do you work per week: Hours worked per day:

Employment Status (eg, Full time, part time): Do you work regular overtime: Yes No

Do you authorise IUS to update you with claims information via SMS? Yes No

Electronic Funds Transfer Information

Following IUS approval of your claim, should you wish to have your claim benefits transferred directly to your bank account please complete details below.

NB. Direct transfers to you are only applicable where it is a selected option under the policy.

Bank Name: Bank Branch:

Account Name: BSB: Account No:

GST Information

Q Are you registered for GST purposes: Yes No If Yes, what is your ABN:

Q Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made: Yes No

Q If Yes, what percentage of the GST did you claim or are you entitled to claim? (If the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%) %

Injury Statement

Please only complete this section if your claim is as a result of an Injury

Date of Injury: / / Time of Injury: am/pm

Q What is the Nature of your injury(ies)?, i.e. Fracture, burn, degenerative etc:

Q What part of the body does it relate to? i.e. leg, face etc:

Q What specific event occurred to cause the injury(ies):

Q Where were you at the time of the injury? Address if applicable:

Q Were there any witnesses to this injury? If so, please provide name(s) and contact detail(s):

Q What date did you cease work as a result of this injury: / /

Q What date did you first consult a doctor for this injury: / /

Q Did the Injury occur during the course of your usual occupation: Yes No

Q Have you ever had a similar condition in the past? If Yes, please give details: Yes No

Q If answered yes to above, please explain below if there is any relation between the previous injury and this injury you are claiming for now?

Or if not, why not:

Q How long do you anticipate you will be away from work as a result of this injury: days / weeks

Q If you have already returned to work, please specify the date: / /

Q Please list all your treating medical practitioners over the past five years.

| Doctors Name | Period of attendance | | Specialty | Phone | Fax |
|--------------|----------------------|----|-----------|-------|-----|
| | From | To | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Q Please list all the doctors you have consulted in relation to this injury and the dates of consultation if known.

| Doctors Name | Period of attendance | | Specialty | Phone | Fax |
|--------------|----------------------|----|-----------|-------|-----|
| | From | To | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Q Please list what usual duties you are still able to perform as a result of this injury

Q Please list what usual duties you are unable to perform as a result of this injury:

Q What is your current treatment program as prescribed by your treating doctor(s) e.g. Medication, surgery, physio, exercise etc:

Sickness Statement

Please only complete this section if your claim is for a sickness

Q What sickness are you suffering from resulting in you claiming under this policy?

Q What date did you first become aware of this condition: / /

Q What date did you first seek treatment from a doctor in relation to this condition: / /

Q What date were you first unable to attend your usual duties as a result of this condition: / /

Q Have you ever had a similar condition in the past? If so, please specify the dates you were being treated for this condition:

| Doctors Name | Periods of Consult | | Phone | Fax |
|--------------|--------------------|----|-------|-----|
| | From | To | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Q In your own words please explain if there is or is not any relation between the previous condition and the condition you are claiming for now:

Q How long do you anticipate you will be away from work as a result of this condition: days / weeks

Q If you have already returned to work, please specify the date: / /

Q Have your treating doctors at any time advised you to cease treatment for this sickness: Yes No

Q Please list all your treating medical practitioners over the past five years.

| Doctors Name | Period of attendance | | Specialty | Phone | Fax |
|--------------|----------------------|----|-----------|-------|-----|
| | From | To | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Q Please list all the doctors you have consulted in RELATION TO THIS SICKNESS and the dates of consultation if known.

| Doctors Name | Period of attendance | | Specialty | Phone | Fax |
|--------------|----------------------|----|-----------|-------|-----|
| | From | To | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Q Please list what usual duties you are still able to perform as a result of this condition:

Q Please list what usual duties you are unable to perform as a result of this condition:

Q What is your current treatment program as prescribed by your treating doctor(s)? e.g. Medication, surgery, physio, exercise etc:

Other Insurance Cover

Q In respect of this injury or sickness are you receiving or planning to lodge a claim against:

- | | | |
|-----------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. Motor Accident Compensation Benefit | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Worker's Compensation Benefit (Workcover) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Sick Leave Benefits: Please specify dates below | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Centrelink and/or Government Disability Benefits | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Sports Insurance with Club | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Superannuation Life Insurance | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Private Health Fund | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Your employer or Any Other party for any benefits (Please specify) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Q If you have answered Yes to any of the above please give details below and number against each (e.g.; 1, 2, 3)

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

Privacy Act

The Privacy Act 1988 contains National Privacy Principles which require Us to tell You that as an agent of the Insurer We collect, handle, store and disclose Your personal and sensitive information in order to:

- Decide whether to issue a Policy,
- determine the terms and conditions of Your Policy,
- compile data, and
- handle claims.

Sensitive information includes, amongst other things, information about an individual's health, membership of professional associations and criminal records.

You have given Us Your consent to collect Your personal and sensitive information in order to issue You with this Policy.

We disclose personal information to third parties who We deal with in providing the relevant services and products. For example, in handling claims, We may have to disclose Your personal information to third parties such as insurers, reinsurers, loss adjusters, external claims data collectors, investigators and agents of other parties as required by law. We limit the use and disclosure of any personal information provided by Us to them to the specific purpose for which We supplied it.

You have the right to seek access to Your personal information and sensitive information and to correct it at any time.

IUS aims to ensure that Your personal information is accurate, up-to-date and complete. Please contact Us on 02-9922 1682 if You would like to seek access to, or revise Your personal information or feel that the information We currently have on record is incorrect or incomplete or believe that the privacy of Your personal information at IUS has been interfered with. Your complaint will be managed and resolved through Our internal dispute resolution process.

Medical Authority and Declaration

I hereby authorise any hospital, physician, insurer, Health Insurance Commission, my employer or other person who has attended me to furnish to International Underwriting Services Pty Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Worker's Compensation claims or claims with any other insurer to be released to International Underwriting Services Pty Limited. I agree that a Photostat or fax copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recovery thereunder or in respect of past or future claims shall be forfeited.

Q I further declare that the claim I am making for Income Protection benefits is/is not (strike out which is not applicable) work-related and is/is not covered by Workers Compensation.

Name: Signed: Date: / /

Important Notice: If a claim is made under IUS Income Protection insurance that is rightfully a Workers Compensation claim, you could possibly be prosecuted for committing a fraudulent act. You should also be aware that in making a claim under IUS Income Protection insurance you will forego any long-term benefits and rights under Workers Compensation entitlements.

Section B - Medical Practitioner's Statement - To be completed by Your Treating Doctor

All certificates and evidence required by Us shall be furnished as required at the Insured Person's expense.

Patient's Full Name: _____ Date of Birth: ____ / ____ / ____

Sex: Male Female Patient's Height: _____ cm Patient's Weight: _____ kg

Q What is your diagnosis of the patient's condition:

Q What was the cause of this condition:

Q Do you consider this condition to be as a result of an injury or illness Please provide reasoning for your response:

Q To your knowledge, on what date did the patient first seek treatment, or advice for treatment from a legally qualified medical practitioner in relation to this condition: ____ / ____ / ____

Q On what date did you first consult the patient in relation to this condition (if different from above): ____ / ____ / ____

Q Has the patient ever suffered from a similar condition in the past, and if so, does it relate to this current condition:

Q How long has the patient been attending you/your practice? _____ months _____ years

Q What is the patient's current treatment program?

Q Have you at any time advised the patient that they can cease all treatment for this condition: Yes No

Q Please provide any relevant medical history that may assist us with this claim:

Q What investigations have been undertaken in determining a diagnosis?

Blank lines for text input.

Q Please supply the names, specialties and contact details of doctors that the patient has been referred to for this condition?

Table with columns: Doctors Name, Period of attendance (From, To), Specialty, Phone, Fax.

Q Do you consider the patient to be/has been wholly and continually prevented from engaging in his/her usual occupation as a result of this condition? Yes [] No []

Q If Yes, for what period: / / to / /

Q Do you consider the patient is/has been unable to carry out a substantial part of his/her usual occupation as a result of this condition? Yes [] No []

Q If Yes, for what period: / / to / /

Q If you answered No to both previous questions, Has/Will there been any period of disablement as a result of this condition? If so, please specify the dates and reasons.

Q From: / / to / /

Blank lines for text input.

Q Estimated date of return to work: / /

Q In your opinion, is the condition work related, or relating to a motor accident compensation claim Yes [] No []

Name: Qualifications:

Telephone: Email address: Fax:

Address:

State: Post Code:

Affix Stamp Here

Signed: Date: / /

Blank area for stamp.



Section C - Employer's Statement - To be completed by Your Employer

In order to process this claim we require:

- a 12 month pay report substantiating the employee's average weekly earnings
- a copy of the employees' job description
- copies of all medical certificates relating to the claimed condition including medical certificates from a previous related condition where applicable.

Employer's Super Number:

Q I hereby certify that **claimant's name** has been unable to attend his/her occupation with

company name as a result of injury/sickness commencing on / /

Q He/She has been Totally/Partially Incapacitated since / / and is due to return /did return to work on / /

Q I confirm the employees' average weekly income before personal deductions and income tax, actually paid to the employee which was earned from personal exertion, based on the twelve (12) month period immediately preceding disablement was \$

Q During the period of disablement he/she has received from the Company:

| | | | |
|-------------------------|--------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------|
| \$ <input type="text"/> | Normal Pay | From <input type="text"/> / <input type="text"/> / <input type="text"/> | to <input type="text"/> / <input type="text"/> / <input type="text"/> |
| \$ <input type="text"/> | Current Sick Leave | From <input type="text"/> / <input type="text"/> / <input type="text"/> | to <input type="text"/> / <input type="text"/> / <input type="text"/> |
| \$ <input type="text"/> | Current Annual Leave | From <input type="text"/> / <input type="text"/> / <input type="text"/> | to <input type="text"/> / <input type="text"/> / <input type="text"/> |
| \$ <input type="text"/> | Salary in Lieu of Notice | From <input type="text"/> / <input type="text"/> / <input type="text"/> | to <input type="text"/> / <input type="text"/> / <input type="text"/> |
| \$ <input type="text"/> | Worker's Compensation | From <input type="text"/> / <input type="text"/> / <input type="text"/> | to <input type="text"/> / <input type="text"/> / <input type="text"/> |
| \$ <input type="text"/> | Other (Please specify) | From <input type="text"/> / <input type="text"/> / <input type="text"/> | to <input type="text"/> / <input type="text"/> / <input type="text"/> |

Q Please confirm which of these payments will continue after the date of signing this form, pending a decision on this claim.

Q If 'Other' or 'Worker's Compensation' please specify name of insurance company, policy number and contact name and number of parties handling the matter

Q This employee has been employed since / / on a Full Time Part Time Casual Contractor basis

Q Please confirm employees current work status: Still an employee Terminated / / To be terminated on / /

Company Name:

Telephone: Fax: Email address:

Address:

State: Post Code:

Declarations

I hereby declare that this Injury/Sickness is/is not work related and is/is not covered by Workers Compensation.

I hereby declare that is prepared/not prepared to take employees back on restricted/suitable duties in the event of a non work related injury/sickness.

Name: Signed: Date: / /

Important Notice: If a claim is made under IUS Income Protection insurance that is rightfully a Workers Compensation claim, you could possibly be prosecuted for committing a fraudulent act. You should also be aware that in making a claim under IUS Income Protection insurance the Claimant will forego any long-term benefits and rights under Workers Compensation entitlements.

Please forward all correspondence to:

International Underwriting Services Pty Limited
PO Box 6215 North Sydney NSW 2060
Phone: 1300 651 450 Fax 02 8920 1915

