Income Protection Claim Form

- To help ensure you receive a prompt assessment, please complete all the required sections of this booklet. If you need assistance please call **1300 307 297**. Please note however, that a claim cannot be assessed until all original documents are received.
- Please note that the information required to be completed in this document is in relation to the Life Insured, unless otherwise stated.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the relevant questions in this document are fully addressed and answered. Responses such as "refer to doctor", "see above", etc., are not acceptable. Failure to address and answer all questions in this document may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which question on this document you are addressing. Please ensure that you sign and date the piece of paper.
- Please note that it is the Policyowner's or Life Insured's responsibility for the payment of all fees associated in the completion of the Specialist Medical Report or Confidential Report.

Filling in this form:

- Use a black or blue pen
- Mark boxes like this ☐ with ✓ or ✗

There are 2 parts to the claim form:

- **Part A** is to be completed by the Life Insured.
- **Part B** is to be completed by the registered Medical Practitioner treating the Life Insured.

Distributed by
Greenstone Financial Services Pty Ltd
trading as Real Insurance
ABN 53 128 692 884, AFSL 343079

Issued by
Hannover Life Re of Australasia Ltd
ABN 37 062 395 484, AFSL 530811
Tower 1, Level 33, 100 Barangaroo Avenue
Sydney NSW 2000
Phone: (02) 9251 6911
Email: hlra@hlra.com.au

H8456_06/24

Please return this form to Real Insurance, Reply Paid 6728, Baulkham Hills, NSW 2153

PART A: Income Protection Claim Form

real INSURANCE®

Privacy Collection Notice

Greenstone Financial Services Pty Ltd ("GFS", "we", "us" or "our") collects and handles personal information about you on behalf of Hannover Life Re of Australasia Ltd ("HLRA") in compliance with the Privacy Act 1988 (Cth). All information collected throughout the claims process by GFS or HLRA will be shared with both companies.

Collection and use

We collect personal information such as identification information and policy details and sensitive information such as health details. Generally, we collect this information so that we can provide our products and services to you and manage, administer, develop and improve our business, including to assess and process your application for insurance, and assess any claims made by you or on your behalf. We generally collect this information directly from you but may collect it from a third party such as our related bodies corporate, authorised administrators, professional advisers or from publicly available information. If you do not provide us with all or part of the personal information we require, we may be unable to provide such services to you.

Disclosure

The information you provide us will be collected by us and may be disclosed to third parties that help us deliver and improve our products and services (including other insurance/reinsurance companies, legal practitioners, Medical Practitioners, health service providers, hospitals, legal tribunals and courts, dispute resolution bodies, investigators/investigation organisations, third parties authorised by you, any current or former employer, our parent company and other related bodies corporate, professional advisers such as accountants or lawyers or other consultants, service providers that assist us in carrying out our business activities, trustees of superannuation funds, administrators of superannuation funds, an organisation appointed by the trustees of a superannuation fund to receive or give information, interpreters and regulatory bodies, government agencies, law enforcement agencies or, as required, other persons authorised or permitted by law) or as required by law.

Overseas disclosure

We or HLRA may disclose your personal information to parties located in other countries, including to our related bodies corporate. The countries in which these recipients may be located will vary from time to time, but may include Germany, Canada, Japan, New Zealand, Hong Kong, United Kingdom, United States of America, India, China, Korea, Malaysia, South Africa, Bermuda, Ireland, Sweden and France.

Access correction and complaints

You can read more about how we collect, use and disclose your personal information in our Privacy Policy, including how to complain about a breach of the Privacy Principles, which is available on our website or you can request a copy by contacting us.

HLRA's Privacy Policy is also available at hannover-re.com/1094181/australia_lh_privacy (or, by contacting HLRA using the details set out in this form or emailing privacyofficer@hlra.com.au). It outlines HLRA's personal information handling practices, including details on how you can seek access or correction of the personal information that HLRA hold about you, how to complain if you believe HLRA has breached the Australian privacy laws and HLRA's complaint handling processes.

If you wish to gain access to your information (including correcting or updating it), have a complaint about a breach of your privacy or have any other query relating to privacy, please call **1300 367 325**.

Section A – Policy Information

Policyowner _____ Policy number _____

Section B – Life Insured's Details

Title _____ First name _____ Surname _____

Date of birth DD / MM / YYYY Gender: Male ☐ Female ☐

Residential address _____

Postal address _____

Phone (home) _____ (work) _____ (mobile) _____

Email _____

Occupation

Are you: Right Handed or Left Handed

Height cm Weight kg

Are you a smoker? No Yes

Country of Birth

How long have you lived in Australia years / months

Do you require an interpreter? No Yes ▶ Language

Section C – Income Protection Claim

1. Do you believe your condition(s) will result in you being unable to work for greater than 6 months?

No Yes

a. Is your disability the result of an injury or an illness?

Injury Illness ▶ Please go to Question 3.

2. Injury details

Only complete Question 2 if your disability was a result of an injury.

a. Where did this injury occur? Please include the exact place and address:

b. What date and time did this injury occur? DD / MM / YYYY TIME

c. Please provide a detailed description of how you were injured. Please ensure you provide as many details as possible:

d. Were there any witnesses to your injury, and if so, what are their names and contact details?

e. Did ambulance, first aid officer or police attend following your injury? No Yes ▶ Who attended and what did they do?

f. Was the injury or accident related to your employment? No Yes ▶ How is it related to your employment?

3. Illness details

Only complete Question 3 if your disability was a result of an illness.

a. Please describe in detail the illness suffered. Please ensure you provide as many details as possible:

4. Symptoms

a. What date did the symptoms of your injury or illness first occur? DD / MM / YYYY

b. Please provide a full description of the symptoms resulting from your injury or illness in the area provided below. If there are more than 5 symptoms please attach a separate sheet with all details in the same format:

Symptom	How often does this symptom occur?	How does this symptom prevent you from working?
1		
2		
3		
4		
5		

c. Are there any secondary medical conditions causing you to claim?

No ☐ Yes ☐ ▶ If 'Yes', please provide details:

5. Pre-existing

Have you had this, or a similar injury or illness before?

No ☐ Yes ☐ ▶ Please provide details and date: DD / MM / YYYY

6. Treatment

a. Please provide the details of the doctor you first consulted about your injury or illness:

Name & qualification	
Telephone	
Doctor's address	
Doctor's email	

b. Date seen? DD / MM / YYYY

c. When did you first consult this doctor about the injury or illness? DD / MM / YYYY

d. What was the date of your last consultation? DD / MM / YYYY

e. Has a follow-up appointment been organised?

No ☐ Yes ☐ ▶ If 'Yes', date of next consultation is: DD / MM / YYYY

f. Is the doctor named in (a) your usual doctor? Yes ☐ No ☐ ▶ If 'No', please provide details of your usual doctor:

Name & qualification	
Telephone	
Doctor's address	
Doctor's email	

7. Please provide details of all other treating practitioners and health care providers seen by you in connection with this condition: (if insufficient space please add an attachment)

Name & specialty	Telephone	Doctor's address	Date seen
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

8. Current treatment

a. Are you currently receiving treatment?

Yes ☐ ▶ If 'Yes', date of next consultation is: DD / MM / YYYY No ☐ ▶ If 'No', please detail reason for ceasing treatment:

b. Current medications:

Medication name	Dosage	Date prescribed	Response	Expected duration
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY

c. Details of any planned or recent surgery:

Hospital name	Surgery type	Date of admission	Date of discharge	Estimated recovery timeframe
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY

d. What is your response to treatment thus far?

9. Occupation

a. What is your job title/occupation?

b. How long have you been in your current job/occupation?

c. **(If self employed)** How long has your business been operating for?

d. **(If self employed)** Please provide ABN and number of Employees?

e. How many hours per week were you working immediately prior to your disability?

f. Did you reduce your hours immediately prior to your last physical hours at work?

No ☐ Yes ☐ ▶ If 'Yes', from what date did your hours reduce: and what were the hours you worked?

g. Please tick the amount of manual labour your occupation involves:

Nil ☐ 1-20% ☐ 21-40% ☐ 41-60% ☐ 61-80% ☐ 81% or more ☐

h. Please list all work duties performed in your occupation immediately prior to your disability: (*Please note that the percentage of working time must equal a total of 100%*)

Duty	Percentage of working time
	%
	%
	%
	%
	%

i. What percentage of time on average did you spend in the following activities while performing your usual occupation?

Sitting	Standing	Walking	Bending	Lifting	Driving
%	%	%	%	%	%
Climbing	**Kneeling**	**Reaching above shoulders**	**Other please specify:**		
%	%	%			

10. Working capacity

a. Have you stopped work completely?

No ☐ Yes ☐ ▶ What date and time did you stop all work completely? DD / MM / YYYY TIME

b. Please list all your work duties you are **unable** to perform due to your illness or injury:

c. Please list all your work duties that you are still **able** to perform:

d. Since completely stopping work have you undertaken any work, regardless whether it is paid work or not?

No ☐ Yes ☐ ▶ Please provide full details of the work that you have undertaken including all the dates, work duties, the number of hours per day worked, and the place of work:

Dates worked	Work duties	Number of hours worked per day	Place of work
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			

e. If you have not returned to work yet, when do you expect to be able to return to work?

Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

11. Income

a. What was your average weekly income before your disability commenced?
(*Please provide us with a copy of your payslips immediately prior to your disability*)

$ Per week

b. Are you in receipt of any sick leave?

No ☐ Yes ☐ ▶ If 'Yes',on what date does sick leave end? DD / MM / YYYY

c. If you have returned to work in a reduced capacity, what is your weekly income?
(*Please provide a copy of your payslips since returning to work*)

$ Per week

d. Do you have any other source of income?

No ☐ Yes ☐ ▶ Please provide details of the source of income, frequency and gross amount:

12. Have you ever made, intend to make, or are entitled to claim any benefits under any insurance policy or Government Benefit:

No ☐ Yes ☐ ▶ If 'Yes', please complete details below:

Income Protection ☐	Total & Permanent Disablement ☐	Unemployment benefits ☐
Sickness Benefit ☐	Veteran's Affairs Benefits ☐	Invalid Pension ☐
Common Law Claim ☐	Trauma ☐	Workers Compensation ☐

What is the organisation's name?

What is your reference number?

How much income have you received? $ (gross before tax)

What period does this cover? From DD / MM / YYYY to DD / MM / YYYY

Please provide copies of all documentation verifying the above payment(s).

Please ensure that all questions have been answered before you proceed further.

Section D – Declaration and Doctor's Authorities

Please ensure you sign both the following Declaration and Doctor's Authorities

a. Declaration & Consent:

I have read and carefully considered the questions in this document and that all the responses are true and correct in relation to me.

I ACKNOWLEDGE that this Declaration is part of a claim for an Income Protection benefit and that the making of a false statement may invalidate my claim, and that if I fail to provide all or part of the information **Hannover Life Re of Australasia Ltd. ("HLRA")** requires to assess this claim, it will not be assessed and processed, and that I am the Insured Person of the Policy shown on this document.

I UNDERSTAND that in order to assess and process my application, HLRA may need information about me, including (but not limited to) medical, financial, legal and employment.

I CONSENT to HLRA obtaining information about me from any Medical Practitioner or health professional that I have consulted at any time and anyone that HLRA wishes to appoint to examine me, legal practitioners, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, the trustees of my superannuation fund, any organisation appointed by the trustees of my superannuation fund to receive or give information, my past and present employers, and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also CONSENT to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosures are necessary for HLRA to perform its functions.

SIGN HERE ✗ _____ DD / MM / YYYY

Life Insured's signature Date

b. Disclosure of Information – Doctor's Authority

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, **Hannover Life Re of Australasia Ltd**, 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.

Doctor's Authority 1 – Release of information, excluding consultation notes

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.*

Doctor's Authority 2 – Release of full record

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.

Doctor's Authority 1 – Release of information, excluding consultation notes

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 Hannover Life Re of Australasia Ltd, or to third parties they engage.

I agree to all of the following:

- My health information can be released in the form Hannover Life Re of Australasia Ltd 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;
- Hannover Life Re of Australasia Ltd 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 Hannover Life Re of Australasia Ltd is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover; and
- 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.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Life Insured's name

SIGN HERE ✗

Life Insured's signature

DD / MM / YYYY

Date

Doctor's Authority 2 – Release of full record

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 Hannover Life Re of Australasia Ltd, or to third parties they engage, only if Hannover Life Re of Australasia Ltd. 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 all of the following:

- Hannover Life Re of Australasia Ltd 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 Hannover Life Re of Australasia Ltd is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover; and
- 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.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Life Insured's name

SIGN HERE ✗

Life Insured's signature

DD / MM / YYYY

Date

c. Disclosure of Information - Nominated Representative

The below authority is only to be completed if you are nominating someone to act or represent you on your behalf. Otherwise it is not required.

For the purpose of assessing my claim for Income Protection benefit, I AUTHORISE the below nominated representative to receive information regarding my claim. I DECLARE that I have advised the nominated representative of this Authority and provided to them a copy of this Income Protection Claim. I acknowledge that the information provided may include any information that Hannover Life Re of Australasia ("HLRA") holds about me in respect to my claim including, health, lifestyle, employment and financial. This representative is bound by the "Declaration and Consent" in this Income Protection Claim. I accept that this electronic authority replaces the need for a personally signed "Disclosure of Information – Nominated Representative".

Nominated Representative's Name

Nominated Representative's Date of Birth DD / MM / YYYY

Nominated Representative's Contact Number

Relationship to the Insured Person

Section E – Direct Credit Authority

Completing the details below will assist us in getting your claim payment to you as quickly as possible.

- Once your claim has been assessed, the Benefit Amount payable will be credited to the account below.

BSB number (branch number) ☐☐☐ - ☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

Account name

Financial institution/ name of bank

Branch name/ location of financial institution

NB. If your account is held with a Credit Union, it may take longer for the Benefit Amount payable to be cleared. May we suggest you contact your nominated Credit Union.

SIGN HERE ✗ Life Insured's signature

DD / MM / YYYY Date

Section F – Checklist

Certified copies of the relevant documentation related to this claim are attached as follows:

What is a certified copy?
This is a signed photocopy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, accountant, solicitor, doctor, bank manager or police officer. It means you keep the original.

Income Protection

☐ The original Policy Document and Policy Schedule.
If these documents have been misplaced, please complete the Statutory Declaration

☐ ▶ **Go to Section H – Statutory Declaration on Page 10**

☐ Either, copies of your individual income tax returns and notice of assessments for the previous 2 financial periods or employer issued pay slips for the same period.

☐ A certified copy of proof of the Life Insured's identity (e.g. Birth Certificate, Driver's Licence or Passport).

☐ A completed and signed Medicare Authority form authorising the release of your Medical and Pharmaceutical Benefits Scheme claim information.

Section G – Statutory Declaration

I, (insert name, address and occupation) Name

Address

Occupation

do solemnly and sincerely declare that I am the legal owner/beneficial owner of Policy number Policy number

("Policy") on the life/lives of Life Insured's name

issued by Hannover Life Re of Australasia Ltd ("HLRA").

I have satisfied myself by exhaustive enquiry that for the above Policy, none of the members of my family or my solicitor has any knowledge of the Policy documents' whereabouts nor have they been disposed of by me or to the best of my knowledge by any other person, nor are the Policy documents held by my bank or any other person for safekeeping or lodgement.

The Policy documents have been lost in the following circumstances:

I have not assigned, mortgaged or otherwise dealt with the above Policy in any way and there is no lien on it.

I undertake to return the previous Policy documents to HLRA should they be found.

I make this solemn declaration by virtue of the Statutory Declarations Act 1959 as amended and subject to the penalties provided by the Act for the making of false statements in statutory declarations, conscientiously believing that the statements contained in this declaration are true in every particular.

SIGN HERE ✗

Policyowner/Life Insured's signature

DD / MM / YYYY

Date

Declared at

DD / MM / YYYY

Date

SIGN HERE ✗

Before me (authorised signatory's signature)

DD / MM / YYYY

Date

Full name

Occupation/title

NOTE 1 – A person who willfully makes a false statement in a statutory declaration under the Statutory Declarations Act 1959 as amended is guilty of an offence against the Act, the punishment for which is a fine not exceeding $200 or imprisonment for a term not exceeding six months or both if the offence is prosecuted summarily, or imprisonment for a term not exceeding four years if the offence is prosecuted upon indictment.

NOTE 2 – A statutory declaration under the Statutory Declarations Act 1959 as amended may be made only before a Chief Police, Resident or Special Magistrate; Stipendiary Magistrate or any Magistrate in respect of whose office an annual salary is payable; a Justice of the Peace; a person authorised under any law in force in Australia or its Territories to take affidavits; a person appointed under the Statutory Declarations Act 1959 as amended or under a State Act to be a Commissioner for Declarations; a person appointed as a Commissioner for Declarations under the Statutory Declarations Act 1959, or under that Act as amended, and holding office immediately before the commencement of the Statutory Declarations Act 1959; a Notary Public; a person before whom a statutory declaration may be made under the law of the State in which a declaration is made; or a person appointed to hold, or act in, the office in a country or place outside Australia of Australian Consul-General, Consul, Vice-Consul, Trade Commissioner, Consular Agent, Ambassador, High Commissioner, Minister, Head of Mission, Commissioner, Charge D'Affaires, or Counsel, or Secretary or Attache at an Embassy, High Commissioner's office, Legation or other post.

PART B: Income Protection
Claim Form – Confidential Medical Report

This section is to be fully completed by the registered Medical Practitioner treating the Life Insured.

- Please note that the information required to be completed in this document is in relation to the Life Insured as indicated below.
- Please note that it is the Life Insured's responsibility for the payment of all fees associated in the completion of this document.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the questions in this section are fully addressed and answered.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

1. Life Insured's details

First name | Surname

Date of birth (DD / MM / YYYY) | Gender: Male ☐ Female ☐ | Height (cm) | Current weight (kg)

Residential address

2. Medical details

a. Please state the insured person's occupation/job title:

b. Please detail the date the insured person was first ever seen at your medical practice: (DD / MM / YYYY)
(*not just for the current medical condition*)

c. In the event that the insured person was referred to you please detail the name and address of the referring health professional:

First name | Surname

Address

d. What date did the insured person consult you in relation to the current medical condition? (DD / MM / YYYY)

e. Please advise the date and nature of the first symptoms related to this condition: (DD / MM / YYYY)

Nature of the first symptoms:

f. Please detail your diagnosis:

g. What process was undertaken in order to come to this diagnosis? **(If tests have been undertaken please attach a copy of all of these)**

3. Hospitalisation details

a. If hospitalisation was necessary, please advise:

i) Hospital attended:

ii) Name of treating Medical Practitioner:

iii) Date admitted: DD / MM / YYYY Date discharged: DD / MM / YYYY

b. Has the insured person ever consulted you, or any other Medical Practitioner, previously for a similar condition or symptoms? If so, please provide dates and doctors consulted:

Doctor	Consultation date
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY

c. Please detail all the current reported symptoms:

d. What specific effect do these symptoms have on the Life Insured's functional work ability?

e. Please detail the last date the Life Insured received any sort of treatment from you for their current medical condition:

f. What date are you next scheduled to treat the Life Insured? DD / MM / YYYY

g. If you have referred the Life Insured to any other medical professional(s) please detail their name, speciality, address and the date of the referral: *If you have received correspondence from other medical professional(s) please attach a copy to this document.*

Name of medical professional	Speciality	Address	Date
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

h. Please detail what treatment has been provided to date:
(If medication has been prescribed please detail the dosage and how often it is to be taken)

i. Is the Life Insured compliant with treatment? No ☐ Yes ☐ ▶ Please detail on what basis you believe this is the case:

j. Please detail the improvements in symptoms (if any) that have been achieved through the treatment to date:

k. If there has not been any improvements in the symptoms to date please detail the reason(s) for this:

l. Please detail the future treatment planned, and objectives hoped to be achieved through this treatment:

m. Please detail your understanding of the Life Insured's usual occupation and specific work duties:

a. Occupation:

b. Details of specific work duties:

n. If the current reported symptoms prevent the Life Insured from undertaking their work duties please detail which work duties they are prevented from undertaking and which symptom(s) is preventing this:

Work duties	Symptoms preventing undertaking work duties

o. In your opinion what date did the Life Insured first become unable to undertake their usual occupation due to injury or illness? DD / MM / YYYY

p. What date has the Life Insured reported to you that they totally ceased all work? DD / MM / YYYY

q. Do you consider the Life Insured currently capable of working either full time or part time?

No ☐ Yes ☐ ▶ Please advise from what date, and in what capacity (i.e. full time or part time):

r. If capable of returning to part time work, please advise which duties of their usual occupation the Life Insured is **incapable** of performing?

s. If the insured person has not yet returned to work, when do you anticipate they will be able to return: Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

t. Have you considered, or are you considering, implementing a return to work program or rehabilitation? If so, please provide a copy of the program or details. If not, please detail the reason(s) you don't consider this is an option at this time:

4. Medical Practitioner's final comments

a. Please detail all ongoing medical problems, past history or other circumstances which you are aware are affecting the Life Insured's current condition and ability to work in their usual occupation:

b. Have you given any certificate or report to?

Another Insurance Company:	No ☐	Yes ☐
Workers Compensation Insurer:	No ☐	Yes ☐
Centrelink:	No ☐	Yes ☐
Third Party Insurer:	No ☐	Yes ☐
Solicitor:	No ☐	Yes ☐
Any other party:	No ☐	Yes ☐

If you have answered "yes" to any of the above, please detail the name of the organisation you have provided this information to and their address:

c. Please provide us with any other comments you may have to assist the Life Insured to return to good health and return to work:

5. Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended to the Life Insured named on page 1 and that all the information supplied by me in this Report is true. I agree that the Insurer may provide copies of this Report to any medical specialist from whom Hannover Life Re of Australasia Ltd ("HLRA") seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom HLRA is obligated under the Privacy Act 1988 to give access to this Report.

Name			
Qualifications			
Address			
Telephone		Facsimile	
Email			

SIGN HERE

✗

Medical Practitioner's signature

DD / MM / YYYY

Date