A delay in providing us with the required documents (including your certified ID and bank details), may lead to a delay in making payment to you.

Your insurance

Salary Continuance Insurance Claim Kit

This checklist will help you keep track of the paperwork contained in this kit that you need to complete.

What you need to complete

- [ ] MetLife Initial Information form
- [ ] Tax file number declaration form
- [ ] EFT payment instructions form
- [ ] Declaration and consent form

What your current treating doctor needs to complete

- [ ] A MetLife Medical Statement

What your employer needs to complete

- [ ] A MetLife Employer Statement

Other documents you need to provide

- [ ] Certified identification documents

  A certified copy of your Driver's Licence or passport (or an acceptable alternative) must be provided to pay your benefit if your claim is approved. For more information please see the Completing Proof of Identity pages in this Claims Kit.

When complete, post your forms to:

ElectricSuper,
Level 1, 89 Pirie Street
Adelaide SA 5000

It may take a few weeks to process your claim.
Submitting a claim does not guarantee that your claim will be paid.

electric super

Your insurance

Salary Continuance Insurance: Important information

This information may help you and your doctor complete the forms and may help you understand why we ask for some of the information we do.

The definition of Disablement

You will find the definition we will use to assess your claim in the enclosed flyer. Please read the enclosed definition carefully.

If your claim is denied

Your claim is not guaranteed to be paid.

If your claim is denied, your tax file number declaration and electronic funds transfer authorisation forms will be destroyed within 30 days of the Trustee (ElectricSuper) advising the administrator (Mercer).

Additional information

During the assessment of the claim, we may request additional information or authorities and we may also request comprehensive reports from your treating doctors, independent doctors and interviewers.

You may also be asked to attend appointments and/or examinations.

What happens next?

ElectricSuper's insurer (MetLife) will assess the application and once the assessment is completed, the Trustee (ElectricSuper) will independently review the evidence and make a determination.

Your privacy

The scheme is administered by us along with our service provider, Mercer Outsourcing (Australia) Pty Ltd. We collect, use and disclose personal information about you in order to manage, process and make a decision regarding your claim or request for insurance underwriting, and respond to any subsequent correspondence in relation to your request.

Our Privacy Policy is available to view at www.electricsuper.au/privacy policy.
If you do not provide the personal information requested, we may not be able to manage your claim or request for underwriting.

electric super

Initial Information Form for Income Protection Insurance Claim

We want to make this process as easy as possible, so please:

- **Complete all sections of the form in full.** An incomplete form will delay our review as we may need to contact you for further information or return the form to you to complete in full. Use the 'Additional comments' section if you need more space to answer a question.
- **Review the checklist below** and ensure all supplementary information is provided. If you don't send this information, we will not be able to complete our review. Before you start we recommend you gather the documents on the checklist to assist you with completing this form.
- It is **important** that you answer the questions below honestly, completely and to the best of your ability. If you are unclear on any question, please contact us. Providing misleading or incomplete answers could lead to your claim being delayed or declined.
- If you **require assistance** or further information please call MetLife on 1300 555 625 and a claims expert will be able to help you complete the form and answer any questions you may have about why the information is required and how it may be used.

Please note that issuing this form is not an admission of liability.

Claim checklist and mandatory requirements

The below checklist will help you ensure that you have all the information we require to assess your claim. Please ensure you have gathered all the requirements before forwarding this form to us. There may be additional information required specific to your claims circumstance, this information will be detailed within the attached covering letter.

Note: Once you have provided this form to us with the additional requirements as set out below, further information may be asked from you at a later time. The case manager who is assigned to your claim will ensure they explain to you what information is required and what the information will be used for.

We will need the following information before we start our review:

- ☐ **Proof of identification -** A certified copy of your passport or driver's licence.
- ☐ **Any other documents -** Provide any additional documents you think might assist with your claim such as insurance or compensation reports.
- ☐ **Medical Statement and Medical Reports -** Please have your treating medical practitioner complete the enclosed Medical Statement and provide any medical reports, scans, referrals letters or any other medical information that you have available.

  Important: Please note that we cannot start the assessment of your claim until we are provided with medical information in support of your claim.
- ☐ **Completed Authority** on page 9 to release health information and other information from third parties - This provides us with authority to collect and use information to assess and manage your claim.
- ☐ **Tax File Number Declaration** - If your income policy is held under superannuation, the benefits paid will be taxed before payment. For further information on your tax liability please speak with a financial advisor or tax agent.
- ☐ **Australian Business Number (ABN)** - If you are self-employed or own part or all of the business you work for.
- ☐ **Payslips** - We require payslips for the 12 months immediately prior to your date of disability and the date last worked, and any payslips you received after this, as well as any relevant PAYG certification.
- ☐ **Full Income Tax Return and Notice of Assessment** - Please provide these for the relevant period including the tax period immediately prior to your date of disability and dates last worked, and also your Business Tax Return if completed.
- ☐ **I have completed all sections of this form.**

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide you with the products and services you have requested from MetLife, and to manage your claim. You do not have to provide MetLife with your personal information, but if you do not do so MetLife may not be able to provide you with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), 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.

Section 1. Declaration and authority

I declare that the answers and statements made on this claim form are true and complete. I have not made any false or misleading statements and have included all information relevant to the assessment of my claim. I understand that making false or misleading statements to claim insurance benefit is fraud and is a criminal offence.

In the event of a fraudulent claim MetLife reserves the right to: decline the claim, and/or cancel all cover held by the Life Insured with MetLife in accordance with the Insurance Contracts Act.

Where I have completed this declaration and authority as the Guardian/Attorney, I have attached a certified copy of the relevant legal documents (e.g. Power of Attorney). If any of the answers have not been completed by myself, I certify that I have checked them and they are correct.

I have read and understood the Privacy Disclosure Statement entitled 'Privacy - Use and Disclosure of personal information'. I consent to the collection, use and disclosure of my personal (including sensitive) information in accordance with the terms of these documents.

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.

Signature ▶	Date *(dd/mm/yyyy)*

Full name (please print)

Section 2. Personal details

Policy number/fund member number (*if applicable*)

Title	Given name(s)

Surname	Previous name(s)

Address	Suburb	State	Postcode

Preferred contact number	Email

Gender	Date of birth *(dd/mm/yyyy)*
☐ Male ☐ Female ☐ Indeterminate, Intersex, Unspecified	

Section 3. Details of medical condition

Benefits under your policy are paid based on your inability to work due to a medical condition. Please detail all your medical conditions below, we will use this information to assist us in understanding how your condition is impacting you.

1. Please detail all medical conditions impacting your ability to function.

What is the medical condition(s) that caused you to be unfit for work?	Date symptoms commenced	Date you first consulted a medical practitioner	Date of disability (the date your doctor first certified you as medically unfit for work)
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /

Section 3. Details of medical condition (continued)

2. Is your condition caused by or related to an accident? ☐ Yes ☐ No

If Yes, please provide details of the accident including date, location and activity performed:

3. What was the date you were last at work performing any work duties (*dd/mm/yyyy*)? / /

4. Have you ever had this/these medical condition(s) or similar before? ☐ Yes ☐ No

If Yes, please provide details:

5. What usual daily activities are you unable to do as a result of your medical condition(s)? e.g. home duties, social activities, etc.

6. Have you had any treatment for your condition? ☐ Yes ☐ No

If Yes, please provide details of treatment that has been prescribed:

7. Please detail all home-based exercises or activities that have been recommended or instructed by your treatment providers. Please include; nature of activity, frequency of activity, your level of success in completing the activity, how the activity is impacting your recovery:

8. Provide the details of all medical practitioners, including allied health professionals, treating you for this/these condition(s). Please attach copies of any letters or referrals you have available:

Doctor's name	Doctor's address, phone number and email	Specialty	Date first consulted	Date last consulted	Usual Doctor (Yes/No)
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

Section 4. Employment and return to work

We will use this information to assist us in understanding how your condition has impacted on your ability to work.

9. Have you returned to work in any capacity, whether paid or unpaid (e.g. voluntary work), since you first ceased work? ☐ Yes ☐ No

If Yes, please provide details.

Start date	End date	Duties and hours performed
/ /	/ /	
/ /	/ /	
/ /	/ /	

10. Is your job available to return to? ☐ Yes ☐ No

If No, please tell us why it is unavailable:

11. If you have not yet returned to work, when do you hope or expect to return to work (*dd/mm/yyyy*)? / /

12. If you can perform all of your usual duties but are only able to work reduced hours, please specify the hours and days:

How many hours per day could you work?

How many days per week could you work?

13. If you could safely perform your role with reduced or modified duties, please detail what duties you remain capable of performing:

14. Are there any other challenges or issues that may prevent you from returning to work?

Section 5. Income details

15. Have you received any income since ceasing work? ☐ Yes ☐ No

16. Please provide details of any money or income you have received since ceasing work from any sources such as superannuation benefits, Workers' Compensation, sick or annual leave, ongoing business income, other insurance payments or Centrelink benefits:

If available, you can provide copies of payment letters or schedules in place of completing the below table.

Type of payment	Payment start date	Payment end date	Amount per week	Is this payment expected to continue?
	/ /	/ /		☐ Yes ☐ No
	/ /	/ /		☐ Yes ☐ No
	/ /	/ /		☐ Yes ☐ No

Section 6. Occupation and duties

17. Please detail your most recent occupation/role.

Occupation/Job title	Full-time/ Part-time/Casual/ Contract/ Self-employed	Industry	Date started (*dd/mm/yyyy*)	Date finished (*dd/mm/yyyy*)
			/ /	/ /

18. Please include any specific work skills as a part of main duties, e.g. supervise others, telephone or face-to-face customer service, cash handling, equipment/tools used, etc.

Please include detail of your employment status (full-time, part-time, etc.) and the hours and days worked per week:

Main duties

19. Were you employed or self-employed in your most recent occupation? ☐ Self-employed ☐ Employed

20. If you were employed, please provide the name and contact details of your supervisor or HR contact:

Name	Role	Contact number	Email

21. If you were self-employed in your prior occupation, please provide details below:

Business trading name	ABN	% Owned by you

22. If you're self-employed, is your business still trading? ☐ Yes ☐ No

If Yes, please provide detail in relation to your ongoing involvement in the business:

If No, when did it stop trading (*dd/mm/yyyy*)? / /

Section 7. Tasks and duties

23. Please complete the following table on how physical your role was, detailing the time per day required of each physical task. If your role varied day to day, please provide in comments on an 'average' day:

a) Sitting ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments:

b) Standing ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments:

c) Walking ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments:

Section 7. Tasks and duties (continued)

d) Lifting	☐ Over 20kg	☐ Up to 20kg	☐ Up to 15kg	☐ Up to 10kg	☐ Up to 5kg	☐ Minimal (1 - 2kg)

Provide detail on lifting position e.g. from floor/ bench, one/two arms

e) Driving	☐ Over 4 hours	☐ 4 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ Nil

Additional comments

f) Travelling by other means e.g. public transport	
g) Pushing/pulling	
h) Bending/twisting/ squatting	
i) Reaching	
j) Fine motor e.g. computer use, gripping	
k) Other (please specify)	

Section 8. Hobbies, pursuits, volunteer work and pastimes

24. What were your regular hobbies, pursuits and pastimes prior to your disablement?

25. Within the last 5 years, have you regularly performed volunteer work activities? ☐ Yes ☐ No

If Yes, please provide details:

Section 9. Language

26. Please indicate your level of English skills:

	Below average	Average	Above average
Speaking	☐	☐	☐
Writing	☐	☐	☐
Reading	☐	☐	☐

27. Is English your first language? ☐ Yes ☐ No

28. Are you interested in re-training? ☐ Yes ☐ No

If Yes, please provide details:

Section 10. Other insurance or claims

29. Have you currently lodged or might you lodge a claim under Workers' Compensation or under any other superannuation or insurance policies? ☐ Yes ☐ No

If Yes, please provide details below:

Name of fund/insurer	Address, phone number and email	Claim number	Payment amount	Benefit type

30. In addition to the above, have you ever had any previous Workers' Compensation, Disability Insurance, TPD, Trauma Insurance claim paid or declined? ☐ Yes ☐ No

If Yes, please provide details including insurer and what was claimed.
If available, please provide copies of any letter or other correspondence that outlines the claim.

Section 11. Claim payment (EFT)

Full name of account holder/payee

Name of bank	BSB number	Account number

NOTE: Payment direct to you is only available if the policyholder has given permission for this. If your policy is under superannuation, the policyholder is the Trustee of the Superannuation Fund.

Additional comments

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, MetLife, 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.

Authority 1 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.

Authority 2 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.

Information from other parties or MetLife

Supporting information from other entities, third parties or MetLife, includes any information held about you, including reports, that relates to MetLife's administration of the policy/plan, including your claim. This information is required to enable MetLife to assess and manage your claim in accordance with the Terms and Conditions of your policy/group life cover.

Authority 3 explanatory notes – through this authority, you are consenting to the parties listed in the authority releasing a copy of any information they may hold about you concerning your claim, for example:

- producing a report;
- supplying MetLife with full particulars of any and all claims you have made for benefits in the event of your sickness and/or injury including copies of evidence they hold; and
- releasing your correspondence with MetLife to your accountant, financial adviser/planner, fund trustee/fund administrator, in order for them to supply MetLife with the requested particulars.

Any information released to MetLife as a result of this authority will be used to assess and manage your claim(s) with MetLife, and we will tell you each time we use your consent.

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

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

Authority 1 - to 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 **MetLife**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **MetLife** 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.
- **MetLife** 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 **MetLife** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- 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.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Authority 2 - to 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 **MetLife**, or to third parties they engage, only if **MetLife** 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 the following:

- **MetLife** 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 **MetLife** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- 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.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Authority 3 - to release other information

I authorise the parties listed below to release to **MetLife** any information held about me (including their reports) which relates to the administration of my **MetLife** policy/plan, including this claim.

- Any claims assessor, investigator, insurance reference service, credit reference service, financial institution, legal or accounting firm, auditor, employer, consultant or reinsurer.
- 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.
- 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 agree to the following:

- My information can be released in the form **MetLife** asks for, such as a general report, correspondence, 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 Financial Adviser/Fund Trustee/Fund Administrator can make enquires regarding the progress of the claim for the purpose of providing me with ongoing service.
- **MetLife** 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 **MetLife** is assessing my claim or is verifying disclosures I made in connection with the cover.
- Any information released to **MetLife** under this Authority, or any previous authorities I have signed, will be used in assessing my claim(s) with **MetLife**.
- 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.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Please return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auclaims@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

MetLife

MetLife Insurance Limited | GPO Box 3319 | Sydney NSW 2001
ABN 75 004 274 882 AFSL NO. 238 096

EFT payment instructions

Provide your bank or credit union details below.

1. Your details

Title ☐ Mr ☐ Ms ☐ Mrs ☐ Other _____ Member number _____

Your name _____

2. Your bank details

BSB _____ – _____

Account number _____

Account name _____

an account in your name or a joint account where you are one of the account holders

Name of bank/ credit union _____

3. Authorisation

I authorise Mercer as administrator of ElectricSuper to credit my Salary Continuance Insurance (SCI) insurance benefit payments to my bank/credit union account above.

Signature _____ Date _____ / _____ / _____

Declaration and consent

1. Your details

Title ☐ Mr ☐ Ms ☐ Mrs ☐ Other _____ Member number _____

Your name _____

2. Your acknowledgement

I acknowledge:

1. This declaration forms part of the processing of my Disablement benefit.
2. I understand and consent to my information being collected, disclosed and used in the manner set out in ElectricSuper's privacy policy.
3. I understand that if I do not provide all or part of the necessary information, my claim may not progress.

Signature _____ Date _____ / _____ / _____

Medical Statement General

Please note: This form needs to be completed by a registered medical practitioner. Any costs associated with the completion of this form is the responsibility of the patient.

The information provided in this form will be used to assist in determining all potential benefit entitlements available for your patient.

Please provide all details you have available as this can assist in minimising the need for further information requests to allow a faster outcome for your patient.

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide your patient with the products and services they have requested from MetLife, and to manage their claim. You do not have to provide MetLife with this personal information, but if you do not do so MetLife may not be able to provide your patient with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of 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.

Section 1. Medical practitioner details

Title	Given name(s)	Surname

Address

Suburb	State	Postcode

Phone number	Qualifications

Signature	Date *(dd/mm/yyyy)*
▶	

Section 2. Patient/claimant details

Title	Given name(s)

Surname	Date of birth *(dd/mm/yyyy)*

Section 3. Patient history

1. Are you the patient's usual doctor? ☐ Yes ☐ No	If Yes, how long have you known the patient?

2. When did the patient first consult you for the present condition (*dd/mm/yyyy*)?	/ /
3. When did the present condition commence (*dd/mm/yyyy*)?	/ /
4. From what date do you believe the patients condition to have prevented your patient from working (*dd/mm/yyyy*)?	/ /
5. Please confirm the total number of consults you have completed with this patient in relation to this condition:	

Section 3. Patient history (continued)

6. Is this your patient's first episode of this condition? ☐ Yes ☐ No

If No, please provide copies of relevant reports or records:

7. Please detail the patient's current condition including cause, symptoms, your current diagnosis and the objective evidence relied on to reach this opinion. Please include copies of any evidence available and copies of any imaging performed.

8. Please provide details of other medical and allied health practitioners the patient has consulted for this condition.
Alternatively, you can provide copies of any referral letters or reports from other medical and allied health professionals in lieu of completing the below.

Name and specialisation	Address and phone number	Date range of consults	
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

9. Please detail the current treatment plan including SMART (Specific, Measurable, Achievable, Realistic, Timely) goals and progress achieved so far:

Treatment	Goals	Progress achieved so far

10. Please provide a summary of all previous treatment provided including outcomes achieved:

11. Is any additional treatment planned in the future (e.g. surgery)? ☐ Yes ☐ No

If Yes, please provide further detail including what might trigger referral for additional treatment, expected outcome and timeframes:

Section 3. Patient history (continued)

12. If your patient is not currently consulting any allied health practitioners, do you believe this would be beneficial to help with functional recovery and management of symptoms? ☐ Yes ☐ No

If Yes, provide recommended speciality below:
If No, provide further detail below:

13. Have there been any barriers to participation in the recommended treatment plan? ☐ Yes ☐ No

If Yes, please indicate what these barriers are below.

☐ Financial ☐ Logistical e.g. transport ☐ Availability e.g. waiting lists

☐ Other (specify details)

14. Are you aware of any social or psychological factors that could impact your patient's recovery and overall wellbeing? ☐ Yes ☐ No

If Yes, please provide further details:

Section 4. Medical certification

15. Please summarise your understanding of your patient's occupation, including core duties:
e.g. Office Manager:
- *Sedentary physical demand level.*
- *Sits at an office desk or in meeting with staff frequently.*
- *Stands and walks about the office frequently.*
- *Repetitive movements of the hands and fingers when operating a keyboard and mouse, phones and writing instruments.*
- *Mental skills necessary include a high level of cognitive functioning with communication, listening, administrative, organisational, financial and budgeting, problem-solving, planning and decision-making capabilities.*

Section 4. Medical certification (continued)

16. If your patient is currently unable to work, or able to work on a restricted basis, please complete the following table with regards to your patient's functional tolerances:

a) Sitting	☐ Over 2 hours	☐ Up to 2 hours	☐ Up to 60 minutes	☐ Up to 30 minutes	☐ Up to 10 minutes	☐ Unable/ limited
Additional comments:						
b) Standing	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable/ limited
Additional comments:						
c) Walking	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable/ limited
Additional comments:						
d) Lifting (consider relevance to injury e.g. position, one or two hands)	☐ Over 20kg	☐ Up to 20kg	☐ Up to 15kg	☐ Up to 10kg	☐ Up to 5kg	☐ Minimal (1 - 2kg)
Additional comments:						
e) Driving	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable
Additional comments:						
f) Travelling by other means e.g. public transport						
g) Pushing/pulling						
h) Bending/twisting/ squatting						
i) Reaching						
j) Fine motor e.g. computer use, gripping						
k) Other (please specify)						

Section 4. Medical certification (continued)

Psychological function

Functional ability	Has this been impacted?	If Yes, please describe the impact:
a) Concentration	☐ Yes ☐ No	
b) Memory	☐ Yes ☐ No	
c) Energy levels	☐ Yes ☐ No	
d) Sleep	☐ Yes ☐ No	
e) Social interaction	☐ Yes ☐ No	
f) Motivation	☐ Yes ☐ No	
g) Mood	☐ Yes ☐ No	
h) Self-care	☐ Yes ☐ No	
i) Emotional regulation	☐ Yes ☐ No	
j) Other (please specify)	☐ Yes ☐ No	

17. Could work capacity be enhanced by modifications and/or equipment (e.g. working from home, sit to stand desk, providing transport to and from office)? ☐ Yes ☐ No

If Yes, please provide further detail below:

18. What do you see as being the key factors limiting recovery and return to work (e.g. difficulty managing symptoms, uncontrolled flare-ups)?

Section 5. Certification - Inability to work

19. What period was the patient totally unable to perform any of the duties of his/her occupation (*dd/mm/yyyy*)?

Period from / / to / /

20. When do you consider that the patient may return to work on a partial/restricted or pre-disability basis (*dd/mm/yyyy*)? / /

21. Basis of return to work ☐ Restricted duties ☐ Pre-disability duties ☐ Restricted hours ☐ Pre-disability hours

Hours of work per day?

Days of work per week?

22. Please detail any restricted duties not captured in Section 4. Medical certification.

Section 5. Certification - Inability to work (continued)

23. Do you believe your patient may be fit to return to work in an alternate occupation or employment within their current education, training or experience? ☐ Yes ☐ No

If No, provide details in relation to why they may not be fit to return:
If Yes, provide details in relation to alternate employment options you believe may be suitable:

Section 6. Other information

24. 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:

25. In your medical opinion, what is your patient's estimated life expectancy inclusive of all reasonable treatment options?
Skip if not applicable to your patient's condition.

☐ < 12 months ☐ 24 to 36 months ☐ N/A

☐ 12 to 24 months ☐ > 36 months

Additional comments

Please use this space if required.

Please attach copies of any medical reports, medical certificates or test results you may have in your possession and return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auclaims@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

Employer's Statement

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide your employee with the products and services they have requested from MetLife, and to manage their claim. You do not have to provide MetLife with this personal information, but if you do not do so MetLife may not be able to provide your employee with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of 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.

Section 1. Employee details

Title	Given name(s)

Surname	Date of birth *(dd/mm/yyyy)*

Date joined company *(dd/mm/yyyy)*	Date joined plan *(dd/mm/yyyy)*

Annual salary at the date last worked (excluding overtime, bonus allowances etc. Please provide copies of pay slips in support of your employee's annual salary)	$

Section 2. Occupation details

1. What is the most recent role the employee held with the company? Please attach a copy of your employee's role description.

Job title	Full-time/ Part-time/Casual/ Contract/ Self-employed	Duties	Period employed

Please provide a copy of the employment history with your business for the named employee. Including role title, period employed in role, reason for changing role and duties of role.

2. Date these were last performed	/ /

3. Hours of work from to	4. No. of days per week

5. Please list below any machines or special equipment used and whether they were operated manually or automatically.

Machine/equipment	Manual	Automatic
	☐	☐
	☐	☐

6. Was the employee employed in a supervisory capacity? ☐ Yes ☐ No	If Yes, how many staff did the employee supervise?

Section 2. Occupation details (continued)

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

8. 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%**	**>70%**	**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	

9. What qualifications, training and experience does the employee have?

10. Are there any alternative roles available or could the employee's skills be used in any other capacity within the company? ☐ Yes ☐ No

If Yes, what similar roles is the employee skilled to perform?

11. Was the employee on any restricted/partial duties prior to the date they ceased work? ☐ Yes ☐ No

If Yes, please provide details.

12. Date restricted/partial duties commenced *(dd/mm/yyyy)*. / /

If Yes, please provide details.

Section 3. Claim details

13. Has the employee resigned from employment?

☐ Yes ☐ No

If Yes, please provide the date of resignation *(dd/mm/yyyy)*.

/ /

14. Were you notified that the employee was certified unfit prior to the employee ceasing work? ☐ Yes ☐ No

15. What reason was provided when the employee ceased work?

16. Has any supported return to work plan been attempted? ☐ Yes ☐ No

If Yes, please provide details including name of provider, roles undertaken and period of rehabilitation (please attach a separate list if insufficient space).

Provider	Roles undertaken	Period of rehabilitation

17. Please provide details of all leave taken in the 12 months prior to the employee ceasing work.
Note: You do not need to complete this question if you are providing leave history reports.

Sick leave - period(s)	
Annual leave - period(s)	
Other leave - period(s)	

18. Please provide details of any money paid to the employee since they ceased work (e.g. superannuation, Workers' Compensation, sick leave, annual leave etc.)?

Type of payment	Period of payment	Amount

19. Are you aware of any other claim including work cover, total and permanent disablement, income cover, etc? ☐ Yes ☐ No

If Yes, please provide details including name and address of insurer.

Insurer	Contact name and number	Claim number

Section 4. Other comments

Section 5. Declaration

I hereby declare that to the best of my knowledge the information stated above is correct.

Employer signature

Date *(dd/mm/yyyy)*

Title

Given name(s)

Surname

Job title

Employer name

Employer address

Suburb

State

Postcode

Phone no.

Fax no.

Email

Please return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auclaims@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

MetLife Insurance Limited | GPO Box 3319 | Sydney NSW 2001
ABN 75 004 274 882 AFSL NO. 238 096

Completing proof of identity

Primary photographic identification

You will need to provide a copy of one of the following primary identification documents:

- current Australian or foreign driver's licence (including the back of the licence if your address has changed)
- Australian passport
- current foreign passport* or similar document issued for the purpose of international travel*
- current card issued under a State or Territory for the purpose of proving a person's age
- current national identity card issued by a foreign government for the purpose of identification*

Identification documents must not be expired (except an Australian passport which may be expired within 2 years).

Alternative identification

If you are unable to provide any primary photographic identification, you will need to provide 2 identification documents, one from each of the following lists:

- Birth certificate or birth extract*
- Citizenship certificate issued by the Commonwealth
- Pension card issued by Services Australia (Centrelink) that entitles the person to financial benefits

AND

- Letter from Services Australia (Centrelink) or other Government body in the last 12 months regarding a Government assistance payment
- Tax Office Notice of Assessment issued in the last 12 months
- Rates notice from local council issued in the last 3 months
- Electricity, gas or water bill issued in the last 3 months
- Landline phone bill issued in the last 3 months (mobile phone bills are not accepted)

Name change

if you have changed your name, you must provide a certified copy of the relevant name change document*, for example a marriage certificate issued by the Registry of Births, Deaths and Marriages, a Decree Nisi or Deed Poll (in addition to the above identification).

If your legal name or date of birth does not match exactly to our records (excluding aforementioned name changes), please contact us for further instructions.

How to have a document certified

To certify your documents, the authorised person needs to:

1. Compare the photocopy to the original
2. Write the following details on the copy:
   - 'Certified true copy',
     and
   - their name, qualification and registration number (if applicable),
     and
   - sign and date the photocopy

The date of certification must be within 12 months

Verification

We may verify the certifying party. If a discrepancy arises, you may be asked to provide re-certified documentation.

Signing on behalf of another person

If you are signing on behalf of the applicant, you will need to provide certified copies of following:

- the Guardianship papers or Power of Attorney,
  and
- the appropriate proof of identity for the holder of the Guardianship or Power of Attorney

Certified ID is still also required for the member.

* Translation

If your identification is written in a language other than English, the identification must be accompanied by an English translation prepared by a translator accredited by the National Accreditation Authority for Translators and Interpreters Ltd (NAATI) at the level of Professional Translator or higher (or an equivalent accreditation) to translate from a language other than English into English.

Completing proof of identity

Who can certify documents in Australia?

- Permanent employee of the Australian Postal Corporation with 2 or more years of continuous service who is employed in an office supplying postal services to the public
- Agent of the Australian Postal Commission who is in charge of an office supplying postal services to the public
- Australian Consular Officer or Australian Diplomatic Officer (within the meaning of the Consular Fees Act 1955)
- Bailiff
- Bank officer, building society officer or credit union officer (with 2 or more continuous years of service)
- Commissioner for Affidavits or Declarations
- Court Officer, Registrar or Deputy Registrar of a Court, Judge, Clerk, Magistrate, Master of a Court, Chief Executive Officer of a Commonwealth Court
- Fellow of the National Tax Accountant's Association
- Finance Company Officer (with 2 or more continuous years of service with one or more finance companies)
- Justice of the Peace
- Legal practitioner
- Marriage celebrant (registered under Subdivision C of Division 1 of Part IV of the Marriage Act 1961)
- Medical practitioner, chiropractor, dentist, nurse, optometrist, physiotherapist, psychologist
- Member of Chartered Secretaries Australia
- Member of Engineers Australia (other than at the grade of student)
- Member of the Association of Taxation and Management Accountants
- Member of the Australasian Institute of Mining and Metallurgy
- Member of the Australian Defence Force (who is an officer; or a non-commissioned officer within the meaning of the Defence Force Discipline Act 1982 with 2 or more years of continuous service or a warrant officer within the meaning of that Act)
- Member of the Institute of Chartered Accountants in Australia, the Australian Society of Certified Practising Accountants or Member of the Institute of Public Accountants
- Member of Commonwealth Parliament, State Parliament, Territory Legislature or a Local Government Authority (State or Territory)
- Minister of Religion (under Subdivision A of Division 1 of Part IV of the Marriage Act 1961)
- Notary Public
- Officer with, or Authorised Representative of an Australian Financial Services Licensee (who has had at least 2 years of continuous service with one or more licensees)
- Officer with, or a credit representative of, a holder of an Australian credit licence (who has had at least 2 years of continuous service with one or more licensees).
- Permanent employee of the Commonwealth (or Commonwealth Authority) or a State or Territory (or State or Territory Authority) or a Local Government Authority with two or more years of continuous service
- Person before whom a statutory declaration may be made under the law of the State or Territory in which the declaration is made
- Pharmacist
- Police Officer, Sheriff or Sheriff's Officer
- Senior Executive Service Employee of the Commonwealth (or Commonwealth Authority) or a State or Territory (or State or Territory Authority)
- Teacher employed on a full-time basis at a school or tertiary education institution
- Trade marks attorney
- Veterinary surgeon

Who can certify documents outside of Australia?

- an authorised staff member of an Australian Embassy, High Commission or Consulate
- an authorised employee of the Australian Trade Commission who is in a country or place outside Australia
- an authorised employee of the Commonwealth of Australia who is in a country or place outside Australia
- a Member of the Australian Defence Force who is an officer or a non-commissioned officer with 5 or more years of continuous service
- a Notary Public from a country ranked 129 or below in the latest Transparency International Corruptions Perception Index: www.transparency.org