Corporate Claim Summary Sheet

All of the information requested below must be provided.
An incomplete Claim Summary Sheet will delay assessment of the Claim.

SECTION A: SSO CIH to complete

Policy Number: MP   Plan Name:

Member Details

Member's Name: Date of Birth: / /

Gender: ☐ Male ☐ Female   Member No (if superannuation owned):

Employer Name:

Date Plan Commenced with AIA Australia / /   Member's last **ACTIVE** day at work / /

Date Member Joined Employer / /   Date of Death (if applicable) / /

Has employment terminated? ☐ Yes ☐ No   Annual Salary on last **Active** day at work $

Completed by:

Name: Email: Date: / /

SECTION B: GIS to complete

Details of Claim Lodged

Type of Cover: ☐ Death Benefit ☐ TPD Benefit ☐ IP/SCI Benefit ☐ Terminal Illness Benefit ☐ Trauma

Sum Insured Amount: $ SG Amount: $

Benefit Design: Category:

Waiting Period: N/A IP/SCI   Benefit Period: N/A   3 months TPD

Date Premium Paid up to / /

Acceptance Basis

Was the member entitled to an Automatic Acceptance Limit? ☐ Yes ☐ No

If 'Yes', please provide Automatic Acceptance Limit (AAL) applicable to member. $

Was the member Underwritten above the AAL? ☐ Yes ☐ No   If 'Yes', please provide copy of the underwriting file.

If a FUL. ☐ Yes ☐ No   If 'Yes', please provide FUL applicable to the member.

Notes (i.e. Please provide any exclusions etc)

Completed by:

Name: Phone Extension: Date: / /

Contact details:

Name: Client/Broker:

Email: Tel:

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, St Kilda Road Central, VIC 8008 Phone: 1800 333 613 Fax: 1800 832 266

SECTION C: SSO CIH to complete

Claim Documentation Enclosed

	From Member	From Employer
SCI/IP	☐ Member Initial Claim Form **or** ☐ Later Claim Notification ☐ Signed Declarations & Authorities ☐ Medical Attendant's Statement ☐ Certified Copy of proof of identity (Driver's Licence, Passport or Birth Certificate) ☐ Signed EFT Authority (if on PAYG) ☐ Signed ATO TFN Declaration (if on PAYG) ☐ Full Occupational History or CV ☐ Authority provided by a Solicitor/Third Party (if applicable)	☐ Employer Statement ☐ Member's Leave & Pay History (last 12 months) ☐ Any other applicable documentation
Death	☐ Certified Copy of the full Death Certificate ☐ Certified Copy of proof of identity (Driver's Licence, Passport or Birth Certificate) ☐ Authority provided by a Solicitor/Third Party (if applicable)	☐ Employer Statement ☐ Member's Leave & Pay History (last 12 months) ☐ Any other applicable documentation
TPD	☐ Member Claim Form **or** ☐ Concurrent or Later Claim Notification ☐ Signed Declarations & Authorities ☐ Medical Attendant's Statement ☐ Certified Copy of proof of identity (Driver's Licence, Passport or Birth Certificate) ☐ Full Occupational History or CV ☐ Authority provided by a Solicitor/Third Party (if applicable)	☐ Employer Statement ☐ Member's Leave & Pay History (last 12 months) ☐ Any other applicable documentation
TIB	☐ Member Claim Form ☐ Signed Declarations & Authorities ☐ Medical Attendant's Statement – Report 1 (usual doctor) ☐ Medical Attendant's Statement – Report 2 (specialist) ☐ Certified Copy of proof of identity (Driver's Licence, Passport or Birth Certificate) ☐ Authority provided by a Solicitor/Third Party (if applicable)	☐ Employer Statement ☐ Member's Leave & Pay History (last 12 months) ☐ Any other applicable documentation
Trauma	☐ Member Claim Form ☐ Signed Declaration & Authorities ☐ Medical Attendant's Statement ☐ Certified Copy of proof of identity (Driver's Licence, Passport or Birth Certificate) ☐ Authority provided by a Solicitor/Third Party (if applicable) ☐ Any other applicable documentation	

Corporate Employer Statement
Death Claim

STATEMENT BY EMPLOYER. Please answer ALL relevant questions fully, not doing so could result in delays in processing this claim.

SECTION A – Background Details

Policy Number	MP	Member Number (if superannuation owned)	
Plan Name			
Employer Name			
Business Address	Postcode		
Full Name of Employee		Date of Birth	/ /
Employee Address	Postcode		
Date joined Employer	/ /	Date joined Plan	/ /
Employee's last physical day at work	/ /		

1. Date of Death? / /

2. Was the employee at work and performing the usual duties of their occupation on the date they joined the plan? ☐ Yes ☐ No
   (a) If '**No**', please provide details why they were not at work/not able to perform usual duties.

   (b) If on modified duties, what was the nature of duties performed?

   (c) How did these differ from their usual duties if they were at work on modified duties?

3. Was the employee still employed by your company on the date of their death? ☐ Yes ☐ No
   If '**No**', please state the reason why (i.e. resignation, retirement, retrenchment, ill health, etc.).

4. Please provide any additional information or comments you feel are relevant to this claim.

Declaration

I am authorised to answer the above questions on behalf of the employer named above and declare that the above statements are true, correct and complete. I understand and agree that the insurer, AIA Australia, may provide the Policy Owner/Trustee of the above plan with copies of this statement.

Name in Full *(please print)*			
Job Title		Telephone	
E-mail		Facsimile	
Signature		Date	/ /