Income Protection
Claim Form

Frequently Asked Questions

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

We've tested it - your section will take 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.

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

We're here to help you, so just call us on **1-3000-COVER** (**1 3000 26837**) and ask for UPlus claims.

Please note: UPlus has an excellent claims settlement rate, 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.

UPlus are acting on behalf of the insurer, Hannover Life Re of Australasia Ltd and will be dealing with this insurance claim as an agent of the insurer and not the insured.

Returning Your Form

1. YOU fully complete Part A of the claim form including either the sickness statement or the injury statement including a Tax File Number Declaration Form.
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 UPlus via post, fax or email.
6. We will send confirmation to you within 24 hours that we have received your claim form.

Checklist

Has the insured person attached copies of any workers comp. correspondence, medical certificates and payment advices relating to the claimed condition? Yes ☐

Has the insured person attached copies of any medical reports/results? Yes ☐

Has the insured person attached a completed Tax File Declaration Form? Yes ☐

Has the medical practitioner attached copies of any pathology reports? Yes ☐

Has the employer attached a 26 week pay report substantiating the employees average weekly earnings (including any payments paid since incapacity)? Yes ☐

Has the employer attached a copy of the employee's job description and any termination documentation (if applicable)? Yes ☐

Have all Privacy Statements & Declarations been signed? Yes ☐

Please check you have correctly filled out all sections and saved the document before submitting the form.

Submit Form >>

If you wish to return your form to UPlus via post, email or fax, please use the details provided below.

Contact UPlus

U-Plus Pty Ltd is managed and administered by U-Plus Pty Ltd who acts as Trustee for the U-Plus Trust
ACN 164 305 284 | ABN 30 779 952 012

Authorised Representative no.441222 of AFSL 238874 held by Coverforce Pty Ltd
ACN 067 079 261 | ABN 31 067 079 261

admin@uplus.com.au
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Level 26, Tower One
International Towers Sydney
Barangaroo NSW 2000

Locked Bag 5273
Sydney NSW 2001

P 02 9376 7888 | **F** 02 9223 1333

Section A: Insured Person's Statement

Section A is to be completed by the claimant. All questions must be completed or this claim form will be returned and assessment of your claim will be delayed.

1. Member Details

Title: | Surname: | Given name(s):

Date of birth (DD/MM/YY): | Height: | Weight: | Sex: Male ☐ Female ☐

Home phone: | Mobile | Email:

Residential address: | Suburb: | State: | Postcode:

Postal address:

What is your preferred method of contact? SMS ☐ email ☐ post ☐

2. Additional Information

If your claim is approved benefits will be paid via direct deposit into your account as nominated below.

Name of bank, building society or credit union:	Account name:	BSB:	Account number:

You may also be entitled to a superannuation benefit. If you are entitled please nominate your super fund details below.

Superannuation fund:	Member number:

Are you a member of a union? Yes ☐ No ☐

Union name:	Member number:

Do you give us authority to speak with representatives of your nominated union in relation to your claim? Yes ☐ No ☐

Do you have private health insurance? Yes ☐ No ☐

3. Employment Details

Name of employer:

Site address:	Suburb:	State:	Postcode:

Occupation/job title:	Department:	Employed since (DD/MM/YY):

Manager/supervisor:	Supervisor contact number:

Please list your usual duties and percentage of time spent on each task:	% time spent on task:

What were your average hours worked per week prior to disablement?

hours: ☐ days per week: ☐

Do you work regular overtime?

Yes ☐ No ☐

What was your employment status prior to the date of injury/sickness?

☐ permanent full time ☐ permanent part time ☐ casual ☐ other: ☐

4. Disability Details

The details of the medical condition for which you are submitting this claim.

What is the date that you first ceased work due to this injury/sickness?

Are you claiming due to injury or sickness?

☐ injury Date of injury (DD/MM/YY): Time of injury:

☐ sickness Date first experienced symptoms (DD/MM/YY):

Please describe your injury or sickness and which part of the body it affects:

Date first consulted a doctor for this condition (DD/MM/YY):

How long do you anticipate you will be away from work as a result of this condition?

If you have already returned to work, please specify the date: (DD/MM/YY):

Please complete the questions highlighted below only if you are claiming for an injury.

Did the injury occur during the course of your usual occupation? Yes ☐ No ☐

What specific event occurred to cause the injury(ies)?

Where were you at the time of the injury? Please specify the address if applicable:

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

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

Please list your current doctor and any other doctors who have treated you for this injury or sickness and the dates of the treatment.

If you require to list more than the allocated space below, please provide in an attachment to the form.

Doctors name & speciality:	Period of attendance (DD/MM/YY) From:	To:	Phone:	Fax:	Primary/usual doctor?
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

Have you ever had a similar condition in the past? Yes ☐ No ☐

If Yes, please give details and specify the dates you received treatment (DD/MM/YY):

Doctors name & speciality:	Period of consult (DD/MM/YY) From:	To:	Phone:	Fax:	Primary/usual doctor?
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

5. Other Insurance Cover

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

Motor accident compensation benefit? Yes ☐ No ☐

Worker's compensation benefit (WorkCover)? Yes ☐ No ☐

Sports insurance with club? Yes ☐ No ☐

Any other insurance policy for loss of wages? Yes ☐ No ☐

If you answered Yes to any of the above, please provide details below.

Claim number:	Name of insurer:	Contact number:

If applicable, please attach copies of copies of any workers compensation correspondence, medical certificates and payment advices relating to the claimed condition.

6. Additional Attachments

Please attach copies of any medical reports/results you may have; and a completed Tax File Number Declaration.

☐ I have provided copies of any medical reports/results

☐ I have provided a completed Tax File Number Declaration

Privacy Statement

We are committed to protecting your privacy. We use the information you provide to advise about and assist with your insurance needs. We provide your information to insurance companies and agents that provide insurance quotes and offer insurance terms to you or the companies that deal with your insurance claim (such as loss assessors and claims administrators). Your information may be given to an overseas insurer (like Lloyd's of London) if we are seeking insurance terms from an overseas insurer, or to reinsurers who are located overseas. We will try to tell you where those companies are located at the time of advising you. We do not trade, rent or sell your information.

If you don't provide us with full information, we can't properly advise you, seek insurance terms for you, or assist with claims and you could breach your duty of disclosure.

For more information about how to access the personal information we hold about you and how to have the information corrected and how to complain if you think we have breached the privacy laws, you can access a copy of our Privacy Policy on our website **uplus.com.au** or alternatively contact our Privacy Officer on **02 9376 7888**.

Medical Authority & Declaration

I hereby authorise any hospital, physician, insurer, Medicare, my employer or other person who has attended me to furnish to U-Plus Pty Ltd 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 U-Plus Pty Ltd. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

I also authorise U-Plus Pty Ltd or its representatives to provide to my employer or my employer's representatives any information about me regarding my claim.

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 further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, payment of my claim may be refused.

Signature:	Name:	Date (DD/MM/YY):

Please note: Depending on your circumstances you may have other rights to claim against other parties for your claimed condition. Should UPlus assess this is to be the case, if you don't object, we will arrange free advice for you in respect of these additional benefits.

☐ I allow U-Plus Pty Ltd or its representatives to arrange free advice for me should they assess that I may have rights to claim against another party for my claimed condition.

Please ensure Sections A, B & C have been completed. Details on returning your form can be found on page 1.

Section B: Medical Practitioner's Statement

Section B is to be completed by your treating doctor. All certificates & evidence required by UPlus shall be furnished as required at the insured person's expense.

1. Patient Details

Title: | Surname: | Given name(s):

Date of birth (DD/MM/YY): | Height: | Weight: | Sex: Male ☐ Female ☐

How long has the patient been attending you/your practice and by whom was the patient referred to you by?

2. Medical And Consultation Details

What is your diagnosis of the patient's condition?

What was the cause of this condition?

In your opinion, is the condition work related or relating to a motor accident compensation claim? Yes ☐ No ☐

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 (DD/MM/YY)?

On what date (DD/MM/YY) did you first consult the patient in relation to this condition (if different from above)?

Has the patient ever suffered from a similar condition in the past? Yes ☐ No ☐

If Yes, please provide details of the previous condition, if it is related to the current condition and when the condition first presented:

What is the patient's current treatment program? (e.g. medication, surgery, physio, exercise etc.)

What investigations have been undertaken in determining a diagnosis?

Please provide copies of any pathology reports/investigations.

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

Doctors name & speciality:	Period of attendance (DD/MM/YY) From:	To:	Phone:	Fax:

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 ☐

If Yes, for what period (DD/MM/YY)? From: To:

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 ☐

If Yes, for what period (DD/MM/YY)? From: To:

If you answered No to the questions above, has/will there been any period of disablement as a result of this condition? Yes ☐ No ☐

If Yes, for what period (DD/MM/YY)? From: To:

Please specify reason(s):

Estimated date of return to work (DD/MM/YY):

Please advise why you provided this estimated date of return to work:

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If you don't provide us with full information, we can't properly advise you, seek insurance terms for you, or assist with claims and you could breach your duty of disclosure.

For more information about how to access the personal information we hold about you and how to have the information corrected and how to complain if you think we have breached the privacy laws, you can access a copy of our Privacy Policy on our website **uplus.com.au** or alternatively contact our Privacy Officer on **02 9376 7888**.

Signature

Name:

Date: Email:

Qualifications:

Phone: Fax:

Address

Please ensure Sections A, B & C have been completed.
Details on returning your form can be found on page 1.

Section C: Employer's Statement

Section C is to be completed by the Employer.

1. Employer Details

Name of employer: | Project: | Employer number: | Contact person:

Phone: | Fax: | Email:

Employee's name that is making the claim: | Employee's payroll number:

The employee has been:

☐ totally incapacitated since: or; ☐ partially incapacitated since:

and

☐ is due to return to work on: or; ☐ did return to work on:

To your knowledge is your employee receiving any benefits from workers compensation or another insurance provider as a result of this injury or sickness? Yes ☐ No ☐

If Yes, please provide details below.

Claim/policy number: | Name of insurer: | Contact name: | Contact number:

This employee has been employed on the following basis:

☐ full time ☐ part time ☐ casual ☐ contractor

Date employment commenced (DD/MM/YY):

Please confirm employees current work status:

☐ still employed ☐ terminated on (DD/MM/YY): ☐ contract end date (DD/MM/YY):

2. Payment Directions

In the event that the employee is entitled to benefits, those benefits will be paid directly to the employee into their nominated account.

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Please attach a 26 week pay report substantiating the employees average weekly earnings (including any payments paid since incapacity).

Please attach a copy of the employee's job description and any termination documentation (if applicable).

Declaration

I hereby declare that this condition:

☐ is work-related
☐ is non work-related

I hereby declare that this condition:

☐ is covered by workers compensation
☐ is not covered by workers compensation

I hereby declare we are:

☐ prepared ☐ not prepared to provide ☐ suitable duties ☐ restricted duties

in the event of a non-work related condition.

Signature

Name:

Position held: | Date:

Please ensure Sections A, B & C have been completed. Details on returning your form can be found on page 1.