Group Income Protection
Claim Form

U-Cover Pty Ltd (ACN 134 723 587) (U-Cover Pty Ltd) is an authorised representative of Coverforce Pty Limited (ABN 31 067 079 261) (AR no. 000441222) and the trustee for U-Cover Trust (ABN 64 608 402 587).

The WageGuard Group Income Protection Product is issued by Integrity Life Australia Limited (ABN 83 089 981 073, AFSL 245492) (Integrity). It is distributed and administered by U-Cover Pty Ltd.

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;

> delays in medical practitioners and medical providers providing medical reports.

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

We're here to help you, so just call us on **1-300-UCOVER** (**1300 826837**) and ask for WageGuard claims.

Please note we will do everything we can to process your claim promptly. Please ensure you complete the claim form to the best of your ability to facilitate the process.

U-Cover are acting on behalf of the insurer, Integrity Life Australia Limited and will be dealing with this insurance claim as an agent of the insurer and not the claimant.

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 U-Cover via post or email.
6. We will send confirmation to you within 24 hours that we have received your claim form.

Checklist

Has the claimant attached copies of any workers compensation or total accident commission correspondence, medical certificates and payment advices relating to the claimed condition? Yes ☐

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

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

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

Has the employer attached a 52 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 U-Cover via post or email, please use the details provided below.

Contact U-Cover

Authorised Representative no.334641 of AFSL 238874 held by Coverforce Pty Limited | ACN 067 079 261 | ABN 31 067 079 261

admin@ucover.com.au
ucover.com.au

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: Claimant'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 ☐

If possible, would you like your union fees to continue to be deducted from your benefits?

Yes ☐ No ☐

If Yes, please indicate the amount of union fees per week you require to be deducted:

per week

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:

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:

If you answered Yes above, please explain below if there is any relation between the previous injury and this injury you are claiming for now. Or if not, why not?

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:

Please provide details of the specific symptoms which prevent you from performing your normal occupation duties:

Please list what duties you are still able to perform:

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

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

Have your treating doctors at any time advised you to cease all treatment for this condition? 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 any workers compensation or total accident commission correspondence, medical certificates and payment advices relating to the claimed condition.

6. Declaration

I further declare that the claim I am making for income protection benefits:

☐ is work-related
☐ is covered by workers' compensation

OR

☐ is not work-related
☐ is not covered by workers' compensation

Privacy Statement

We are subject to the Australian Privacy Principles as per the *Privacy Act 1988 (Cth)* (the Act). We collect your personal information to enable us to provide, offer and administer our products and services or otherwise as permitted by law. Reasons for collection include, but are not limited to, responding to your enquiries, providing you with assistance you request us, maintaining and administering our products and services (for example processing requests for quotes, applications for insurance, offering insurance terms and any other purpose identified at the time of collecting your information). We may be required to disclose your information to third parties to assist with your insurance needs (this can include disclosure to an overseas insurer such as Lloyd's of London or insurer).

You can read more about how we collect, use and disclose your personal information through requesting a copy of our Privacy Policy from our privacy officer on **02 9376 7888** or accessing our website at **ucover.com.au.**

Medical Authority & Declaration

I hereby authorise U-Cover Pty Ltd and its representatives to seek information from:

- any medical practitioner or other health professional that has attended me;
- any hospitals that I have attended;
- my private health insurer or any other insurer;
- past or present employers or their representatives;
- my accountant or financial institution; or
- any relevant government bodies.

I authorise those parties to release to U-Cover Pty Ltd or its representatives all information, notes, documents, reports and history required for the assessment of and consideration of my claim.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I declare that the answers provided to all questions on this form are true and I have not withheld any information relevant to the assessment of this claim. I agree that if I have made any false and misleading or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, payment of my claim may be refused and any benefits already paid, based on the false or misleading information, may be recovered.

Signature:

Name:

Date (DD/MM/YY):

Notes on 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, 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.

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 Coverforce or its representatives or to third parties they engage.

I agree to the following:

> My health information can be released in the form Coverforce and its representatives 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.
> Coverforce and its representatives 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 Coverforce and its representatives are assessing my claim or application for cover, or are 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.

Name:

Signature: Date:

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 Coverforce and its representatives, or to third parties they engage, only if Coverforce and its representatives 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:

> Coverforce and its representatives 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 Coverforce and its representatives are assessing my claim or application for cover, or are 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.

Name:

Signature: Date:

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 UCover shall be furnished as required at the claimant'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 your practice?

2. Medical And Consultation Details

What is your diagnosis of the patient's condition?

If you can please provide the ICD10 Code (Australian Modification) for the primary diagnosis *and any secondary diagnosis*

What was the cause of this condition?

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

Do you consider this condition to be as a result of an injury or sickness? ☐ injury ☐ sickness

Please provide reasoning for your response:

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, how does it relate to this current condition?

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

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

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:

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):

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

Privacy Statement

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You can read more about how we collect, use and disclose your personal information through requesting a copy of our Privacy Policy from our privacy officer on **02 9376 7888** or accessing our website at **ucover.com.au.**

Signature

Name:

Date: Email:

Qualifications:

Phone:

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. Please include all requested attachments when you submit this form.

1. Employer Details

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

Phone:	Email:

I hereby certify that:

Employee's name: _____ has been unable to attend his/her occupation with:

Name of employer: _____ as a result of: injury ☐ illness ☐ commencing on: _____

He/she has been:

☐ totally incapacitated since: _____ ☐ is due to return to work on: _____

or; and or;

☐ partially incapacitated since: _____ ☐ did return to work on: _____

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

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

	Amount:	From:	To:
Normal pay:			
Current sick leave:			
Current annual leave:			
Other:			

If other, please specify details below:

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

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

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

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 should be paid to the:

☐ EMPLOYEE - the employee will nominate their account details on the Member; or

☐ EMPLOYER - if you have elected EMPLOYER, please provide bank details for claim payments below:

Account name: BSB: Account number:

Please attach a 52 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).

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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:

Date: Email:

Qualifications:

Phone:

Address:

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