Disability Claim Form

Part A: To be completed by employer/organisation

Employer	
Policy Reference Number	
Policy Effective Date	dd/mm/yyyy
Address of Insured	
Name of Claimant	
Date of Birth	dd/mm/yyyy
Claimant Occupation	
Social Security Number	
Place of Employment	
Date last Worked	dd/mm/yyyy
Date Returned to Work	dd/mm/yyyy

Did Disability Occur due to Occupational Causes? ☐ Yes ☐ No

Has Employment Terminated? ☐ Yes ☐ No If 'Yes', please detail below.

Date of termination	dd/mm/yyyy
Reason	

Claimant's Salary Details immediately preceding disability

Currency			
Average Basic (Monthly)		or Wage (Weekly)	
Signed by			
Title			
Date	dd/mm/yyyy		

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Part B: To be completed by the employee

Date of injury, or first manifestation of illness dd/mm/yyyy

If you have had an accident, describe when and where this occurred

Has this claim been filed with any other insurance carrier? ☐ Yes ☐ No

If 'Yes', please list name, address, phone number and name of policyholder

Statement of Deductible Sources of Income

Are currently receiving income benefits from any of the following sources? ☐ Yes ☐ No

- Occupational Disability compensation – as a monthly annuity, or lump sum;
- Any other similar country, or law benefits;
- Other group insurance plan;
- Governmental retirement system;
- Country compulsory benefit act or law;
- Social security, or similar act;
- Worker's Compensation or similar act due to loss of time;
- Automobile liability insurance policy;
- Retirement payments to Insured Persons, or Insured Person's spouse and children as a result of disability.

If you have answered 'Yes' to any of the above, please provide the following information:

Type of Benefit			
Amount		Frequency (Weekly, Monthly etc.)	
Effective Date	dd/mm/yyyy	End Date	dd/mm/yyyy

Name of Claimant	
Date of Birth	
Claimant Occupation	
Social Security No	

I hereby certify that the information provided is true, complete and precise, to the best of my knowledge. I understand that in the event that this claim is found to be misleading or fraudulent, in whole or part, then the claim will be invalidated.

I authorise any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, previous insurer, or other person or firm to provide the Insurer or their authorised representative with information, including copies of records, concerning advice, care, or treatment provided to me, including without limitation, information relating to mental illness or use of drugs or alcohol.

In order to process this claim for benefits, I authorise release to underwriters or its representative of any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorisation shall be considered as effective and valid for the duration of this claim.

Signed	
Date	dd/mm/yyyy

Part C: Statement by Medical Examiner

ICD.9 Diagnosis Code Primary | Secondary

Diagnosis and Concurrent Conditions

Is the condition due to an injury or sickness arising from the patient's employment? ☐ Yes ☐ No

Date symptoms first appeared or accident happened dd/mm/yyyy

Has the patient ever experienced the same or a similar condition? ☐ Yes ☐ No

If 'Yes', please state date of occurrence and provide further details.

If the condition is related to pregnancy, include estimated delivery date:

From | Until

Was the patient disabled? ☐ Yes ☐ No If you have responded 'Yes', please answer one of the following. Either:

Patient was continuously and totally disabled and unable to work for the following period: ☐ Yes ☐ No

From _____ Until _____ Or:

Patient was partially disabled ☐ Yes ☐ No

From _____ Until _____

If still disabled, please estimate date when patient should be able to return to work _____

Dates of Treatment _____

Was the patient confined to hospital? ☐ Yes ☐ No If so, please provide further information.

Dates of confinement _____

Name of hospital _____

Location of hospital _____

Was surgery performed? ☐ Yes ☐ No If so, please provide further details.

Date _____ dd/mm/yyyy

Procedure _____

Please print the following

Name of doctor _____

Address _____

Post Code _____

Telephone _____

Email _____

Signature _____

Date _____ dd/mm/yyyy

UL Disability Claim 12.16

If you require any further details, please ask your financial adviser.
Alternatively you can contact your nearest Unilife office, details of which are available on our website, or get in touch using our email address:
claims@unihealthandlife.com