

Part A: To be completed by employer/organisation

Employer

Policy Reference Number

Policy Effective Date

Address of Insured

Name of Claimant

Date of Birth

Claimant Occupation

Social Security Number

Place of Employment

Date last Worked

Date Returned to Work

Did Disability Occur due to Occupational Causes? Yes No

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

Date of termination

Reason

Claimant's Salary Details immediately preceding disability

Currency

Average Basic (Monthly) or Wage (Weekly)

Signed by

Title

Date

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

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 End Date

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

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

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