MTA Loan Protection Insurance
Traumatic Event Claim Form

This form is issued by
Suncorp Life & Superannuation Limited
ABN 87 073 979 530 AFSL 229880

We want to make the claims process as easy as possible. With this in mind we ask you to remember the following things when you are completing the claim form. This will help speed up the assessment of your claim.

- Please note there are 4 sections of this claim form. Please ensure all sections are fully completed. An incomplete claim form may delay the assessment of the claim.
- If there is not enough space please complete the 'Other Comments' section. Please ensure that you note the question number to which the information relates.

Please note that issuing this claim form is not an admission of liability. If you have any questions or need assistance with the completion of this form please call us on 1800 634 294.

Insured Person Details

Policy Number

Title | Given Name(s) | Surname

Date of Birth

/ /

Home Address

State Postcode

Contact Telephone Numbers

Phone | Mobile

Email Address

Details of your Medical Condition

What medical condition are you suffering from?

Please advise of the date of the first onset of symptoms and describe the onset of symptoms.

/ /

What is the exact nature of your medical condition?

In relation to this condition, please give names and address of all doctors consulted by you, including any to whom you were referred for further opinion or investigations and the dates of first consultations.

Name of Doctor	Address	Date of First Consultation
		/ /
		/ /
		/ /
		/ /
		/ /

Please advise the name and address of your usual doctor(s) if different from above.

Name

Address

State Postcode

Did you require hospital treatment? Yes ☐ No ☐

If 'Yes', please give name of hospital and relevant date.

Name of Hospital	Date of Admission	Date of Discharge	Nature of Treatment
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

Have you ever suffered from the same or similar related condition? Yes ☐ No ☐

If 'yes', please state:

Date of each episode / /

The period you were unable to work as a result of each episode / / to / /

Name and address of doctor consulted:

Name

Address

State Postcode

Do you wish us to communicate with someone else about your claim? Yes ☐ No ☐

If 'Yes' please provide the full name of that person

And their relationship to you

Claim Requirements

Please return this claim form with the following documents (if not already provided):

- Copies of any medical reports, medical certificates or test results you have.
- Completed treating specialist statement (section E) to be completed by the treating specialist.
- Certified copy of your proof of identification (birth certificate, driver's licence or passport).

Declaration and Authority

I declare that the answers and statements made on this claim form are true and complete. I have not made any false or misleading statements. If any of the answers are not in my handwriting, they have been checked by me and are correct.

I confirm that, before or at the time I provided any personal information, I have read and understood the Privacy Statement which has been provided to me with this form. The Statement is also available on the web site at www.suncorp.com.au/privacy.

I consent to the Suncorp Life & Superannuation Limited ABN 87 073 979 530, AFSL 229880 (SLSL) collecting, using and disclosing my personal information, including sensitive information, in accordance with the Statement, including for the purpose of assessing my claim.

I authorise SLSL or any person duly authorised by SLSL to disclose my personal information (which may include sensitive health information) to the parties referred to in the Statement some of which are included in the medical and information authorities below.

Medical authority

I authorise any doctor, hospital or any other health care provider who has attended or examined me to supply SLSL, or its representatives, with full particulars of my medical history, consultations, prescriptions or treatment, including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.

Information authority

I authorise any adviser/broker, claims assessor, financial or professional institution, independent medical assessor, insurer or reinsurer, insurance reference service, investigator, legal and accounting firm, auditor, employer, trustee or consultant to supply SLSL, or its representatives, personal information about me which SLSL, reasonably requests for the purpose of assessing my claim.

I further consent to these parties releasing information about me to SLSL. This information may include but is not limited to information about my sickness or injury.

I understand:

- I am responsible for any expenses incurred with the gathering of information for this claim form, including medical reports or test results;
- if I do not give the information requested, my claim may not be reviewed, and therefore my claim may not be payable.

I hereby acknowledge and understand that in accordance with policy conditions I am liable for the costs of the medical report fees obtained in support of my claim and that such cost will be deducted from any proceeds payable to me.

I agree that a photocopy (or similar copy) of my authorisation shall be as effective and valid as the original.

Your signature Date / /

Please return this form and documentation to:

AAI Limited
IPC 4CI231
PO Box 1453
Brisbane QLD 4001

If you have any queries, please call us on 1800 634 294.

Treating Specialist Statement (Traumatic Event)

This form is to be completed by the treating specialist of the patient making a claim under their Loan Protection Insurance Traumatic Event cover.

Purpose of this form

This form has been given to you to complete so that a claim can be assessed by us. Please fill out all sections and provide a copy of any supporting documentation. We'd like to assess this claim as soon as possible, so we ask you to complete this form as a matter of priority.

The form contains two sections:
Section I: Patient's medical details
Section II: Declaration (the treating specialist)

If you have any questions or need assistance please call us on 1800 634 294.

Please note any costs associated with you completing this form are the responsibility of the patient.

This form has been completed for the following patient:

Full name

Date of Birth

/ /

Section I: Patient's Medical Details

Are you the usual treating specialist? Yes ☐ No ☐

Please state your speciality.

Date the patient was first seen by you? / /

On what date did the medical condition commence? / /

What was the date of your last attendance? / /

Has the claimant made an appointment to consult you again? Yes ☐ No ☐

If 'yes', please give approximate date. / /

Please advise the name and address of the patient's referring medical practitioner.

Name

Address

State Postcode

Has the patient been referred to any other doctors/specialists for further opinion or investigation? If so, please provide details in the table below.

Name of Doctor/Specialist	Specialty	Date Referred / Date of Consults	Address and Phone Number
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

Please advise the symptoms that led to the detection of the patient's condition and how long these symptoms were present:
Description of symptoms that led to detection

Length of time symptoms present

Exact nature and description of current symptoms

What is your current diagnosis for the patient?

Date of Diagnosis

/ /

Please provide details of tests, surgical procedures, scans that have been performed which have assisted in forming your diagnosis.
Please also provide dates and results.

Important: please attach copies of all investigations/results.

Details of Tests / Scans / Procedures	Date of Result	Results / Findings
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Please advise at what stage/level the patient's condition is presently at:

Has the patient ever had the same or similar condition Yes ☐ No ☐

If 'Yes', please provide the date and details:

/ /

What treatment/surgery has been undertaken to date and please advise of the effectiveness of treatment/surgery?

If available, please provide a copy of the operation report.

Is there any further treatment/surgery planned? Yes ☐ No ☐

If 'Yes', please provide details:

Please comment on the patient's current medical status.

Please advise if there is a history of contributing factors leading to the connection or causation of the patient's condition (e.g. health or lifestyles factors).

Use this space to add any additional information that may assist us in assessing this claim.

Section II: Declaration (The Treating Specialist)

I declare the information on this form is true and complete. I've attached any relevant medical reports or test results.

Treating Specialist's Full Name

Treating Specialist's Signature Date / /

Postal Address

State Postcode

Contact Numbers

Phone Fax

Email Address

Qualifications

How to contact us:

Mail: PO Box 1453
IPC: 4CI231
Brisbane QLD 4001

Phone: 1800 634 294

Fax: (07) 3031 2862

Email: enquiries@mtai.com.au

Web: www.mtai.com.au