Loan Protection Insurance Claim Form – Disablement or Accidental Injury

Important Information

Please ensure that all sections of this claim form are fully completed and the requested evidence attached. We are unable to consider your claim unless all relevant information has been provided.

Insured Details

Loan Protection Insurance Policy Number

Title | Given Name(s) | Surname

Sex | Date of Birth | Occupation

Please select | / / |

Address

State Postcode

Contact Telephone Numbers

Home | Business | Mobile

Email Address

Please attach certified proof of your identity (birth certificate, driver's licence or current passport).

GST Information

Are you registered for GST purposes? Yes ☐ No ☐

If YES, what is your Australian Business Number (ABN)?

Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? Yes ☐ No ☐

If YES, what percentage of the GST did you claim or are entitled to claim? %
(If the GST paid and your ITC entitlement is the same amount, the answer to this question is 100%)

Loan Contract Details

Credit Provider Name

Loan Contract Number | Monthly / Fortnightly / Weekly Repayment | Payment Due Date

$

Please provide a copy of your finance contract.

Declaration / Authorisation (To be signed be the Insured)

Insurance issued by AAI Limited ABN 48 005 297 807 AFSL 230859 and distributed by MTA Insurance Pty Ltd. AAI Limited and MTA Insurance Pty Ltd are members of the Suncorp Group.

I hereby declare that the information I have provided is factual and correct and I agree that if I make any false statements my right to compensation may be forfeited.

I acknowledge that the information I have provided on this form is necessary for AAI Limited, ABN 48 005 297 807, to assess my claim.

I agree that AAI may disclose information to, or obtain information from, other insurers, credit providers, claims assessors, Centrelink, my current or a previous employer, insurance contractors, medical practitioners and specialists, including but not limited to, those named on this claim from.

Please note that if you do not agree to this, then it may not be possible to properly asses your claim. For a copy of AAI's privacy policy please refer to your Product Disclosure Statement or www.suncorp.com.au/privacy

Signed Date / /

MTA Insurance Pty Ltd ABN 35 070 583 701 AFS Licence No. 239912. PO Box 1453, IPC: 4CI231 Brisbane QLD 4001

Details of Illness (To be completed by the Insured)

Date of Illness / /

Details of Illness

Were you taken to hospital? Yes ☐ No ☐ If yes, which hospital?

When was the illness first diagnosed?

Have you suffered from this (or a similar) condition before? Yes ☐ No ☐ If yes, provide details below.

Details of Injury (To be completed by the Insured)

Date of Injury / / Time of Injury Please select

How did the Injury occur?

Where did the Injury occur? (eg. workplace, public park, home)

Did the police attend the scene of your injury? Yes ☐ No ☐

Were you taken to hospital? Yes ☐ No ☐ If yes, which hospital?

Have you suffered from this (or a similar) condition before? Yes ☐ No ☐ If yes, provide details below.

Alcohol Compsumption (To be completed by the Insured)

Were you under the influence of an intoxicating liquor at the time of injury? Yes ☐ No ☐

If yes, please provide the following details:

What time did you have your first drink? Please select What time did you have your last drink? Please select

What type of intoxicating liquor did you consume?

How many standard drinks did you consume prior to the injury?

Non-Prescribed Drug Consumption (To be completed by the Insured)

Were you under the influence of any non-prescribed drug at the time of injury? Yes ☐ No ☐

If yes, please provide the following details:

What time did you start taking the drug/s? Please select What type of drug/s did you take?

Witnesses (To be completed by the Insured)

Were there any witnesses present at the time of your injury? Yes ☐ No ☐

If yes, please provide the following details:

Name

Address

State Postcode

Contact Number

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Medical History (To be completed by the Insured)

Name and Address of Doctor who first attended you after the occurrence

Name

Address

State Postcode

Name and Address of other Doctors or Specialists who have been consulted on this matter

Name

Address

State Postcode

Name

Address

State Postcode

Name

Address

State Postcode

Name and Address of Doctor holding your current medical records

Name

Address

State Postcode

Name and Address of Doctor/s holding past medical records

Name

Address

State Postcode

Name

Address

State Postcode

Are you entitled to any form of compensation from any other company? Yes ☐ No ☐ If yes, provide details below.

Are you entitled to any form of compensation from any other company? Yes ☐ No ☐ If yes, provide details below.

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Statement of Employment (To be completed by the Employer)

Name of Employer

Address

State Postcode

Telephone Fax ABN Number

Date First Employed / / Average Hours Per Week

Employment Status: ☐ Permanent ☐ Part Time ☐ Seasonal ☐ Contract ☐ Specified Period ☐ Self Employed

Occupation at time of Injury/Illness

Provide full details of employee's usual duties

Reason for stopping work

Last Day Worked / /

Is the employee's disablement a result of an injury? Yes ☐ No ☐

If yes, did the injury occur during work hours? Yes ☐ No ☐

Is the employee in receipt of, or entitled to, Workers' Compensation benefits? Yes ☐ No ☐

If yes, provide benefit details:

Name of Insurer

Address

State Postcode

Has the employee returned to work? Yes ☐ No ☐

If yes, please provide date / / If yes, how many hours per week?

If the employee has not returned to work, when do you expect him/her to return? / /

Has the employee carried out any form of activity relating to their occupation since the occurrence of the injury/illness? Yes ☐ No ☐

If yes, please provide details

Employers Declaraton

Print Name

Title

Signed

Company Stamp

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Medical Certificate (Pages 5 & 6 are to be completed by your Doctor)

The claimant must arrange completion of this Certificate at their own expense.

NOTE: If you are unable to answer any of the questions from personal knowledge of the injury or illness, please indicate.

Name of patient

How long has this person been a patient of your practice?

Are you the patient's usual medical practitioner? Yes ☐ No ☐

Do you hold the patient's full medical records? Yes ☐ No ☐

How long have you known the patient?

State fully the exact nature and extent of the injury/illness

Was the patient under the influence of any alcohol and/or non-prescribed drugs at the time of the injury/illness? Yes ☐ No ☐

What date did you first attend the patient in connection to this injury/illness? / /

When was the injury/illness first diagnosed? / /

Please provide details of treatment provided

Has the patient previously suffered from this or a similar condition? Yes ☐ No ☐

If yes, please provide full details of previous occurrence, including when the condition was first diagnosed

Is the patient (to your knowledge) complying with your treatment instructions? Yes ☐ No ☐

Do you consider this injury/illness will result in permanent disablement? Yes ☐ No ☐

Has the patient been referred to, or do you intend to send the patient to, a specialist? Yes ☐ No ☐

If yes, please provide name and address of specialist:

Name

Address

State Postcode

Please provide a history of the patient's current and past medical conditions, irrespective of the injury/illness stated above.

Condition	Date of Diagnosis	Current Treatments/Medications
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

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Have any of these conditions contributed to the patient's current injury/illness? Yes ☐ No ☐

If yes, please provide details

The patient has been totally disabled from attending any part of his/her usual business or occupation

From / / To / / (inclusive)

If the patient is only partially disabled from attending any part of his/her usual business or occupation, please indicate when you expect him/her to fully recover / /

General Remarks

Print Name

Provider Number

Address of Practice

State Postcode

Telephone

Fax

Signature Date / /

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