WageGuard Group Income Protection Claim Form

Frequently Asked Questions

How long will it take to complete my section of the form?

We've tested it -- it takes 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.

> When medical practitioners and medical specialists are too busy to get around to 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 (1 300 826 837) and ask for WageGuard claims.

Please note

Coverforce is a 50% shareholder in U-Cover. All documentation including claims management is undertaken by Coverforce. Coverforce has an excellent claims settlement rate, so you can be sure we will do everything we can to process your claim promptly. You can play your part by double-checking that your claim form really has been accurately completed before you send it to us.

Thank you. The Coverforce Claims Team.

U-Cover are acting on behalf of the insurer, Hannover Life Re of Australasia Ltd and will be dealing with this insurance claim as an agent of the insurer and not the insured.

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, fax or email.
6. We will send confirmation to you within 24 hours that we have received your claim form.

Contact U-Cover

Wageguard is managed and administered by U-Cover Pty Ltd
(ACN 134 723 587) as the Trustee for the U-Cover Trust
(ABN 64 608 402 587)

Authorised Representative no.334641 of AFSL 238874
held by Coverforce Pty Ltd
ACN 067 079 261
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Level 12, 9 Castlereagh Street Sydney NSW 2000

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Section A: Insured Person'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

1.1 What is your preferred method of contact? ☐ SMS ☐ Email ☐ Post

2. Additional Information

2.1 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

2.2 You may also be entitled to a superannuation benefit. If you are entitled, please nominate your Super fund details below:

Superannuation Fund | Member Number

2.3 Are you a member of a union? ☐ Yes ☐ No

Union Name | Member Number

2.4 Do you give us authority to speak with representatives of your nominated union in relation to your claim? ☐ Yes ☐ No

2.5 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.

2.6 Do you have Private Health Insurance? ☐ Yes ☐ No

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Section A: Insured Person's Statement (continued)

3. Employment Details

Name of Employer

Site Address

Occupation/Job Title | Department | Employed Since (DD/MM/YY)

Manager/Supervisor | Supervisor Contact Number

3.1 Please list your Usual Duties and percentage of time spent on each task | % Time Spent On Task

3.2 What were your average hours worked per week prior to disablement? | Hours | Days Per Week

3.3 Do you work regular overtime? ☐ Yes ☐ No

3.4 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.

4.1 What is the date that you first ceased work due to this injury/sickness? (DD/MM/YY)

4.2 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)

4.3 Please describe your injury or sickness and which part of the body it affects.

4.4 Date first consulted a doctor for this condition (DD/MM/YY)

4.5 How long do you anticipate you will be away from work as a result of this condition?

4.6 If you have already returned to work, please specify the date: (DD/MM/YY)

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Section A: Insured Person's Statement(continued)

4.7 Please complete Question 4.7 only if you are claiming for an injury:

4.7 a. Did the Injury occur during the course of your usual occupation? ☐ Yes ☐ No

4.7 b. What specific event occurred to cause the injury(ies)?

4.7 c. Where were you at the time of the injury? Address if applicable

4.7 d. Where there any witnesses to this injury? If so, please provide name(s) and contact details

4.8 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	Fax

4.9 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?

4.10 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 known (should 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	Fax

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

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4.12 Please list what duties you are still able to perform as a result of this condition

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

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

4.15 Have your treating doctors at any time advised you to cease all treatment for this condition? ☐ Yes ☐ No

5. Other Insurance Cover

5.1 In respect of this injury or sickness are you receiving or planning to lodge a claim against

a. Motor Accident Compensation Benefit	☐ Yes	☐ No
b. Worker's Compensation Benefit (WorkCover)	☐ Yes	☐ No
c. Sports Insurance with Club	☐ Yes	☐ No
d. Any Other insurance policy for loss of wages	☐ Yes	☐ No

5.2 If you answered Yes to any of the above, please provide details below:

Claim Number	Name Of Insurer	Contact Number

Please attach copies of copies of any Workers Compensation or TAC correspondence, medical certificates and payment advices relating to the claimed condition if applicable.

6. I further declare that the claim I am making for Income Protection benefits

☐ is work-related OR ☐ is not work-related

☐ is covered by Workers Compensation ☐ is not covered by Workers Compensation

7. Privacy Statement

We are committed to protecting your privacy. We use the information you provide to advise about and assist with your insurance needs. We provide your information to insurance companies and agents that provide insurance quotes and offer insurance terms to you or the companies that deal with your insurance claim (such as loss assessors and claims administrators). Your information may be given to an overseas insurer (like Lloyd's of London) if we are seeking insurance terms from an overseas insurer, or to reinsurers who are located overseas. We will try to tell you where those companies are located at the time of advising you. We do not trade, rent or sell your information.

If you don't provide us with full information, we can't properly advise you, seek insurance terms for you, or assist with claims and you could breach your duty of disclosure.

For more information about how to access the personal information we hold about you and how to have the information corrected and how to complain if you think we have breached the privacy laws, you can access a copy of our Privacy Policy on our website www.ucover.com.au or alternatively contact our Privacy Officer on 02 9376 7888.

8. Medical Authority And 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

And 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 or fax copy 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)

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Section B: Medical Practitioner's Statement

Section B is to be completed by your treating doctor.
All certificates & evidence required by Us shall be furnished as required at the Insured Person'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

2.1 What is your diagnosis of the patient's condition?

2.2 What was the cause of this condition?

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

2.4 Do you consider this condition to be as a result of an Injury or Sickness? ☐ Injury; or ☐ Sickness
Please provide reasoning for your response.

2.5 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)

2.6 On what date (DD/MM/YY) did you first consult the patient in relation to this condition (if different from above)?

2.7 Has the patient ever suffered from a similar condition in the past? (If yes, how does it relate to this current condition) ☐ Yes ☐ No

2.8 Have you at any time advised the patient that they can cease all treatment for this condition? Please provide any relevant medical history that may assist us with this claim? ☐ Yes ☐ No

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Section B: Medical Practitioner's Statement (continued)

2.9 What investigations have been undertaken in determining a diagnosis?

Please provide copies of these pathology reports / investigations

2.10 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	Fax

2.11 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? (If yes, for what period? DD/MM/YY) ☐ Yes ☐ No From To

2.12 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? (If yes, for what period? DD/MM/YY) ☐ Yes ☐ No From To

2.13 If you answered No to questions 2.11 and 2.12, Has/Will there been any period of disablement as a result of this condition? (If yes, for what period? DD/MM/YY) ☐ Yes ☐ No From To

Please specify reason(s)

2.14 Estimated date of return to work (DD/MM/YY)

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

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We are committed to protecting your privacy. We use the information you provide to advise about and assist with your insurance needs. We provide your information to insurance companies and agents that provide insurance quotes and offer insurance terms to you or the companies that deal with your insurance claim (such as loss assessors and claims administrators). Your information may be given to an overseas insurer (like Lloyd's of London) if we are seeking insurance terms from an overseas insurer, or to reinsurers who are located overseas. We will try to tell you where those companies are located at the time of advising you. We do not trade, rent or sell your information.

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Name

Email

Qualifications

Phone

Fax

Signed

Address

Date (DD/MM/YY)

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Section C: Employer's Statement

Section C is to be completed by the Employer. Please include all requested attachments when you submit this form.

Please attach a 52 week pay report substantiating this employees average weekly earnings and any payments paid since incapacity in an Excel format.
Please attach a copy of the employee's job description
Please attach copies of all medical certificates relating to the claimed condition including medical certificates from a previous related condition where applicable.
Please attach copies of ANY termination documentation. (if applicable) (e.g. resignation, separation certificate etc)

Name of Employer

Employer Number | Project

Contact Person | Phone | Fax

Email

1.1 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 ☐ Partially Incapacitated since

and ☐ is due to return to work ☐ did return to work on

1.2 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:

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

	Amount	From	To
Normal Pay			
Current Sick Leave			
Current Annual Leave			
Other (please specify below)			

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1.3 a. 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 Number/Policy Number	Name of Insurer	Contact Name	Contact Number

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

1.4 This employee has been employed on the following basis:

☐ Full Time ☐ Part Time ☐ Casual ☐ Contractor Date Employment Commenced (DD/MM/YY)

1.5 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

3. Declaration

3.1 I hereby declare that this condition:

☐ is work-related

☐ is not work-related

3.2 I hereby declare that this condition:

☐ is covered by Workers Compensation

☐ is not covered by Workers Compensation

3.3 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 (DD/MM/YY)

Position Held

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