WageCare Group Income Protection Claim Form

WageCare by COVERFORCE

IMPORTANT: READ BEFORE CLAIMING

WorkCover VS Income Protection

Make sure you're claiming the right benefits

If you've been injured or become ill due to your work (even if the event or diagnosis occurred outside of work), you may be eligible to lodge a WorkCover claim.

While income protection insurance provides valuable financial support, it's important to understand the differences between WorkCover and income protection to ensure you're accessing all the benefits available to you.

WHAT WORKCOVER PROVIDES THAT INCOME PROTECTION DOESN'T:

WorkCover includes a range of benefits that income protection does not. These may include:

> **Medical & like expenses** – WorkCover covers treatment costs, while income protection does not.
> **Hospital cover** – Included under WorkCover but not income protection.
> **Rehabilitation & return-to-work support** – WorkCover requires employers to assist with return-to-work plans, including suitable duties. Income protection does not include this requirement.
> **Emergency ambulance services** – Covered under WorkCover, not under income protection.
> **Lump sum compensation** – WorkCover may provide lump sum payments for permanent impairment or disability, which are typically not included in income protection.
> **Benefit period** - WorkCover can provide long-term support (up to 5+ years in some cases), whereas your income protection cover has a maximum benefit period of 104 weeks.
> **Common law damages** – WorkCover may allow for compensation due to loss of future income, unlike income protection.
> **No waiting period** – WorkCover has no waiting period, whilst income protection policies will typically have applicable waiting periods.

Note: This is not a complete list of WorkCover benefits. You may be eligible for additional entitlements depending on your circumstances.

GOOD NEWS: YOU MAY BE ENTITLED TO BOTH

Many income protection policies, including WageCare, can work alongside WorkCover. If you lodge a WorkCover claim first, your income protection can top up your salary. Depending on the WageCare options your employer has chosen your top up amount will be between 80% and 100% of your usual income including all overtime and allowances.

Before proceeding with your claim, take the time to consider your options to ensure you don't miss out on valuable benefits.

If you require further info, contact the WageCare claims team on 02 9376 7888 or scan the QR code to learn more about Workers Compensation in your state.

WageCare Group Income Protection Claim Form

The WageCare Group Income Protection Product is issued by AIA Australia Limited (ABN 79 004 837 861, AFSL 230043) (AIA).
It is distributed and administered by Coverforce Pty Limited (ABN 31 067 079 261).

Frequently Asked Questions

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

We've tested it - your section will take 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;

> delays in medical practitioners and medical providers providing medical reports.

I need help completing this form, what can I do?

We're here to help you, so just call us on **1-3000-COVER** (**1 3000 26837**) and ask for WageCare claims.

Coverforce are acting on behalf of the insurer, AIA Australia Limited (ABN 79 004 837 861, AFSL 230043) and will be dealing with this insurance claim on behalf of the insurer and not the claimant.

Checklist

Has the claimant attached copies of any medical certificates/reports, Workers Compensation or total accident commission correspondence and payment advices relating to the claimed condition? Yes ☐

Has the medical practitioner attached copies of any pathology reports or investigations? Yes ☐

Have all Privacy Statements & Declarations been signed? Yes ☐

Please check you have correctly filled out all sections and saved the document before submitting the form.

Submit Form >>

If you wish to return your form to Coverforce via post or email, please use the details provided below.

Returning Your Form

1. YOU fully complete Part A of the claim form and attach all requested documents for this section.
2. Have YOUR DOCTOR fully complete Part B of the claim form and attach all requested documents for this section.
3. Ensure all the details are correct and that each section is signed.
4. Send the claim form to Coverforce via post or email.
5. We will send confirmation to you within 24 hours that we have received your claim form.
6. We will arrange for Section C (not included in this document) to be completed by your employer.

Contact Coverforce

wagecare@coverforce.com.au
coverforce.com.au

Level 26, Tower One
International Towers Sydney
Barangaroo NSW 2000

Locked Bag 5273
Sydney NSW 2001

P 02 9376 7888
F 02 9223 1333

Section A: Claimant'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:

What is your preferred method of contact? SMS ☐ email ☐ post ☐

2. Additional Information

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:

You may also be entitled to a superannuation benefit. If you are entitled please nominate your super fund details below.

Superannuation fund:	Member number:

Do you have private health insurance? Yes ☐ No ☐

3. Employment Details

Name of employer:

Site address: | Suburb: | State: | Postcode:

Occupation/job title: | Department: | Employed since (DD/MM/YY):

Manager/supervisor: | Supervisor contact number:

Please list your usual duties and percentage of time spent on each task:	% time spent on task:

What were your average hours worked per week prior to disablement?

hours: ☐ days per week: ☐

Do you work regular overtime?

Yes ☐ No ☐

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.

What is the date that you first ceased work due to this injury/sickness?

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):

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

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

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

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

Please complete the questions below only if you are claiming for an injury (you MUST complete these questions if you are claiming for an injury).

Did the injury occur during the course of your usual occupation? Yes ☐ No ☐

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

Where were you at the time of the injury? Please specify the address if applicable:

Were there any witnesses to this injury? If so, please provide name(s) and contact details:

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:

4. Disability Details (cont.)

If you have had a similar condition in the past, please provide details of any relation between the previous condition and the condition you are claiming for now. If there is no relation, please explain the reasons:

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 you require to list more than the allocated space below, please provide as an attachment to the form.

Doctors name & speciality:	Period of attendance (DD/MM/YY) From:	To:	Phone:

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

Please list which duties you are still able to perform:

Please list which duties you are unable to perform:

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

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

5. Other Insurance Cover

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

Motor accident compensation benefit? Yes ☐ No ☐

Worker's compensation benefit (WorkCover)? Yes ☐ No ☐

Sports insurance with club? Yes ☐ No ☐

Any other insurance policy for loss of wages? Yes ☐ No ☐

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

Claim number:	Name of insurer:	Contact number:

If applicable, please attach copies of copies of any workers compensation or total accident commission correspondence, medical certificates/reports and payment advices relating to the claimed condition.

Privacy Statement

We are subject to the Australian Privacy Principles as per the *Privacy Act 1988 (Cth)* (the Act). We collect your personal information to enable us to provide, offer and administer our products and services or otherwise as permitted by law. Reasons for collection include, but are not limited to, responding to your enquiries, providing you with assistance you request us, maintaining and administering our products and services (for example processing requests for quotes, applications for insurance, offering insurance terms and any other purpose identified at the time of collecting your information). We may be required to disclose your information to third parties to assist with your insurance needs (this can include disclosure to an overseas insurer such as Lloyd's of London or insurer).

You can read more about how we collect, use and disclose your personal information through requesting a copy of our Privacy Policy from our privacy officer on **02 9376 7888** or accessing our website at **coverforce.com.au**.

Medical Authority & Declaration

I hereby authorise any hospital, physician, insurer, health insurance commission, my employer or other person who has attended me to furnish to Coverforce Pty Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding worker's compensation claims or claims with any other insurer to be released to Coverforce Pty Ltd. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I also authorise Coverforce Pty Limited or its representatives to provide to my employer or my employer's representatives any information about me regarding my claim.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, payment of my claim may be refused.

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

☐ is work-related
☐ is covered by Workers Compensation

OR

☐ is not work-related
☐ is not covered by Workers Compensation

Signature:

Name"

Date (DD/MM/YY):

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below:

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

> Preparing a general report and/or a report about a specific condition;
> Accessing and releasing your records in SafeScript;
> Releasing your hospital patient notes;
> Releasing the results of any investigations they have done; and/or
> Releasing correspondence with other health providers.

Authority 2 explanatory notes - through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

> They will be unable to, or did not, provide the report within 4 weeks; or
> The report provided is incomplete or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Authority 1

To release any of my health information except the consultation notes held by my General Practitioner/Practice.

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Coverforce or its representatives or to third parties they engage.

I agree to the following:

> My health information can be released in the form Coverforce and its representatives asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
> Coverforce and its representatives can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
> This Authority is valid only while Coverforce and its representatives are assessing my claim or application for cover, or are verifying disclosures I made in connection with the cover.
> A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature: Date:

Authority 2

To release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances.

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Coverforce and its representatives, or to third parties they engage, only if Coverforce and its representatives has asked them for a report on my health and either:

> The General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
> The report is incomplete, or contains inconsistencies or inaccuracies.

I agree to the following:

> Coverforce and its representatives can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
> This Authority is valid only while Coverforce and its representatives are assessing my claim or application for cover, or are verifying disclosures I made in connection with the cover.
> A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature: Date:

Please ensure Sections A & B have been completed.
Details on returning your form can be found on page 1.

Section B: Medical Practitioner's Statement

Section B is to be completed by your treating doctor. All certificates and evidence required shall be furnished as required at the claimant'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 you/your practice?

2. Medical And Consultation Details

What is your diagnosis of the patient's condition?

If you can please provide the ICD10 Code (Australian Modification) for the primary diagnosis *and any secondary diagnosis*

What was the cause of this condition?

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

Do you consider this condition to be a result of an injury or sickness? injury ☐ sickness ☐

Please provide reasoning for your response:

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)?

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

Has the patient ever suffered from a similar condition in the past? Yes ☐ No ☐

If Yes, how does it relate to this current condition?

Have you at any time advised the patient that they can cease all treatment for this condition? Yes ☐ No ☐

Please provide any relevant medical history that may assist us with this claim:

2. Medical And Consultation Details (cont.)

What investigations have been undertaken in determining a diagnosis?

Please provide copies of any pathology reports/investigations.

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:

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? Yes ☐ No ☐

If Yes, for what period (DD/MM/YY)? From: To:

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? Yes ☐ No ☐

If Yes, for what period (DD/MM/YY)? From: To:

If you answered No to the questions above, has/will there been any period of disablement as a result of this condition? Yes ☐ No ☐

If Yes, for what period (DD/MM/YY)? From: To:

Please specify reason(s):

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

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

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You can read more about how we collect, use and disclose your personal information through requesting a copy of our Privacy Policy from our privacy officer on **02 9376 7888** or accessing our website at **coverforce.com.au**.

Signature

Name:

Date: Email:

Qualifications:

Phone:

Address:

Please ensure Sections A & B have been completed.
Details on returning your form can be found on page 1.