Life Insurance
Initial claim form
for Practise Expense Cover

Avant
By doctors for doctors

Office use only

Avant plan number(s): _____

☐ Practice Expense Cover (PE)

Who is to complete this form?

This form is to be completed for any Practice Expense Cover claims.

Sections 1–17 of this form are to be completed by the **Life Insured**, being the individual insured under the relevant Avant Life Insurance policy.

Section 18 of this form is to be completed by the **Plan Owner**, being the owner of the relevant Avant Life Insurance policy.

How to complete this form?

Please print this form, fill in the responses and email a copy of the completed form back to us at avantlifeclaims@avant.org.au

Please answer all questions unless indicated otherwise.

Should you require additional space to answer any of the questions or provide additional information in relation to your claim, we have provided additional space on page 10 of this form. Please make reference to which question you are responding to (if applicable).

Questions?

Avant is here to support you in any way we can, please contact us on 1800 128 268 or email us at avantlifeclaims@avant.org.au. Should you wish to discuss your claim or need help completing this claim form, please contact NobleOak's claims team directly on 1300 756 817.

1. Your personal details

Full name			
Date of birth		Mobile	
Telephone		Business	
Email address			
Occupation			
Medical specialty			
Residential address			
Postal address ☐ Same as residential address			
Height		Weight	
Are you a smoker?	☐ Yes ☐ No		
If **YES**, how old were you when you commenced smoking?			

2. Your practice/business details

Full name			
Practice/business address			
State		Postcode	
Practice/business structure	☐ Self-employed ☐ Partnership ☐ Company ☐ Trust		

3. Treating doctor

Your treating doctor

Full name			
Specialty		Contact number	
Address			
State		Postcode	

When did you first see this doctor for this condition? (DD/MM/YYYY)

List all of the dates of consultation you have had with this doctor for this condition. (DD/MM/YYYY)

Did you know the treating doctor personally before you consulted them professionally? ☐ Yes ☐ No

If **YES**, please provide details.

Is the treating doctor for this injury or illness your regular doctor? ☐ Yes ☐ No

If **NO**, please provide your regular doctor's details.

Full name			
Specialty		Contact number	
Address			
State		Postcode	

How long have you attended your regular doctor?	Years/months

Which doctor would best know the complete history of your medical condition(s)? ☐ My treating doctor ☐ My regular doctor ☐ Other

If **Other**, please provide details of the doctor and/or surgery.

Full name			
Specialty		Contact number	
Address			
State		Postcode	

4. Other doctors/healthcare professionals consulted in relation to this injury or illness

Other doctors/healthcare professionals consulted					
Full name					
Specialty		Contact number			
Address					
State		Postcode			
Dates of medical treatment		From (DD/MM/YYYY)		To (DD/MM/YYYY)	
Other doctors/healthcare professionals consulted					
Full name					
Specialty		Contact number			
Address					
State		Postcode			
Dates of medical treatment		From (DD/MM/YYYY)		To (DD/MM/YYYY)	
Other doctors/healthcare professionals consulted					
Full name					
Specialty		Contact number			
Address					
State		Postcode			
Dates of medical treatment		From (DD/MM/YYYY)		To (DD/MM/YYYY)	

Have you been referred to any other doctors, medical providers, rehabilitation providers or other health professionals for treatment or consultation?	☐ Yes	☐ No
If **YES** please provide details.		

Complete **Section 5** in case of an **injury** only.

5. Nature of injury

When did the injury occur?		Date (DD/MM/YYYY)		Time (am/pm)	
Location of injury (address)					

Did police or first aid services attend the accident scene? ☐ Yes ☐ No

If **YES**, please provide details of police station or first aid service to which the accident was reported.

Please provide details of how the injury occurred.

What was the nature of injury sustained? Please provide full details of the nature of your injuries e.g. if to a limb, specify whether left or right.

What restrictions occurred as a result of this injury?

How have these restrictions affected your ability to work?

Are there any secondary medical condition(s)? ☐ Yes ☐ No

If **YES**, please provide details.

Have you had the same, similar or related injury in the past? ☐ Yes ☐ No

If **YES**, please provide details.

Complete **Section 6** in case of an **illness** only.

6. Nature of illness

Date symptoms first appeared?		Date of diagnosis?	

Was this condition diagnosed by your current treating doctor? ☐ Yes ☐ No

If **NO**, please provide name of doctor.

Please provide full details of your illness.

Please describe your current symptoms and their severity.

What restrictions occurred as a result of this illness?

How have these restrictions affected your ability to work?

Are there any secondary medical condition(s)? ☐ Yes ☐ No

If **YES**, please provide details.

Have you had the same, similar or related illness in the past? ☐ Yes ☐ No

If **YES**, please provide details.

7. Medical treatment details

Did you require the services of an ambulance?				☐ Yes	☐ No
Did you attend hospital as an outpatient?				☐ Yes	☐ No
If **YES**, please provide details.					
Have you been admitted to hospital for this injury or illness?				☐ Yes	☐ No
If **YES**, please provide the following details:					
Hospital name		Date admitted		Date discharged	
Hospital name		Date admitted		Date discharged	
Hospital name		Date admitted		Date discharged	
Please provide details of the treatment prescribed (including the names and dosages of any medication).					
Treatment/medication					
Dosage and frequency		Prescribed by			
Treatment/medication					
Dosage and frequency		Prescribed by			
How have you responded to treatment?					
Have you followed the treatment plan prescribed?				☐ Yes	☐ No
If **NO**, please comment.					
Are you being treated for any other medical condition (e.g. high blood pressure, diabetes etc)?				☐ Yes	☐ No
If **YES**, please provide details.					

8. Your occupation details

When you first suffered the injury or illness (more than one may apply), were you:

Occupation	Details			
Employed	Employer 1		Commencement date (DD/MM/YYYY)	
	Employer 2		Commencement date (DD/MM/YYYY)	
Self-employed	Business name		Commencement date (DD/MM/YYYY)	
Other (please provide details)				
Regular occupation				

9. Work since illness or injury

When was your last day at work?	(DD/MM/YYYY)	
Since your illness or injury, have you worked in any capacity?	☐ Yes	☐ No
If **YES**, please provide details.		
Duties performed		
Date started (DD/MM/YYYY)	Date stopped (DD/MM/YYYY)	
Income earned	($)	
When do you expect to return to work?		
☐ Full-time	(DD/MM/YYYY)	
☐ Part-time	(DD/MM/YYYY)	
☐ Unknown		
Has a return to work been discussed with your employer?	☐ Yes ☐ No	☐ N/A
Will your employer allow you to return to work on a flexible basis if required?	☐ Yes ☐ No	☐ N/A
Will you have a job to return to at the end of your illness or injury?	☐ Yes	☐ No
If **NO**, please provide details as to why this is the case.		
Did you stop working because of your illness or injury?	☐ Yes	☐ No
If **NO**, please provide details as to why you stopped working.		

10. Occupational duties

Please list each duty of your occupation that you performed before you were injured or became ill.	How many hours per week did you usually perform this duty?	What percentage of your income was usually earned from performing this duty? (%)	Please indicate whether you are currently able to perform this duty, perform it partially, or not at all.
Total hours usually worked per week		(Hours)	

11. Income earning employees/contractors

Name			
Occupation/specialty		Monthly billings ($)	
Employment basis	☐ Full-time	☐ Part-time	☐ Contractor
Name			
Occupation/specialty		Monthly billings ($)	
Employment basis	☐ Full-time	☐ Part-time	☐ Contractor
Name			
Occupation/specialty		Monthly billings ($)	
Employment basis	☐ Full-time	☐ Part-time	☐ Contractor
Name			
Occupation/specialty		Monthly billings ($)	
Employment basis	☐ Full-time	☐ Part-time	☐ Contractor
Name			
Occupation/specialty		Monthly billings ($)	
Employment basis	☐ Full-time	☐ Part-time	☐ Contractor

12. Non-income earning employees/contractors

Name		Occupation/specialty	
Monthly remuneration ($)		Commencement date (DD/MM/YYYY)	
Name		Occupation/specialty	
Monthly remuneration ($)		Commencement date (DD/MM/YYYY)	
Name		Occupation/specialty	
Monthly remuneration ($)		Commencement date (DD/MM/YYYY)	
Name		Occupation/specialty	
Monthly remuneration ($)		Commencement date (DD/MM/YYYY)	
Name		Occupation/specialty	
Monthly remuneration ($)		Commencement date (DD/MM/YYYY)	
Name		Occupation/specialty	
Monthly remuneration ($)		Commencement date (DD/MM/YYYY)	

Are any of these non-income earning employees/contractors related to you relatives? ☐ Yes ☐ No

If **YES,** please provide details.

13. Details of all partners of the practice

Name		Interest in Practice (%)	
Name		Interest in Practice (%)	
Name		Interest in Practice (%)	
Name		Interest in Practice (%)	
Name		Interest in Practice (%)	
Name		Interest in Practice (%)	

14. Your interest in the practice/business

What percentage interest of the practice/business do you have? (%)	
What percentage of the monthly income of the practice/business is derived from your billings? (%)	
What percentage of the monthly practice/business expenses are you responsible for/liable to pay? (%)	

Whilst you are/were injured or ill and unable to work, will/did you:

☐ Temporarily suspended your practice ☐ Instructed your employees to continue the practice ☐ Employ a replacement locum ☐ Other (please provide details below)

15. Other benefits

Have you received, claimed or are you eligible to claim any other benefits to cover the cost of practice/business expenses included since your illness or injury?	☐ Yes	☐ No		
If **YES,** please provide details (insurer's name, contact name, reference number).				
Amount received ($)				
Period for which this amount relates:	From (DD/MM/YYYY)		To (DD/MM/YYYY)	

16. Additional information

Please provide any additional information or comments you feel are relevant to this claim.

17. Checklist

- ☐ I have fully completed this form as required.
- ☐ I have provided my treating doctor with my Medical Attendant's Statement form to complete in support of this claim.
- ☐ I have provided copies of all available supporting medical evidence confirming the diagnosis of my claimed condition, including test results, medical reports, histopathology reports, hospital admission and discharge reports. Please leave this checkbox blank if this information is not available to you, or if the information provided is incomplete.
- ☐ I have attached a Profit and Loss Statement for the practice / business since the date I ceased work, reflecting the breakdown of gross income and the amount of my monthly practice / business expenses incurred since the date I ceased work.
- I have attached a certified copy of my: ☐ Driver's licence ☐ Passport ☐ Birth Certificate
- ☐ I have provided all the other required information as requested.

Declaration and authorities

In signing below, I am making the following Declaration and am providing the Authorities to obtain information.

Declaration

- I declare that the information in this claim form is true, correct and complete.
- I have not made any false or misleading statements and I have included all information relevant to the assessment of the claim.
- I understand and agree that if I make any false or fraudulent statements in this claim, NobleOak may be entitled to reject this claim and/or cancel my cover and/or to avoid the cover or the Plan altogether.
- I declare that I have read and understood the Privacy Statement which follows the Declaration and the Authorities below and I consent to the collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy Statement.
- I consent to NobleOak and its representatives to use my personal and sensitive information (whether received by NobleOak from me or a third party) to investigate, assess and manage my claim and to disclose that information to medical, or health professionals and institutions and:
  a) reinsurers and other insurers (including Workers' Compensation insurers);
  b) investigators;
  c) the ambulance;
  d) NobleOak's service providers;
  e) Statutory bodies including law enforcement agencies;
  f) insurance or credit reference agencies;
  g) financial institutions; and
  h) such other third parties as is necessary for that purpose.

Authorities – release of health information

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, Avant Life Insurance (a registered business name of Doctors Financial Services Pty Ltd ABN 56 610 510 328) as administrator of the life risk product issued by the Insurer, NobleOak Life Limited (and within this health authority consent, references to Avant Life Insurance and "we" or "us" shall mean Avant Life Insurance and/or the Insurer, together with administrators acting on their behalf), 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.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure as prescribed by NobleOak Life Limited's Rules for the Avant Benefit Fund and to the extent relevant under the *Insurance Contracts Act 1984* (Cth).

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 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 Avant Life Insurance, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form to Avant Life Insurance 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.
- Avant Life Insurance 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 Avant Life Insurance is assessing my claim or application for cover, or is 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 of **Life Insured**			
Signature of **Life Insured**		Date (DD/MM/YYYY)	

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 Avant Life Insurance, or to third parties they engage, only if Avant Life Insurance 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 all the following:

- Avant Life Insurance can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is only valid while Avant Life Insurance is assessing my claim or application for cover, or is 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 of **Life Insured**			
Signature of **Life Insured**		Date (DD/MM/YYYY)	

Privacy statement

Within this section, 'we' and 'us' refer to NobleOak, Avant and Avant Life Insurance.

We collect, use and retain personal information in accordance with the Australian Privacy Principles and the *Privacy Act 1988 (Cth)* (Privacy Act). Our detailed privacy policies are available on our respective websites at:

- avant.org.au/privacy-policy
- nobleoak.com.au/terms-of-use-privacy-policy
- or by calling us on 1800 128 268.

We collect your personal information (which may include sensitive information such as health information) when you are applying for or changing an insurance plan with us, or when we are processing a claim, in order to help us properly administer your insurance application, plan or claim.

The primary purpose for our collection and use of your personal information is to enable us to provide insurance services to you. Sometimes, we may use your personal information for our marketing campaigns, in relation to new products, services or information that may be of interest to you.

We may also disclose your personal information to third parties, including service providers engaged by us to carry out certain business activities on our behalf, other companies within our group of companies, other insurers, our reinsurers, medical and health practitioners, government agencies and regulators (where we are required to by law), law enforcement bodies and agents and/or representatives of persons covered under our plans. Some of these third parties may be located outside Australia. Lists of countries in which recipients of your information are likely to be located are available in the privacy policies on our respective websites.

In all instances where personal information may be disclosed to third parties who may be located overseas, in addition to any local data privacy laws to which those entities are subject, we have measures in place to ensure that those parties hold and use such information in accordance with the consent provided by you and in accordance with our obligations under the Privacy Act. In dealing with us, you agree to us using and disclosing your personal information as set out in this section and in our respective privacy policies. This consent remains valid unless you alter or revoke it by giving written notice to our respective privacy officers. However, should you choose to withdraw your consent, it is important for you to understand that this may mean we may not be able to provide you with this insurance or respond to any claim.

Section 18 is to be completed by the **Plan Owner**.

18. Benefit payment			
Direct credit details Please provide the bank account details where you would like any claim funds payable to be deposited into.			
Name of financial institution		Account name	
BSB number		Account number	

Name of **Plan Owner**			
Signature of **Plan Owner**		Date (DD/MM/YYYY)	

Please return this form to **Avant Insurance Limited PO BOX 746 Queen Victoria Building NSW 1230**, or email **memberservices@avant.org.au** or contact us on **1800 128 268**.