Life Insurance
Ongoing medical attendant's statement

Avant
By doctors for doctors

Office use only

Avant plan number(s): _____

Who is to complete this form?

This form is to be completed by the Life Insured's Doctor or Medical Provider consulted for the injury or illness.

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 4 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. Patient's details	
Patient's full name	
Date of birth (DD/MM/YYYY)	
Occupation	
Medical specialty	

2. Medical treatment	
a)	What is your current diagnosis and the patient's current level of disability?
b)	What objective clinical evidence do you have to support your diagnosis?
c)	Please provide details of the treatment plan currently prescribed (including the names and dosages of any medication(s)).

2. Medical treatment (cont'd)

d) To the best of your knowledge, is the patient following the treatment plan prescribed? ☐ Yes ☐ No

If **NO**, please provide details.

e) Do you consider any other treatment plan necessary and/or beneficial to the recovery and possible return to work at full capacity of the patient in their usual occupation? ☐ Yes ☐ No

If **YES**, please provide details.

f) Would the patient benefit from occupational rehabilitation (e.g. graduated RTW program, studying, re-training, up-skilling etc.)? ☐ Yes ☐ No

If **YES** or **NO**, please provide details.

g) What is your short term and also longer term prognosis for this patient's current condition?

h) Has the patient been referred to any other doctor(s), or medical provider(s), or rehabilitation provider(s) or other healthcare professionals for treatment or consultation? If **YES**, please state. ☐ Yes ☐ No

Date of referral (DD/MM/YYYY)	Name of medical provider and field of practice (eg. Oncologist, Cardiologist etc.)	Address and telephone contact details

3. Occupational details

a) Is the patient, in your view, able to perform any duties in their usual occupation?

☐ Yes – Please complete questions (b)(i), (ii) and (iii) ☐ No – Please continue to question (c) (i)

3. Occupational details (cont'd)

b) (i) If the patient is able to perform some duties and/or responsibilities of their usual occupation, please list the date from which the patient became capable of resuming at least some duties they perform and to what capacity (e.g. 50% etc.)

Work duties able to be performed	Date able to perform work duties (DD/MM/YYYY)	% Capacity
(ii) How many hours per week can the patient perform these duties?		
(iii) When do you consider the patient will be able to perform all of their usual occupation duties? (DD/MM/YYYY)		

Please continue to Section 4

c) (i) What are the reasons why the patient is unable to perform any duties of their usual occupation?

Work duties unable to be performed	Reason why they are unable to perform these duties

d) When do you consider the patient will be:

(i) able to perform some of the duties of their usual occupation?			(ii) able to perform all of the duties of their usual occupation?		
(DD/MM/YYYY)	to	(DD/MM/YYYY)	(DD/MM/YYYY)	to	(DD/MM/YYYY)

e) If you consider the patient will never again be able to perform their usual occupation, in your view, will they be able to perform any work/duties within their education/training or experience? ☐ Yes ☐ No

If **YES**, please provide details.	

f) If you consider the patient will never again be able to perform their usual occupation, in your view, will they be able to perform any work/duties within their education/training or experience? ☐ Unknown ☐ Yes ☐ No

If **YES**, please provide details.	(DD/MM/YYYY)	to	(DD/MM/YYYY)	inclusive

Also, if **YES**, please provide full details of the actual duties (if known) which you understand your patient is currently performing and the number of hours per week these duties are being performed.

Duties	No. of hours per week duties are being performed

4. Additional information

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

Declaration and authorities

Declaration

- I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true, correct and complete.
- I agree that NobleOak Life Limited (NobleOak) may provide copies of this statement to any medical specialist from whom NobleOak seeks an independent report.
- I understand that NobleOak may be required to submit a copy of my report to the patient for comment or to a mediator, solicitor, Complaints Resolution Tribunal, court or to any other person necessary for determination of the claim.
- I further understand that the patient may access a copy of my report from NobleOak under Government Privacy Legislation.

Full name			
Signature		Date (DD/MM/YYYY)	