Life Insurance
Initial medical attendant's statement

Office use only:
Avant plan number(s): ____________

- ☐ Income Protection Cover
- ☐ Practice Expense Cover
- ☐ Life Insurance Cover – Terminal Illness
- ☐ Total and Permanent Disablement Cover
- ☐ Trauma Cover

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 7 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. Patients details

Patients full name			
Date of birth (DD/MM/YYYY)			
Occupation			
Medical specialty			
Home address			
State		Postcode	
Height and weight	Height (cm) cm	Weight (kg)	
Are they a smoker?		☐ Yes	☐ No

2. Your details

Your full name			
Your qualifications			
Occupation			
Medical specialty			
Contact details			
State		Postcode	

3. Relationship with patient

Are you the patient's regular doctor? ☐ Yes ☐ No

If **NO**, who is?
Please provide details.

Did you know the patient personally before they consulted you professionally? ☐ Yes ☐ No

If **YES**, please provide details.

Is the patient a family member, relative, or a current or former business partner, employee or employer? ☐ Yes ☐ No

If **YES**, please provide details.

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

List all of the dates of consultation. (DD/MM/YYYY)

4. Nature of injury or illness

What is the exact diagnosis of the primary condition?

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

If **YES**, please provide details.

What is the objective clinical evidence to support your diagnosis?

What are your patient's current symptoms and severity?

4. Nature of injury or illness (cont'd)

Question		
Are the symptoms consistent with the diagnosed condition?	Yes	No
Is the severity of the condition consistent with the pathology?	Yes	No
Has the condition stabilised?	Yes	No

What is your short term and long term prognosis?

Short term	
Long term	

Are there any predisposing factors associated with the patient's condition?	Yes	No

If **YES**, please provide details.	

In your opinion, is your patient's life expectancy being affected?	Yes	No

If **YES**, please provide details.	
As far as you are aware, how did the injury/illness arise?	

Has the patient had the same, similar or related condition in the past?	Yes	No

If **YES**, please provide details.	
When did the patient first become aware of the claimed condition? (DD/MM/YYYY)	
When was the condition first diagnosed? (DD/MM/YYYY)	

5. Patient's mental status

Have you or any other medical practitioner assessed the patient's mental health?	☐ Yes ☐ No
If you did not assess the assess the patient, please provide advise the medical practitioner's details	
Is the patient experiencing high levels of stress, anxiety or depression?	☐ Yes ☐ No
If **YES**, please provide details as to any known cause and impact on recovery or ability to return to work.	
Have you prescribed treatment or made a referral in relation to their mental health?	☐ Yes ☐ No
If **YES**, please provide details.	

6. Medical treatment

Please provide details of the treatment plan currently prescribed (including the names and dosages of any medication).	
How is the patient responding to treatment?	
To the best of your knowledge, is the patient following the treatment plan prescribed?	☐ Yes ☐ No
If **NO**, please comment.	
Do you consider any other treatment plan necessary and/or beneficial for recovery?	☐ Yes ☐ No
If **YES**, please comment.	
Has the patient 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.	

7. Occupational details (IP, PE and TPD only)

From what date was the patient first certified by a medical practitioner as unfit to work? (DD/MM/YYYY)	
If you did not certify the patient, please advise the medical practitioners details:	
Is the patient, in your view, able to perform some duties and or responsibilities of their usual occupation?	☐ Yes ☐ No
If **YES**, please provide details.	
How many hours per week can the patient perform these duties? (HRS)	
When do you consider the patient will be able to perform all of their usual occupation duties? (DD/MM/YYYY)	
When do you consider the will be able to perform all of their usual occupation duties on a full time basis? (DD/MM/YYYY)	
What are the reasons why the patient is unable to perform the full duties of their usual occupation?	
Is the patient currently performing alternative duties?	☐ Yes ☐ No
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 comment.	

8. Additional information (all products)

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

9. Checklist

Please attach the following to this completed form. Please tick the box to confirm document is attached.

- ☐ Any specialist or other medical reports.
- ☐ X-ray and other radiology reports, pathology and other test results.
- ☐ List of all consultations or copies of clinical notes since first consultation.
- ☐ If hospitalised for condition, please provide the hospital discharge summary/ies.
- ☐ Any other information that will assist with the assessment of this claim.
- ☐ Please provide the history your patient gave you at first consultation for the injury/illness.

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.

Full name			
Signature		Date (DD/MM/YYYY)	

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

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