Millennium

Underwriting Agencies

Attending Physicians Supplementary Statement

Millennium Underwriting Agencies Pty Ltd
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Attending Physicians Supplementary Statement

Claims Procedure

This claim form is to be completed when Your Property has been lost, damaged, stolen or destroyed. It may be necessary for You to arrange urgent temporary repairs to protect Your Property.

It is necessary for You to complete all Sections of this claim form. Please answer all parts of the appropriate questions relevant only to the type of claim that You are lodging. If there is insufficient space provided for any information requested or to be supplied, please supply these details on a separate sheet and attach to the claim form.

Please attach (or promptly supply) where possible the original repair invoice or quotations with this completed form as well as any notices to the Police for Property lost or stolen or any Malicious Damage.

On receipt of the above We will assess and administer Your claim in accordance with Your Policy. We will also keep You informed of any other requirements should they be required and we will keep you advised on the progress on the processing of Your claim. If You have any queries on any of the information required on this form, please do not hesitate to contact Your Authorised Representative or Broker or Millennium Underwriting Agencies Pty Ltd

Privacy

Millennium Underwriting Agencies Pty Ltd respects your privacy and complies with the Privacy Act and the Australian Privacy Principles. A copy of our Privacy Policy is available at www.millennium.com.au

Complaints Procedure

If you do not agree with any decision we make in relation to the Policy, please write to us stating what you disagree with and why.

We will then resolve or attempt to resolve your complaint immediately, or we will refer the matter to our Internal Dispute Resolution Committee (IDRC). If you are not satisfied with a decision by the IDRC, the matter may be referred to an independent dispute resolution body, Financial Ombudsman Service (FOS), provided the matter falls within their jurisdiction.

Financial Ombudsman Service (FOS)
Freecall 1300 78 08 08
Post: GPO BOX 3, Melbourne Victoria 3001
Website: www.fos.org.au
Email: info@fos.org.au

The Insurance Contracts Act 1984 (as amended) requires you to provide all information which your insurer may reasonably require, and stipulates that any omission may adversely affect the cover under your Policy.

If you would like more information on your Duty of Disclosure (or any other aspect), please contact your Authorised Representative, Broker or Millennium Underwriting Agencies Pty Ltd

Claim Details

Claim Number:

Date Lodged:

Dear Doctor,

Your Patient has submitted a claim under an accident and sickness policy with us. In order to receive benefits, your patient must objectively demonstrate incapacity to attend to the core components of their normal occupation. In order for us to determine their liability for this claim and/or on-going beets, we need to establish the precise nature and extent of your patient's health concerns. Therefore your assistance in completing this form would be greatly appreciated in providing the necessary objective evidence of incapacity and the outcome expectations.

Patient Details

Patients Surname:

Patients Given Name(s):

Patients Address:

Patients D.O.B.:

Height:

Weight:

Gender:

Occupation:

Email:

IIllness/Condition/Injury

Please describe the precise nature and extent of your patients primary health concern:

Has a diagnosis been reached?:

○ Yes ○ No

IIllness/Condition/Injury *(continued)*

Please provide details of subsequent consolations with your or one of your colleagues at the practice:

Please outline the treatment(s) provided to date:

Please describe your patients response to this:

Please indicate whether you consider the patient to be TOTALLY or PARTIALLY incapacitated?:

If TOTALLY incapacitated , please identify activities of the patient's normal occupation that he/she is unable to presently perform:

If PARTIALLY incapacitated, do you endorse your patient being able to return to work in a limited/supported capacity at this time?:

○ Yes ○ No

If no, when might this be achievable form a clinical standpoint?:

Have you referred or do you intend to refer your patient to specialist management?:

○ Yes ○ No

IIllness/Condition/Injury *(continued)*

If yes, please provide details of whom and dates of referrals:

Please outline your outcome expectations/prognosis to include a realistic timeframe for a return to PARTIAL or FULL duties:

Partial duties date:

Full duties date:

Are you aware of any factors delaying or could delay your patient's anticipated recovery?:

Doctors Name:

Qualification:

Address:

Telephone No.:

Declaration

I/We solemnly and sincerely declare:

That the information supplied on this Claim Form and Statement of Claim is true in every respect.

1. I/We understand that the claim may be refused if information is withheld, false, misleading or concealed
2. That there was no other insurance covering this loss current at the date of this incident.
3. I/We acknowledge that this Claim Form is a Legal Document and as such may be used in any legal proceedings resulting from this claim.

Submission

○ By ticking this box, I acknowledge this declaration and acknowledge that the information I have supplied to be true and accurate to the best of my knowledge.

Please print name: Signed: Date:

/ /

Please complete and return this form to:

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