CLAIM FORM ➲

Domestic Duties Assistance

Call ATC for assistance on 1800 994 694

The Protect Injury and Sickness policy provides Domestic Duties Assistance as an additional benefit for financial union members. If your spouse or partner is unable to complete their normal domestic duties due to a covered injury or sickness, Domestic Duties Assistance provides cover for up to $200 per week for a maximum of 10 weeks, although no benefits are payable for the first 2 weeks of your spouse / partner's condition, which is considered a 'waiting period'.

For the cover to apply:

- You must be a financial union member when your partner / spouse's condition becomes apparent and also at the time the claim is received,
- Your spouse / partner must not be employed, and
- Your spouse / partner must normally perform full-time, non-income earning domestic duties.

We will pay up to $200 per week for domestic duties such as washing, cooking, cleaning and child-minding, so long as:

- The services are provided by someone other than your or your spouse / partner's immediate family or relatives or anyone currently living with you,
- The costs are considered by us to be fair and reasonable, and
- You provide us with a copy of the tax invoice from the service provider.

1. **You** complete Sections A and B.

2. If you have already paid for the domestic duties, provide a copy of the tax invoice from the service provider. If you have not yet arranged the domestic duties assistance, please note you will need to provide copies of the tax invoices prior to being reimbursed.

3. Your **Medical Practitioner** completes Section C.

5. Check all questions have been answered (including by selecting either Yes or No wherever this option is given) and each section has been signed and dated.
Your claim will be delayed if we have to return your claim form to you because it is incomplete.

6. Please keep a copy of the completed claim form and attachments for your records.

7. Send, or fax, or scan and email, or deliver your completed form in person to:
Post: ATC Insurance Solutions Pty Ltd
Level 4, 451 Little Bourke Street, Melbourne Vic 3000
Fax: 03 9867 5540
Email: info@atcis.com.au

ATC Insurance Solutions Pty Ltd (ABN 25 121 360 978 AFSL 305802) is acting under the authority of the underwriters and will handle this claim as agent of the underwriters and not the claimant.

SECTION A ➲ Protect Member's Statement

Member's Details

Protect number (if known)____

Union member Yes ◯ No ◯ Union name ______________________ Membership no.______________________

Title______ First name/s__________________________________ Last name__________________________________

Sex Male ◯ Female ◯ Date of birth _____/_____/_________

Home Telephone__________________________________ Mobile__________________________________

Email____

Street Address ____

Suburb__________________________________ State________________ Postcode________________

Postal Address (if different from above)____

Suburb__________________________________ State________________ Postcode________________

What is your preferred method of communication (telephone, postal or email)?______________________

Employment Details

Name of employer____

Employed since_____/_____/_________ Occupation/Job title__________________________________

Employment status Full time ◯ Part time ◯ Casual ◯ Contractor ◯

Bank Details

If your claim is approved, your claim benefits will be transferred directly to your bank account. Please provide your account details.

Bank name__________________________________ Bank branch__________________________________

Account name____

BSB__________________________ Account no.__________________________________

Details of Domestic Duties ➲ SECTION B

1. Title_______ First name/s___________________________________ Last name____
2. Sex Male ◯ Female ◯ Date of birth _______/_______/_________
3. Home Telephone_____________________________________ Mobile____
4. Email____
5. Is this person your legal spouse or de facto partner with whom you have lived together for 3 months or more? Yes ◯ No ◯
6. Was your spouse/partner employed prior to his/her incapacity? Yes ◯ No ◯
7. If "Yes", please advise the date employment was ceased and the reason

   Date ceased: _____ / _____ / _____ Reason: ____
8. On what date did the injury occur or were the symptoms of the condition first noticed? _____ / _____ / _______
9. On what date was medical treatment first sought? _____ / _____ / _______
10. Please describe the types of domestic duties your spouse / partner is unable to carry out as a result of their medical condition?

    ____

    ____
11. Does your spouse / partner normally provide these services on a full-time basis? Yes ◯ No ◯
12. Date from which your spouse has been or/ will be unable to provide the domestic duties listed above: _____ / _____ / _____

Optional Authority

The following authority is optional and should only be completed if you wish or require another person to act on your behalf in relation to this claim. Generally, such an authority should only be provided when the claimant is incapacitated, not an adult, or other difficulties prevent you from acting effectively on your own behalf with regard to this claim.

Complete if applicable. I hereby authorise the person named below to act on my behalf in relation to this claim and authorise ATC to discuss and share any relevant information.

Name of person acting on your behalf ____

Relationship to claimant ____

Telephone ____ Email ____

Street address ____

Suburb____ State________________ Postcode_________________

Signature (of claimant, if appropriate)____

Privacy Act

In this statement "we", "us" and "our" means Lloyd's and ATC Insurance Solutions (ATC) as its agent.

We are bound by the requirements of the *Privacy Act 1988* (Cth), the Privacy Amendment *(Private Sector) Act 2000* (Cth) and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. This sets out standards on the collection, use, disclosure and handling of personal information.

Our Privacy Policy is available at www.atcis.com.au or by calling us on the number below.

We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties (and/or collect additional personal information about you from them) who assist us in providing the above services and some of these are likely to be overseas recipients in the United Kingdom. These parties which include our related entities, distributors, agents, insurers, claims investigators, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Medicare Australia and Centrelink will only use the personal information for the purposes we provided it to them for (unless otherwise required by law).

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information and request correction if required. You may also opt out of receiving materials sent by us by contacting ATC on (03) 9258 1700 or write to us at the address given on page 1.

Authority by Spouse/Parnter of Member

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to ATC 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 Workers' Compensation claims, claims with any other insurer or any leave benefits and payments, to be released to ATC. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

Name (print) ____

Signature ______________________________ Date ____/____/________

Declaration by Member

I declare that:

a) the claim I am making for domestic duties assistance for my spouse/partner is not engaged in any paid employment andnormally completes full time domestic duties, and

b) my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.

Name (print) ____

Signature ______________________________ Date ____/____/________

ATC Insurance Solutions Pty Ltd Telephone 1800 994 694 (ATC Claims) Fax 03 9867 5540 Email info@atcis.com.au Web www.atcis.com.au

SECTION C ➲ Medical Practitioner's Statement

All questions in this Section C to be completed in full by the medical practitioner. Please provide as much detail as possible.
Important: The patient is responsible for any fee for this statement.

Patient's full name____

Sex Male ◯ Female ◯ Date of birth ____/____/________

1. Date of injury / Date of onset of the first symptoms of the patient's condition: ____/____/________

2. Date you were first consulted for this condition ____/____/________

3. What is your current diagnosis of the patient's condition?____

____

____

4. What was the proximate cause of the condition (eg describe the incident that resulted in an injury)? ____________________

____

____

5. Has or will the patient's condition prevent them from completing domestic duties, such as cooking, cleaning or child minding?

Yes ◯ No ◯

6. If Yes, please advise a minimum period for which the patient has been, or will be, prevented from completing domestic duties:-

From: ____/____/________ To: ____/____/________

I hereby certify that I have personally examined the above-named patient.

Name ______________________________ Qualification ______________________________

Telephone____________________ Fax____________________ Email______________________________

Street address ____

Suburb ______________________________

State____________________Postcode____________________

Signature ______________________________

Date ____/____/________

AFFIX STAMP HERE

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