



CLAIM FOR CONTINUING BENEFITS

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PRORISK CLAIM FOR CONTINUING BENEFITS

Name: _____
Number: _____

Important Information

Please ensure that all relevant sections of this claim form are fully completed. We are unable to consider assessment of your claim unless all information has been given. Failure to complete all information may result in a delay in the assessment of your claim.

Personal details

Title: _____ Surname: _____ Given Names: _____

Address: _____ State: _____ Postcode: _____

Home Phone: _____ Business Phone: _____ Mobile: _____

Email: _____

Disability details

Please answer the following questions and where required, tick the appropriate boxes.

If you answer 'YES' to any question, please give details in the space provided.

What is the current nature of your disability?: _____

What treatment are you currently receiving?: _____

What is the name and address of the medical practitioner you are currently attending for your disability?

Name: _____

Address: _____ State: _____ Postcode: _____

When did you last consult him/her?: / /

When do you expect to return to work? / / Full time basis / / Part time basis

Do you feel that your condition has: Improved Remained Unchanged Deteriorated

If 'deteriorate' please provide further details: _____

For the period: / / to / / have you:

(i) Engaged in any aspect of your occupation, or any other occupation? Yes No

If YES, give details: _____

(ii) Received remuneration of any kind from your employer/business, and/or returned to work on a full or part-time basis?

Yes No

If YES, please provide full details and evidence of earnings (i.e. copies of payslips/letter from employer)

Date Income Received	Days and Hours Worked	Gross Amount Received
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

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(iii) Received remuneration of any kind from Centrelink, Worker's Compensation, other Disability Benefits or income from any other source? Yes No

If YES, please provide full details

Date Received	Source	Gross Amount	Period Paid For
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

DECLARATION

I (the Insured), _____
hereby declare that the above information is true and correct and that I have not withheld any material information.

Signature: _____ Date: _____

PRORISK MEDICAL ATTENDANTS STATEMENT

Name:
Number:

Important Information

This claim form relates to _____ as

being totally/partially disabled for the period _____ to

The cost of this report will be met by your patient.

Please ensure that all relevant sections of this claim form are fully completed. We are unable to consider assessment of your patient's claim unless all information has been given. Failure to complete all information may result in a delay in the assessment of your patient's claim.:

Disability Details

Please answer the following questions and where required, tick the appropriate boxes.

If you answer 'YES' to any question, please give details in the space provided.

What is the exact nature of our client's disability?: _____

Please provide full details of current symptoms being experienced by our client: _____

What factors, if any (medical or otherwise), are contributing to our client's disablement?: _____

Please provide full details of current treatment, including all medication prescribed, including dosage and compliance: _____

Has this treatment regime changed since the last time these forms were completed?: Yes No

If 'YES', please provide full details: _____

Please indicate all dates on which you have examined our client for this disability within the above period: _____

Has our client been treated or referred to any other doctor/health provider within the above period?: Yes No

If 'YES', please provide full details:

Name	Address	Phone	Specialty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What reduction (if any) in the level of disability has our client achieved in this period?: _____

To the best of your knowledge, has our client sought, performed or is trying to obtain any work, on either a paid or unpaid basis (including voluntary work)?: Yes No

If 'YES', please provide full details: _____

In your professional opinion, is our client medically fit to resume work on either a full or part-time basis?: Yes No

PRORISK MEDICAL ATTENDANTS STATEMENT

If 'YES', please provide full details:

Full time basis: _____ Part Time basis: _____

If 'Part-time', please provide details of duties and number of hours per week that you consider would be currently appropriate:

If 'NO', when do you anticipate that our client will be fit to resume work?:

Full time basis: _____ Part Time basis: _____

Please provide further details if you are unable to provide an indication of our client's anticipated return to work.: _____

What future management (if any) has been planned to assist in our client's return to work?: _____

Would you be prepared to discuss our client's disability with one of our Claims Handlers?: Yes No

Name: _____

Qualifications: _____

Address: _____ State: _____ Postcode: _____

Phone: _____

Fax: _____

Signature: _____ Date: _____