TOTAL AND PERMANENT DISABILITY INSURANCE CLAIM GUIDE

2021

OnePath

WE'RE HERE TO HELP DURING A DIFFICULT TIME

We understand that making a claim can be daunting. That's why we want to help you understand the process.

The aim of this guide is to assist you when making a claim for Total and Permanent Disability. Keep in mind, this is a general guide, so some things may vary depending on individual circumstances and your policy.

GUIDE TO MAKING A TOTAL AND PERMANENT DISABILITY CLAIM AND UNDERSTANDING THE CLAIM PROCESS

STARTING THE INSURANCE CLAIM PROCESS

Your Claim Pack includes:

- Total and Permanent Disability Claim Application Form
- Preliminary Medical Attendant's Statement Form
- Preliminary Employer's Statement
- Preliminary Member's Statement
- Two Medical Attendant Certificates
- Privacy Statement, Declaration and Authority
- Withdrawal Form
- This Guide

To start the claim process, you'll need to complete the **Total and Permanent Disability Claim Form** and the **Privacy Statement, Declaration and Authority**.

You'll also need to provide Two Medical Attendant Certificates. These need to be completed by two different medical practitioners. You can return this with your Claim Form and Privacy Statement or as soon as possible after.

Please ensure these forms are fully completed, signed and dated.

Return these to us by mailing to:
OnePath Custodians Pty Limited
GPO Box 5306
SYDNEY NSW 2001

The **Withdrawal Form** isn't required as part of your claim application. However, you'll need to provide this if you wish to withdraw your superannuation once an insurance benefit is paid to your account. You'll also need to provide a **certified copy of an acceptable form of identification**, such as driver's licence or passport. We need to receive this within 90 days of the date of certification – the **Withdrawal Form** includes information about who can certify your documents.

See **Claim decision and payment** on page 7 for more information.

ADDITIONAL INFORMATION THAT MAY BE NEEDED

We'll let you know if we need the Preliminary Employer's Statement, Preliminary Member's Statement or Medical Attendant Certificates to be completed or further information is required. The Insurer may also contact your treating doctors directly.

A DEDICATED CASE MANAGER WILL HELP YOU THROUGH THE PROCESS

To ensure the claims process is as easy as possible, you'll be assigned a dedicated Case Manager to answer your questions, keep you updated and to support you through the process.

Once we receive your claim, a Case Manager will contact you. This person will then be your point of contact throughout the claim process and will also liaise with the Insurer in relation to the status of your claim.

Your Case Manager will oversee the claims process. They can:

- Explain the process to you and help guide you through what comes next
- Respond to any questions you may have.

They will also:

- Communicate the Insurer's and Trustee's decision with respect to your claim
- Arrange to process your payment as per your withdrawal request, if the insured benefit is approved by the Insurer and/or if the Trustee approves release of your benefits on Permanent Incapacity grounds.

WHAT IS A TOTAL AND PERMANENT DISABILITY INSURANCE CLAIM?

If you have Total and Permanent Disability insurance cover and suffer an illness or injury to an extent that you're no longer able to work or look after yourself, you may be entitled to make a Total and Permanent Disability claim.

As you hold your insurance cover within your superannuation, if your claim is approved, your benefit will be paid into your superannuation account where it is subject to superannuation preservation laws. The Trustee will then need to assess whether you're eligible to withdraw from your super by applying the SIS definition of Permanent Incapacity on whether you meet the condition of release. The Trustee may request additional medical information to determine eligibility for release of your benefits – see Claim decision and payment on page 7 for more information.

GENERAL TERMS OF COVER

Total and Permanent Disability insurance is designed to provide financial support if you suffer a lifelong disability due to an injury or illness that prevents you from working. Your capacity to work is assessed by the Insurer and is based on your ability to perform a suited occupation based on your education, training and experience. If you had not been working in any capacity before becoming injured or ill, different conditions of assessment may apply and is subject to the terms and conditions of the insurance policy.

Like any other insurance policy, Total and Permanent Disability insurance is subject to exclusions. For example, in some circumstances a benefit may not become payable if your claim arises directly or indirectly from a pre-existing condition.

Terms and conditions of the cover vary between insurers. For the specific terms and conditions, exclusions and limitations and eligibility criteria of your insurance cover, see the Insurance Guide or Group Life Policy on our website at **onepath.com.au**, your Welcome Pack and any subsequent correspondence relating to change in your insurance cover, contact us on **13 36 65** or speak to your Case Manager.

HOW DO I MAKE A CLAIM?

1 CONTACT US

Call us on **133 665** weekdays 8.30am to 6.30pm (AEST). We can help you with any questions you have, even if you're not sure if you can apply.

2 SEND CLAIM PACK

We'll send you a Claim Pack, which includes this Guide and the Claim Form and other required documents.

You can also download this Guide and Claim Forms from our website: **onepath.com.au/superandinvestment/claims**

3 COMPLETE AND RETURN CLAIM DOCUMENTS

You'll need to complete the Claim Form and return it to us, along with the other required documents. If you have any questions or need help call us on **133 665**.

Make sure your Claim Form is fully completed, signed and dated.

Return the Claim Form and other required documents to:

OnePath Custodians Pty Limited
GPO Box 5306
Sydney NSW 2001

WHAT HAPPENS NEXT?

4 ASSESS CLAIM

Once we receive your claim application, we'll acknowledge receipt of your claim within 5 business days.

Before sending the claim to the Insurer, the Trustee will complete an Assessment of Eligibility for Insurance cover within 5 business days of receiving it.

If we assess that you're not eligible to claim, we'll explain this in writing and give you the opportunity to provide more information.

If we assess that you're eligible to claim, we'll lodge a claim with the Insurer on your behalf.

While the Insurer is assessing your claim, the Trustee will concurrently and independently review your claim to track its progress. The Trustee will also verify that the Insurer has made a properly informed decision.

The time needed to assess your claim will depend on things including:

- The type and complexity of your claim
- The amount of information we need to review
- How quickly the information needed can be obtained.

Your Case Manager can give you an estimate of the time it will take based on the individual circumstances of your claim.

In some cases, the Trustee will also rely on the time frame provided by the Insurer on the progress of the claim.

We'll keep you updated about the progress of your claim – at least every 20 business days.

During the process we may need your help or authority to seek additional information. The Insurer may contact you directly for further information. You may also need to attend an independent medical examination or interview.

5 CLAIM DECISION AND PAYMENT

If your insurance claim is approved by the Insurer, your benefit will be paid into your superannuation account where it will be subject to superannuation preservation laws.

The Trustee will then make an assessment to determine whether you meet the Superannuation Industry Supervisions Regulations 1994 (SIS law) definition of Permanent Incapacity for release of your superannuation benefits.

The Trustee will make this assessment within 5–10 business days. If we need further information to do this, we'll let you know within 5 business days of completing the assessment.

Permanent Incapacity is defined in superannuation law as:

'…in relation to a member, means ill-health (whether physical or mental), where the trustee is reasonably satisfied that the member is unlikely, because of the ill-health, to engage in gainful employment for which the member is reasonably qualified by education, training or experience.'

Important: You may also want to consider these options:

- Retain your benefit within your superannuation account
- Roll all or part of your account balance, including your insurance benefit into a pension account or into another superannuation account
- Withdraw all or part of your account balance, including your insurance benefit.

As your insurance benefit forms part of your superannuation, you'll need to complete and provide the Withdrawal Form enclosed with your letter to withdraw from your superannuation account.

If you wish to do this, you can provide this with your claim application, or later once your benefit has been paid into your account and you have decided your strategy to manage your superannuation savings and insurance benefit.

Before making a decision, we encourage you to seek personal tax and/or financial advice that takes in account your personal circumstances. A financial or tax adviser can provide advice taking into account your personal circumstances, needs and financial objectives.

If your claim is declined by the Insurer, the Trustee will let you know within 5 business days of the Insurer's decision. They will let you know the reasons for the decline and an outline of the material relied on for this decision.

The Trustee will carry out a review within 15 business days of receiving the notification from the insurer.

You will have an opportunity to make further submissions or provide further information about your claim.

If the Trustee disagrees with the Insurer's decision to decline, it may first refer your claim back to the Insurer for reconsideration.

If you disagree with a decision to decline your claim, you may lodge an objection in writing with the Trustee.

The Trustee will review the objection and provide a final response within 90 days. In exceptional cases we may require more time to investigate and respond. We'll ensure you're kept informed during this period and provide an update every 20 days.

THE TRUSTEE AND INSURER RESPONSIBILITIES

Group	Responsibilities
The Trustee	**The Trustee is the customer advocate and has a duty of care to act in the best interests of members and beneficiaries.** • Is the Issuer of your super product and ultimately responsible for the way it operates. • Is the Policy Owner of the Insurance Policy. • Has specific duties to the fund's members, including a duty to act in the best interests of members and beneficiaries. • Works to minimise any delays in the claims process and to ensure a consistent and efficient process. • Completes an independent review of the Insurer's decision. • Manages any objections to claim proposals or decisions. ✓ **If the Insurer accepts the claim**, and the member wishes to withdraw their benefit or transfer or transfer to a pension account, the Trustee then determines whether the member has met a Condition of Release under superannuation law to be able to do this. ✓ **If the Insurer declines the claim:** The Trustee must independently review the Insurer's decision. If the claim has a reasonable prospect of success, the Trustee has a duty to do everything that is reasonable to pursue an insurance claim for your benefit. If the Trustee agrees with the Insurer's decision to decline the claim, they must write to you stating the reason/s why it agrees with the Insurer's decision.
The Insurer	• Must act in good faith in assessing the claim. • Reviews the claim for insured benefits and will contact claimants directly if it determines more information is required. • Decides if a Total and Permanent Disability insurance payment can be made based on the policy terms and conditions. • Depending on the Insurer you may also receive updates on the progress of the claim, regarding insured benefits.

FREQUENTLY ASKED QUESTIONS

Who can receive a Total and Permanent Disability benefit payment?

A Total and Permanent Disability benefit can only be paid to the insured member. It is initially paid into the member's superannuation account.

Do I need a solicitor to make a claim?

No, there's no need to engage a solicitor to make a claim. The Trustee of the super fund can assist you with your claim throughout the insurance claim process. Simply contact us if you need help.

However, you may choose to seek independent legal advice in relation to your claim. This means you must authorise your legal adviser/solicitor to contact the Trustee on your behalf if you would like us to correspond with your legal adviser/solicitor.

You are responsible for paying the fees for any legal advice. The Trustee doesn't fund this on your behalf.

What does 'certified' mean?

Apart from the forms we send you, each document provided as part of your claim must be certified to be a genuine copy of an original document. Only an authorised person can certify original documents, sighting the original and the copy to ensure both are identical.

On a single-page document, the authorised person must write or stamp:

'This is a certified true copy of the original as sighted by me.'

or, on a multi-page document:

'I certify this and the following [number of pages] pages to be a true copy of the original as sighted by me' on the first page and initial all other pages.

The authorised person must also date, sign and print their name and qualification (for example, Justice of the Peace) on the document.

Authorised persons include a Justice of the Peace, solicitor or medical practitioner or anyone who can certify under the Statutory Declaration Act 2018. Please retain the original documents as they may be needed for other purposes.

What does eligibility mean?

All claims must satisfy the Trustee's claim requirements and meet the terms and conditions of the insurance policy.

The Trustee will assess eligibility to lodge a claim for insured benefits within 5 Business Days of receiving your claim.

If you have a query about your claim while it is being assessed?

We will acknowledge your query by the next business day and provide a full response within 10 business days.

What happens if the Trustee disagrees with the Insurer's decision to decline the claim?

If our review results in us querying the Insurer's decision, we will tell the Insurer within 5 business days of completing our review. If we believe the claim has a reasonable prospect of success, we'll advocate on your behalf. We will keep you informed at least every 20 business days.

In exceptional cases, we will tell you that we need more time, and will clearly communicate our revised expected timeframes until a decision is reached.

If we obtain new information or assessments, or you make further representations and submissions or provide further information, we will have another 15 business days from the receipt of the new information to review that information.

Is there a time limit to claim a Total and Permanent Disability benefit?

There's generally no set time limit for claiming a Total and Permanent Disability benefit, providing that you are eligible to make a claim as at the date of event (injury or disability). However, we recommend lodgement of the claim as soon as practicable, particularly as some insurers will only consider a claim where, in their opinion, the delay in notification doesn't prejudice their ability to assess the claim. We encourage members to notify us of any potential claim as soon as it is reasonably possible, and within 30 days from the Date of Disablement.

What is the Trustee's role regarding insurance claims?

The Trustee will conduct a thorough review and investigation into the Insurer's decision on the member's behalf. No portion of the insurance benefit will be paid until the Trustee is satisfied that all issues are resolved.

How are benefit payments taxed?

The Trustee may be required by law to withhold tax from payments made. As the tax treatment of your superannuation, including your Total and Permanent Disability benefit, may differ depending on whether you retain it within your superannuation account, transfer to a pension account or withdraw it from superannuation, **we encourage you to seek personal tax and/or financial advice that takes into account your personal circumstances before making a decision.**

ADDITIONAL INFORMATION

The Trustee's responsibilities under the Financial Services Council Insurer Code (the Code)

We will oversee the progress of the claim to minimise delays and intervene if we become aware that the Insurer isn't complying with the timeframes provided in the Code.

If the Insurer tells us that it can't make a decision on your claim within the timeframes provided in the Code because information necessary to complete the assessment hasn't been provided, we'll let you know the revised timeframes. If your medical condition hasn't yet stabilised to allow a decision to be made, we'll tell you that your claim will be progressed further when more information is available.

Review of additional information or submissions

If we obtain or are provided with new information for assessments, or you make further representations and submissions or provide further information, we will have another 15 business days from when we receive this to review the information.

COMPLAINTS

You can lodge complaint if you disagree with:

- the Insurer's or Trustee's decision
- the decision on your insurance claim, or
- you are dissatisfied with the management of your claim.

We'll acknowledge your complaint within 24 hours or as soon as practicable. Our investigation may take up to 90 days, however we will aim to provide a written response within 30–45 days.

Next steps

If you have any questions or would like further information, please:


email us at **customer@onepath.com.au**


visit our website **onepath.com.au**


call Customer Services on **133 665**,
weekdays between 8.30am and 6.30pm (AEST).

Keep in mind, the Trustee is the customer advocate and has a duty of care to act in the best interests of members and beneficiaries.

If you wish to lodge a complaint, you can write to:

Address: **Trustee Benefit Review**
OnePath Custodians Pty Limited
GPO Box 5367
Sydney NSW 2001

Email: **TBRT@ioof.com.au**

Further help – the Australian Financial Complaints Authority (AFCA)

You have the option to lodge a complaint with AFCA directly rather than lodging a complaint with us. Otherwise, you can also lodge a complaint with AFCA if you're not satisfied with our response or if your complaint has not been resolved within the maximum timeframe prescribed by legislation. AFCA provide a fair and independent financial services complaint resolution that is free to consumers.

Website: **www.afca.org.au**
Email: **info@afca.org.au**
Phone: **1800 931 678** (free call)

In writing:
Australian Financial Complaints Authority
GPO Box 3
Melbourne VIC 3001

Time limits may apply to complain to AFCA and so you should act promptly or otherwise consult the AFCA website to find out if or when the time limit relevant to your circumstances expires.

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Customer Services

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email us at **customer@onepath.com.au**

visit our website **onepath.com.au**

call us on **133 665**,
weekdays 8:30am to 6:30pm (AEST)

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