

**12** Have you undertaken any Rehabilitation?

No ☐

Yes ☒

*Please provide details below*

Type of Rehabilitation

*Mabnet.*

Name and Address of Provider

*Not sure*

Postcode

**Declaration**

I declare the answers on this claim form are true and complete.

I have not made any false or misleading statement and I have included all information relevant to the assessment of my claim.

If any answers to the questions are not in my handwriting I certify that I have checked them and they are correct.

I hereby authorise MLC to make any enquiries and obtain any information they consider relevant from my past or present employers, the Department of Social Security, Commonwealth Employment Service or other employment services.

I hereby authorise MLC to provide my personal information (which may include sensitive or health information) to any physician, hospital or any other healthcare provider that has attended or examined me in order for them to supply MLC with full particulars of my medical history including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.

Information may be required from an insurer or government department that provides benefits in the event of sickness and/or injury. This may include private medical insurers, workers' compensation, third party, insurers, Centrelink, Department of Veteran Affairs and similar benefit providers. I authorise MLC to disclose and collect, and the third party to release to MLC any information related to my claim.

I hereby authorise MLC to provide my personal information (which may include sensitive or health information) to any claims assessor, investigator, medical professional, medical or healthcare facility operator, insurance reference service, credit reference service, legal or accounting firm, auditor, consultant or reinsurer for the purposes of producing a report concerning my claim. I consent to these third parties collecting information about me and releasing to MLC their report and any information they may hold about me.

I understand and agree that if I do not provide information requested by MLC or its representative that MLC may not be able to assess, investigate or pay my claim.

I authorise MLC to provide personal information (which may include sensitive information) regarding my claim to my Life Insurance Adviser or Financial Service Intermediary.

A photocopy of this authority is as valid as the original.

Name (please print)

*SIVA KUMAR REDDY*

Signature

*X S. Siva Kumar*

Date

*18/02/2015*

**Please attach copies of any reports and/or test results relating to your current medical condition you may have in your possession.**

**Return this form and any attachments to:**

Claims  
MLC Limited  
PO Box 200  
NORTH SYDNEY NSW 2059