



# Claim for terminal illness benefit

## CLAIMANT STATEMENT



### Instructions on completing this form:

- Please read carefully and complete all sections A through I.
- Please print clearly and use a black pen to assist document imaging.
- If there is insufficient space for answers, please attach additional information to this form.
- If the claimant is unable to complete this form, their guardian, attorney or other representative may do so. Please have the two attached medical statements completed, one by your usual medical practitioner and one by your treating specialist.
- Any charge for the completion of these forms is your responsibility.

**Return the completed documents to:** Colonial First State, Reply Paid 27, Sydney NSW

### Section A – Claimant’s details

Plan name  Account number

Surname  Given name(s)

Residential address

State  Postcode

Contact number  Email (if available)

Is a representative completing this form on the Claimant’s behalf?  
 No  Yes ► If ‘Yes’, please provide details of representation and attach a copy of the relevant legal document.

### Section B – Details of medical condition

1. What is the condition(s) being claimed?

2. Did this condition(s) result from (please tick one of the boxes):  
 Illness  Injury, or  not applicable

a. Provide details of the illness or how the injury occurred

3. Please provide the following details in relation to the condition(s)

Condition(s)	Date of first onset of symptoms	Date of initial consultation	Date of earliest diagnosis	Date first hospitalised
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

Condition(s)	Name and address of current treating specialist and/or General Practitioner

► Form continued next page

## Section B – Details of medical condition (continued)

Condition(s)	Name and address of hospital

## Section C – Medical practitioner's details

Please provide details of your usual medical practitioner.

1. Title  Given name(s)  Surname

Full address

State  Postcode

How long have you been attending this medical practitioner?

Years  Months

2. Name and address of medical practitioner you first consulted for this condition(s) (if same as Q1 above, write 'Same as above')

State  Postcode

3. Name and details of other medical practitioners or health providers you consulted for this condition(s)

Name	Address	Initial consultation
		/ /
		/ /
		/ /

## Section D – Employment details

1. Have you ceased all work?

No  Yes

▶ If 'No', please provide details of your current work below

Employer's name  Position  Hours per week

## Section E – Other insurance details

1. Have you claimed, or are you intending to claim, on another insurance policy as a result of your condition(s)?

No  Yes ▶ If 'Yes', please provide details below

Insurer	Type of cover	Amount	Date policy commence
		\$	/ /
		\$	/ /
		\$	/ /

## Section F – Additional information

Please note: If you answer 'Yes' to any of the following questions, please advise the number of pages attached.

1. I have attached the two completed Medical Attendant's statements.  No  Yes ▶ pages
2. I have attached all test results (MRI, CT scan, laboratory tests, etc.) and any relevant medical notes.  No  Yes ▶ pages
3. Where space provided for the questions was inadequate, I have attached a supplementary response.  No  Yes ▶ pages
4. I have attached additional information which may assist in the assessment of my claim.  No  Yes ▶ pages

## Section G – Consent for accessing health information

### Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We (AIA Australia) collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

Please read each Authority carefully and the explanatory notes below.

**Authority 1 explanatory notes** – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

**Authority 2 explanatory notes** – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- They will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

### **Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice**

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to

AIA Australia, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form AIA Australia asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- AIA Australia can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while AIA Australia is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature

Date

### **Authority 2 - to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances**

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to AIA Australia, or to third parties they engage, only if AIA Australia has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- AIA Australia can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while AIA Australia is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature

Date

## Section H – Privacy of your personal information

Our privacy policy contains information on how we collect, use and disclose your personal information (including disclosure to overseas recipients). Visit [aia.com.au/privacy](http://aia.com.au/privacy) for a copy.

## Section I – Declaration

I declare that the answers to all questions on this form are true and correct, including those not in my own handwriting and I have not withheld any information relevant to this claim.

I understand that if I make false or misleading statements or recklessly or intentionally fail to disclose information, AIA Australia may:

- Refuse to pay this claim.
- Recover benefits paid that were based on false or misleading information I provided.
- Be obliged to refer such cases to the relevant Authority.

I authorise and consent to AIA Australia and its authorised representatives seeking information from:

- other insurers,
- my past and present employers,
- my accountant or financial institution, and
- any relevant government bodies.

I authorise the release to AIA Australia or its authorised representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatments, and copies of all hospital or medical records, employment records and financial records relevant to my insurance cover or claim.

I have read and understood the “Privacy of your personal information” and I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section.

I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Name of claimant (please use block letters)

Claimant signature

Date



# Claim for terminal illness benefit

## MEDICAL ATTENDANT'S STATEMENT



### To be completed by treating medical practitioner

If there is a charge for the completion of this form or for associated copying of your records, it is the responsibility of your patient. Please note that AIA Australia reserves the right to release a copy of this statement and all attachments to the relevant Superannuation Fund Trustees (if any). With your authority and your patient's authority, AIA Australia may share this information with other Medical Practitioners and others involved in assessing this claim. Failure to provide complete information will delay the assessment of your patient's claim.

**Return the completed documents to:** Colonial First State, Reply Paid 27, Sydney NSW

### Section A – Patient's details

Patient's full name

Date of birth

 /  / 

Patient's residential address

  


State

Postcode

1. How long have you known your patient?

 Years

 Months

2. How long has your patient attended the practice?

 Years

 Months

3. Does the patient attend any other practice or practices?

No  Yes ▶ If 'Yes', please provide details including name of practice and address (if known)

Name of practice	Practice address

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /

5. Please provide the following details for each of the conditions listed in Q4 above.

**Please also provide copies of the results for all tests performed and any reports completed.**

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?

6. To the best of your knowledge and assuming reasonable medical treatment, what is your patient's expected survival period or prognosis as at today's date (please tick (✓) the appropriate box)

Less than 6 months  6 to 12 months  13 to 24 months  Greater than 24 months ▶ If greater than 24 months, please state estimated life expectancy.





# Claim for terminal illness benefit

## MEDICAL ATTENDANT'S STATEMENT

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**Return the completed documents to:** Colonial First State, Reply Paid 27, Sydney NSW

### Section A – Patient's details

Patient's full name	Date of birth
<input type="text"/>	<input type="text" value="/ /"/>

Patient's residential address	
<input type="text"/>	
State	Postcode
<input type="text"/>	<input type="text"/>

1. How long have you known your patient?

<input type="text" value="Years"/>	<input type="text" value="Months"/>
------------------------------------	-------------------------------------

2. How long has your patient attended the practice?

<input type="text" value="Years"/>	<input type="text" value="Months"/>
------------------------------------	-------------------------------------

3. Does the patient attend any other practice or practices?

No  Yes ► If 'Yes', please provide details including name of practice and address (if known)

Name of practice	Practice address

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /
	/ /	/ /	/ /		/ /

5. Please provide the following details for each of the conditions listed in Q4 above.

**Please also provide copies of the results for all tests performed and any reports completed.**

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?

6. To the best of your knowledge and assuming reasonable medical treatment, what is your patient's expected survival period or prognosis as at today's date (please tick (✓) the appropriate box)

Less than 6 months  6 to 12 months  13 to 24 months  Greater than 24 months ► If greater than 24 months, please state estimated life expectancy.

## Section A – Patient’s details (continued)

7. a. To the best of your knowledge and assuming reasonable medical treatment, what is the likelihood of recovery or remission (as a percentage)?

 %

b. Are there any other factors that influence or impact your patient’s life expectancy (e.g. response to treatment, secondary condition)?


8. a. When did you first diagnose your patient to be suffering from this condition?

Date

 / /

8. b. If applicable, on what date did you consider your patient to have a life expectancy of less than 24 months condition?

Date

 / /

9. Has the patient ever had the same or similar condition (If known)?

No  Yes ▶ If ‘Yes’, please provide details below

Diagnosis	Date of diagnosis	Treatment provided/ received	Name of health professional consulted
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you previously (or will you be) completing forms/reports regarding this patient for another party (e.g. another insurer)?

No  Yes ▶ If ‘Yes’, please provide details below


## Section B – Medical practitioner’s details

Title  Surname  Given name(s)

Business address   
 State  Postcode

Phone number  ( ) Fax number  Qualifications

Email

I certify that I have examined the patient and that all statements made in this document are correct in all aspects. I consent to AIA Australia providing copies of this document to any medical specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of the claim. I further consent to AIA Australia’s Chief Medical Officer contacting me to discuss this patient’s claim.

Signature

Date  / /



# Claim for terminal illness benefit

## MEDICAL ATTENDANT'S STATEMENT

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Return the fully completed form to: Group Super GPO Box 4758, SYDNEY NSW 2001

### Section A – Patient's details

Patient's full name

Date of birth

 /  / 

Patient's residential address

  

State

Postcode

1. How long have you known your patient?

 Years Months

2. How long has your patient attended the practice?

 Years Months

3. Does the patient attend any other practice or practices?

 No Yes

► If 'Yes', please provide details including name of practice and address (if known)

Name of practice	Practice address
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
<input type="text"/>	/ /	/ /	/ /	<input type="text"/>	/ /
<input type="text"/>	/ /	/ /	/ /	<input type="text"/>	/ /
<input type="text"/>	/ /	/ /	/ /	<input type="text"/>	/ /

5. Please provide the following details for each of the conditions listed in Q4 above.

**Please also provide copies of the results for all tests performed and any reports completed.**

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

6. To the best of your knowledge and assuming optimal treatment, what is your patient's expected survival period or prognosis as at today's date. (Please tick (✓) the appropriate box)

 Less than 6 months 6 to 24 months Greater than 24 months

## Section A – Patient’s details (continued)

7. a. To the best of your knowledge and assuming optimal treatment, what is the likelihood of recovery or remission (as a percentage)?

 %

b. Are there any other factors that influence or impact your patient’s life expectancy (e.g. response to treatment, secondary condition)?


8. When did you first diagnose your patient to be suffering from this condition? Date

 / /

9. Has the patient ever had the same or similar condition (If known)?

No  Yes ► If ‘Yes’, please provide details below

Diagnosis	Date of diagnosis	Treatment provided/ received	Name of health professional consulted
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you previously (or will you be) completing forms/reports regarding this patient for another party (e.g. another insurer)?

No  Yes ► If ‘Yes’, please provide details below


## Section B – Medical practitioner’s details

Title  Surname  Given name(s)

Qualifications, Specialty and Specialty subtype as registered with The Australian Health Practitioner Regulation Agency

Business address

 State  Postcode 

Phone number

 ( ) 

Fax number

Email

I certify that I have examined the patient and that all statements made in this document are correct in all aspects. I consent to AIA Australia providing copies of this document to any medical specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of the claim. I further consent to AIA Australia’s Chief Medical Officer contacting me to discuss this patient’s claim.

Signature

Date

 / /



# Claim for terminal illness benefit

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Return the fully completed form to: Group Super GPO Box 4758, SYDNEY NSW 2001

### Section A – Patient's details

Patient's full name  Date of birth  /  /

Patient's residential address   
 State  Postcode

1. How long have you known your patient?

Years  Months

2. How long has your patient attended the practice?

Years  Months

3. Does the patient attend any other practice or practices?

No  Yes ► If 'Yes', please provide details including name of practice and address (if known)

Name of practice	Practice address
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

4. Please list the diagnosed condition or conditions suffered by your patient and details for each condition listed

Diagnosed condition(s)	Date of first onset of symptoms	Date of earliest diagnosis	Date of your initial consultation	Place of consultation	Date first hospitalised
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

5. Please provide the following details for each of the conditions listed in Q4 above.

**Please also provide copies of the results for all tests performed and any reports completed.**

Name of medical practitioner making diagnosis	Qualifications	How was this diagnosis reached (e.g. investigations performed)?
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

6. To the best of your knowledge and assuming optimal treatment, what is your patient's expected survival period or prognosis as at today's date. (Please tick (✓) the appropriate box)

Less than 6 months  6 to 24 months  Greater than 24 months

## Section A – Patient’s details (continued)

7. a. To the best of your knowledge and assuming optimal treatment, what is the likelihood of recovery or remission (as a percentage)?

 %

b. Are there any other factors that influence or impact your patient’s life expectancy (e.g. response to treatment, secondary condition)?


8. When did you first diagnose your patient to be suffering from this condition? Date

 / /

9. Has the patient ever had the same or similar condition (If known)?

No  Yes ▶ If ‘Yes’, please provide details below

Diagnosis	Date of diagnosis	Treatment provided/ received	Name of health professional consulted
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

10. Have you previously (or will you be) completing forms/reports regarding this patient for another party (e.g. another insurer)?

No  Yes ▶ If ‘Yes’, please provide details below


## Section B – Medical practitioner’s details

Title  Surname  Given name(s)

Qualifications, Specialty and Specialty subtype as registered with The Australian Health Practitioner Regulation Agency

Business address

 State  Postcode 

Phone number

 ( ) 

Fax number

Email

I certify that I have examined the patient and that all statements made in this document are correct in all aspects. I consent to AIA Australia providing copies of this document to any medical specialist from whom AIA Australia seeks an independent report or to any other person deemed necessary to assist in the assessment of the claim. I further consent to AIA Australia’s Chief Medical Officer contacting me to discuss this patient’s claim.

Signature

Date

 / /



# Authority to release information

## Section A – Privacy of your personal information

Our privacy policy contains information on how we collect, use and disclose your personal information (including disclosure to overseas recipients). Visit [aia.com.au/privacy](http://aia.com.au/privacy) for a copy.

## Section B – Authorisation and consent

I, ,  
authorise and consent to AIA Australia and its authorised representatives seeking information from:

- my private health insurer or other insurers,
- my past and present employers,
- my accountant or financial institution and,
- any relevant government bodies.

I authorise the release to AIA Australia or its authorised representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatments, and copies of all hospital or medical records, employment records and financial records relevant to my insurance cover or claim.

I have read and understood the “Privacy of your personal information” and I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section.

I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Full name of Insured (please print)

Date of birth

Insured's current residential address

<input type="text"/>		
		State
		Postcode

Signature of Insured

Date

**Please return completed form to: AIA Australia Wholesale Life Claims PO Box 322 SILVERWATER NSW 2128**

Below is a comprehensive list of prescribed persons who are authorised to certify copies of identification documents for the purposes of Anti-Money Laundering and Counter-Terrorism Financing laws.

## List of persons authorised to certify true copies of original documents for customers in Australia.

- 1 A person who, under a law in force in a State or Territory, is currently licensed or registered to practise in one of the following occupations:
  - Chiropractor
  - Dentist
  - Legal practitioner
  - Medical practitioner
  - Nurse
  - Optometrist
  - Patent attorney
  - Pharmacist
  - Physiotherapist
  - Psychologist
  - Trademarks attorney
  - Veterinary surgeon
- 2 A person who is enrolled on the roll of the Supreme Court of a State or Territory, or the High Court of Australia, as a legal practitioner (however described)
- 3 An officer with, or authorised representative of, a holder of an Australian financial services licence (AFSL), having 2 or more years of continuous service with one or more licensees
- 4 An officer with, or a credit representative of, a holder of an Australian credit licence (ACL), having 2 or more years of continuous service with one or more licensees
- 5 Agent of the Australian Postal Corporation who is in charge of an office supplying postal services to the public
- 6 Australian Consular Officer, within the meaning of the Consular Fees Act 1955. This includes a person appointed to hold or act in any of the following offices of the Commonwealth (of Australia) in a country or place outside Australia:
  - Consul-General
  - Consul
  - Vice-Consul
  - Trade Representative
  - Consular Agent
- 7 Australian Diplomatic Officer, within the meaning of the Consular Fees Act 1955. This includes a person appointed to hold or act in any of the following offices of the Commonwealth (of Australia) in a country or place outside Australia:
  - Ambassador
  - High Commissioner
  - Minister
  - Head of a Mission
  - Commissioner
  - Charge d'Affaires
  - Counsellor, Secretary or Attache at an Embassy, High Commissioner's office, Legation or similar
- 8 Bailiff
- 9 Bank officer with 2 or more continuous years of service
- 10 Building society officer with 2 or more years of continuous service
- 11 Chief executive officer of a Commonwealth court
- 12 Clerk of a court
- 13 Commissioner for Affidavits
- 14 Commissioner for Declarations
- 15 Credit union officer with 2 or more years of continuous service
- 16 Employee of the Australian Trade and Investments Commission who is:
  - in a country or place outside Australia; and
  - authorised under paragraph 3 (d) of the Consular Fees Act 1955; and
  - exercising his or her function in that place

Continued over the page...

- 17 Employee of the Commonwealth who is:
  - in a country or place outside Australia; and
  - authorised under paragraph 3 (c) of the Consular Fees Act 1955; and
  - exercising his or her function in that place
- 18 Fellow of the National Tax Accountants' Association
- 19 Finance company officer with 2 or more years of continuous service
- 20 Holder of a statutory office not specified in another item on this list
- 21 Judge of a court
- 22 Justice of the Peace
- 23 Magistrate
- 24 Marriage celebrant registered under Subdivision C of Division 1 of Part IV of the Marriage Act 1961
- 25 Master of a court
- 26 Member of Chartered Secretaries Australia
- 27 Member of Engineers Australia, other than at the grade of student
- 28 Member of the Association of Taxation and Management Accountants
- 29 Member of the Australian Defence Force who is:
  - an officer; or
  - a non-commissioned officer within the meaning of the Defence Force Discipline Act 1982 with 2 or more years of continuous service; or
  - a warrant officer within the meaning of the Defence Force Discipline Act 1982
- 30 Member of the Institute of Chartered Accountants in Australia, the Australian Society of Certified Practising Accountants or the Institute of Public Accountants
- 31 Member of:
  - the Parliament of the Commonwealth; or
  - the Parliament of a State; or
  - a Territory legislature; or
  - a local government authority of a State or Territory.
- 32 Minister of religion registered under Subdivision A of Division 1 of Part IV of the Marriage Act 1961
- 33 Notary public
- 34 Permanent employee of the Australian Postal Corporation with 2 or more years of continuous service who is employed in an office supplying postal services to the public
- 35 Permanent employee of:
  - the Commonwealth or a Commonwealth authority; or
  - a State or Territory or a State or Territory authority; or
  - a local government authority;
 with 2 or more years of continuous service and the person is not already specified in another item on this list
- 36 Person before whom a statutory declaration may be made under the law of the State or Territory in which the declaration is made
- 37 Police officer
- 38 Registrar, or Deputy Registrar, of a court
- 39 Senior Executive Service employee of:
  - the Commonwealth or a Commonwealth authority; or
  - a State or Territory or a State or Territory authority
- 40 Sheriff
- 41 Sheriff's officer
- 42 Teacher employed on a full-time basis at a school or tertiary education institution
- 43 Member of the Australasian Institute of Mining and Metallurgy

**List of persons authorised to certify true copies of original documents for customers outside Australia.**

- 1 A legal practitioner who holds a current practicing certificate under a law in force in a State or Territory in Australia
- 2 Commonwealth Bank of Australia officers at offshore branches with 2 or more years continuous service with Commonwealth Bank of Australia
- 3 Officers of any other Australian bank or other Australian financial institution that holds either an AFSL or ACL (being either a bank, building society or credit union) or Australian finance company with offices outside Australia where the officer has 2 or more years' service with the relevant Australian financial institution or the relevant Australian finance company
- 4 A judge, magistrate, registrar or deputy registrar of an overseas court

- 5 An Australian consular or diplomatic officer who holds one of the following positions:
- Consul-General
  - Consul
  - Vice-Consul
  - Trade Representative
  - Consular Agent
  - Ambassador
  - High Commissioner
  - Minister
  - Head of a Mission
  - Commissioner
  - Charge d'Affaires
  - Counsellor, Secretary or Attache at an Embassy, High Commissioner's office, Legation or similar.
- 6 A member of the Institute of Chartered Accountants in Australia, the Australian Society of Certified Practising Accountants or the Institute of Public Accountants with 2 or more years of continuous membership.
- 7 A person authorised as a notary public in a foreign country
- 8 Employee of the Australian Trade and Investment Commission who is:
- in a country or place outside Australia; and
  - authorised under paragraph 3 (d) of the Consular Fees Act 1955; and
  - exercising his or her function in that place
- 9 Employee of the Commonwealth who is:
- in a country or place outside Australia; and
  - authorised under paragraph 3 (c) of the Consular Fees Act 1955; and
  - exercising his or her function in that place.