INSURANCE ADVISERNET
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CLAIM FORM
SMSF LIFE INSURANCE COVER

Privacy Act 1988 – Our obligations under the ACT

The Privacy Act 1988 ("the Act") sets out a number of principles that we must comply with in the collection, security, storage, use and disclosure of personal information. These principles are known as the National Privacy Principles. The following information is provided to you in accordance with these Principles.

The organisation collecting information about you is Hannover Life Re of Australasia Ltd ("HLRA"). If you ask us, we must provide you with access to the personal information we hold about you. We may be entitled to refuse access to some information as set out in the Act. Your right to access this information is set out in our Privacy Policy, which is available on request.

The information we collect will be used to access and process your claim. The information may also be used if you are applying for insurance cover from us. The information we collect may be disclosed to other organisations, including but not limited to, medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation, an organisation that is duly appointed to manage the administration of such insurance policy, or interpreters.

If you fail to provide us with all or part of the information we require, we will be unable to assess and process your claim.

To ensure your claim is processed promptly, please complete the details below.

If the policy owner nominated a third party beneficiary in accordance with the Insurance Contracts Act, the proceeds will be paid to the nominated beneficiary. If no nomination has been made, the proceeds will be paid to the Estate.

PART A POLICY DETAILS

Policy owner: Policy number:

PART B DECEASED'S DETAILS

Deceased's name:

Date of birth: Date of death: Cause of death:

PART C CLAIMANT'S DETAILS

I am the: ☐ Nominated beneficiary ☐ Relative ☐ Executor ☐ Other:

Title: First name: Surname:

Postal address:

Suburb: State: Postcode:

Home phone: Work phone: Mobile phone:

E-mail address:

PART D REQUIRED DOCUMENTATION

Please tick the boxes to confirm that you have submitted all the required documents to us:

- ☐ A CERTIFIED COPY of evidence of death *(eg, Death Certificate or Coroners Report)*
- ☐ A CERTIFIED COPY of evidence of the Deceased's age *(eg Birth Certificate or Driver's License)*
- ☐ A CERTIFIED COPY of proof of your identity *(eg Birth Certificate or Driver's License)*

What is a certified copy?

This is a signed photocopy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, accountant, solicitor, doctor, bank manager or police officer. It means you keep the original as we do not require it.

PART E AUTHORITY TO RELEASE INFORMATION

I, _____ as Executor / Administrator / Guardian of _____ hereby authorise any physician, clinic, hospital, institution or Insurance Company to supply upon request to HLRA, on a confidential basis all details of any medical test, treatment or history that it may reasonably request.

A photocopy of this declaration shall be as valid an authority as the original.

NOTE: This authority is to be completed by the Executor / Administrator / Guardian and a copy of the relevant legal documents must be provided, (eg Will, Letter of Administration, Power of Attorney).

Your signature: Date:

PART F DOCTOR'S DETAILS

Doctor's name: Telephone number:

Address:

Period of time attending this doctor? Months: Years:

PART G BENEFICIARY PAYMENT AUTHORITY

This section must be completed by the nominated beneficiary/ies. Once the claim has been accepted the benefit will be credited to the account below. If no nomination has been made proceeds will be paid to the estate in the form of a cheque.

Name of bank: Name of account holder:

BSB number: ☐☐☐ - ☐☐☐ Account number: ☐☐☐☐☐☐☐☐

PART H POLICY DISCHARGE AND DECLARATION

Please note this section of the form will only be used if HLRA accept liability for the claim

I hereby request payment of the benefit payable for the Life Insurance Policy in full satisfaction for all claims whatsoever under the Policy and do hereby discharge HLRA from all liability there under other than for payment of the benefit.

As the claimant I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim.

I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information HLRA requires to assess this claim, it will not be assessed and processed.

Claimant 's signature: Date:

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Please return completed form to IA Life via one of the following methods:

Scan and email (with your name and policy number as the subject line) to claims@ialife.com.au

Mail to PO Box 471, Seaforth NSW 2092