INSURANCE ADVISERNET
Quick. Smart. life

CLAIM FORM
TRAUMA BENEFIT

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.

The Trauma benefit option is applicable only to Superior Life Cover Policies. You must have taken out cover for this optional benefit to be eligible to claim. Please check your Policy Schedule if you are unsure.

PART A POLICY DETAILS

Policy number:

PART B POLICY OWNER DETAILS

Title: First name: Surname:

Date of birth: Weight (Kg): Height (cm):

Occupation:

Postal address:

Suburb: State: Postcode:

Home phone: Work phone: Mobile phone:

E-mail address:

PART C TRAUMA CLAIM

Medical details of the Policy Owner/Claimant

1. Has the injury or illness that occurred resulted in any of the following conditions? *(Please tick one)*

- ☐ Chronic kidney (renal) failure
- ☐ Chronic liver failure
- ☐ Chronic lung failure
- ☐ Coronary artery bypass surgery*
- ☐ Diplegia
- ☐ Heart attack*
- ☐ Major organ transplant
- ☐ Malignant cancer*
- ☐ Paraplegia
- ☐ Quadriplegia
- ☐ Stroke*

Trauma events marked with an asterisk (*) are not covered if any symptom of the event first became apparent either prior to or during the first 90 days following the Policy Commencement Date or the commencement of this benefit cover under the Policy.

2. On what date did the symptoms or injury first occur?

3. Have you previously had the same or similar condition or symptoms? ☐ Yes ☐ No
If YES, please provide full details:

4. The doctor you first consulted about the claimed condition is:

Doctor's name: Telephone number:

Address:

Date of first consultation? Date of last consultation?

5. Is the doctor named in (4) above the usual doctor you attend? ☐ Yes ☐ No
If NO, please provide details of your usual doctor:

Doctor's name: Telephone number:

Address:

PART D PAYMENT AUTHORITY

Once the claim has been accepted the benefit will be credited to the account below.

Name of bank: Name of account holder:

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

PART E 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 Trauma benefit 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 policy owner 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.

Policy Owner's signature: Date:

Please have your treating medical practitioner complete parts F & G on the following pages.

PART F CONFIDENTIAL MEDICAL REPORT - TRAUMA BENEFIT OPTION

This section is to be fully completed by the registered treating medical practitioner.

Please note that the information required is in relation to the policy owner/claimant.

To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this section are fully addressed and answered. Responses such as "refer to doctor", "see above", etc, are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.

If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

1. Claimant's details

First name: Surname:

Address:

Suburb: State: Postcode:

2. Medical details

a. Are you the Claimant's usual medical practitioner? ☐ Yes ☐ No

b. Which of the following conditions has been suffered by your patient? *(Please tick one)*

☐ Chronic kidney (renal) failure	☐ Chronic liver failure	☐ Chronic lung failure
☐ Coronary artery bypass surgery*	☐ Diplegia	☐ Heart attack*
☐ Major organ transplant	☐ Malignant cancer*	☐ Paraplegia
☐ Quadriplegia	☐ Stroke*	

c. What was the date of diagnosis?

d. Date of the first consultation in connection with the current condition?

e. Provide the dates and results of any X-rays, ECG, blood pressure or other tests performed:

Date	Test	Results

f. What treatment is currently being given, including surgery and medication, if any:

g. Please provide the names and addresses of any consulting specialist(s) or medical services the patient has been referred to:

Name	Speciality or medical service

PART F CONFIDENTIAL MEDICAL REPORT - TRAUMA BENEFIT OPTION (CONTINUED)

This section is to be fully completed by the registered treating medical practitioner.

h. If the patient has been hospitalised, provide the following details:

Admission date	Discharge date	Name of hospital

i. Have you ever treated the Claimant before for any condition? ☐ Yes ☐ No
If YES, please supply details:

Date consulted	Nature of the condition

j. Please provide details if the Claimant has a previous history of the current condition, or any impairment likely to be connected with the current condition:

PART G DOCTOR'S DECLARATION AND AGREEMENT

I hereby certify that I have personally attended the above named patient and that all the information supplied by me in this Report is true. I agree that HLRA may provide copies of this Report to any medical specialist from whom HLRA seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom the Insurer is obligated under the Privacy Act 1988 to give access to this Report.

First name: Surname: Qualifications:

Address:

Suburb: State: Postcode:

Telephone number: Facsimile:

Your signature: Date:

INSURANCE ADVISERNET Quick. Smart. life

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