

ONGOING ACCIDENT AND SICKNESS CLAIM FORM

Please complete this claim form and return to:

The Claims Department
St Andrew's Australia
PO Box 7395
Cloisters Square 6850

If you have any queries regarding your claim you can contact St Andrew's on
Ph: 1300 653 751 or fax 1300 552 695 or email: claims@standrews.com.au.

IMPORTANT INFORMATION

1. The issue of this claim form is not an admission of liability
2. It is a condition of your policy that you provide a fully completed claim form as quickly as possible (within 120 days of the claim commencement date). A delay in submitting this form may prejudice your entitlement to a claim.
3. Please ensure that all questions are fully answered to avoid any delay in the handling of your claim.
4. If you do not complete all relevant sections of your claim form we may have to return it to you to be fully completed and your claim may be delayed.
5. It may be necessary during the period of your claim for a company representative to call you.
6. It is important that you notify us of any change in circumstances during your at the earliest opportunity.
7. If there is not enough room within the form to provide your responses please attach any documentation/word document that will aid us in assessing your claim.

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Insured to complete

Details of Insured

1. Claim Number: _____

2. Date of Birth (dd/mm/yy):

3. Surname:

4. First Names:

5. Residential Address:

6. Suburb/Town:

7. Phone: Home: Mobile:

8. Email:

Medical Details

9. Have your symptoms changes since your last claim form was completed? Yes No
If yes, please provide details below.

10. How do your current symptoms impact your ability to perform your occupational duties?

11. Since your last claim form, have you consulted any medical practitioner and/or allied health professional? Yes No
If yes, please provide details.

12. Is your current treatment providing relief of your symptoms? Yes No
If no, has a change in your treatment been discussed with your Doctor, please provide details/outcome of any discussion:

13. Have you returned to any paid or unpaid work? Yes No

If yes, when: Part-time (dd/mm/yy) Full Time (dd/mm/yy)

Please detail the duties performed and hours worked per week
(e.g. computer work)

% of time performing duties eg 55%

14. Other Information

Are you making any other insurance claims in respect of this period of disability? Yes No
If yes, please provide the name of the insurer and contact details

Authority

I authorise any doctor, hospital, dentist, allied health professional insurer, other person whom I have consulted or has attended to me and other insurance companies to release to: - St Andrews; and/or
- Its Authorised representative; and/or
all information with respect to any illness, accident or injury, medical consultation, prescriptions or treatment and copies of all hospital records or medical records, reports or notes.

I agree that a photocopy or a scanned, electronic copy of this authorisation shall be as effective and valid as the original.

Signature of Insured X Date (dd/mm/yy) / /

Name of Insured

Privacy Policy Statement

We collect your personal information so that we can process your claim, identify you for inquiries, concerns and complaints you may have, deal with any requests you may make, tell you about products and services offered by us or our affiliate companies and conduct customer satisfaction surveys to improve our products and services. With respect to your claim, we may need to collect sensitive information related to your health. Without your information we will not be able to process your claim.

If you provide us with personal information about someone else, you should ensure that you are authorised to do so and agree to inform that person of the contents of the notice.

We exchange your personal information with organisations in the normal operations of our business, for example, with our related companies and agents, coinsurers, reinsurers and with service providers (such as professional advisors, IT support and mailing houses).

In relation to your claim, your information may also be exchanged with other parties including ex-employers, government agencies, financiers, your insurers, underwriters, claims investigators, other insurance companies, lawyers, recovery agents, hospitals, doctors, medical specialists or other health professionals and any party nominated by you. We may also disclose your personal information overseas to countries in certain circumstances that are likely to include India and USA.

By providing this information you consent to us:

1. collecting, using and disclosing information about you in the manner described above; and
2. (unless you opt out) using your personal information to identify and provide you with information about products and services you may be interested in.

Our Privacy Policy, a copy of which can be found at www.standrews.com.au, sets out how you can access and correct information we hold about you, how you can complain about a breach by us of your privacy rights and how your complaint will be handled. It also contains a more comprehensive list of countries to which your information may be disclosed and will be updated regularly.

You may contact our Privacy Officer in relation to your personal information (or to opt out of marketing) on 1300 363 159 or standrews@standrews.com.au

Declaration

I declare that the information contained in this statement is true, complete and correct in every detail. I understand that if I do not give full particulars or if I provide incorrect information my rights to obtain benefits under the policy may be prejudiced.

Signature of Insured X Date (dd/mm/yy) / /

Name of Insured

Left blank intentionally.

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Medical Practitioner to complete

- All questions must be completed by a medical practitioner.
- Any costs associated with the completion of this form are to be met by the patient.
- Please complete and return to the patient.
- A copy of this statement and any other report you provide may be passed to other parties reasonably deemed necessary for the assessment of the patient's claim.

Patient's Name:

Date of birth (dd/mm/yy):

 / /

Date you last examined the patient
(dd/mm/yy):

 / /

- 1.** What is the current diagnosis and has it changed in any way since the last claim form was completed?

- 2.** What are the current subjective symptoms reported by your patient and severity of each symptom (e.g. mild, moderate or severe)?

- 3.** On examination what are the patient's current objective symptoms?

- 4.** What treatment (medication, doses and other therapies) is currently being provided?

- 5.** Are you coordinating the treatment/management plan? Yes No
If **no**, please provide details of the treatment coordinator.

- 6.** Has the patient undergone any test or investigations since the last claim form? Yes No
If **yes**, please provide copies of all test results.

7. Is the current treatment providing any relief of symptoms? Yes No
If **no**, what future treatment/management plans are there for your patient?

8. Has the expected duration of disability exceeded the initial prognosis? Yes No
If **yes**, please provide the reasons for this extension of the duration of disability.

9. a) Is your patient still unfit for work: if yes date from to

b) If totally disabled please list the occupational duties that the patient is unable to perform.

10. Is the patient currently able to perform their usual occupational duties? Yes No
If **yes**, on what date was the patient able to perform their usual occupational duties?

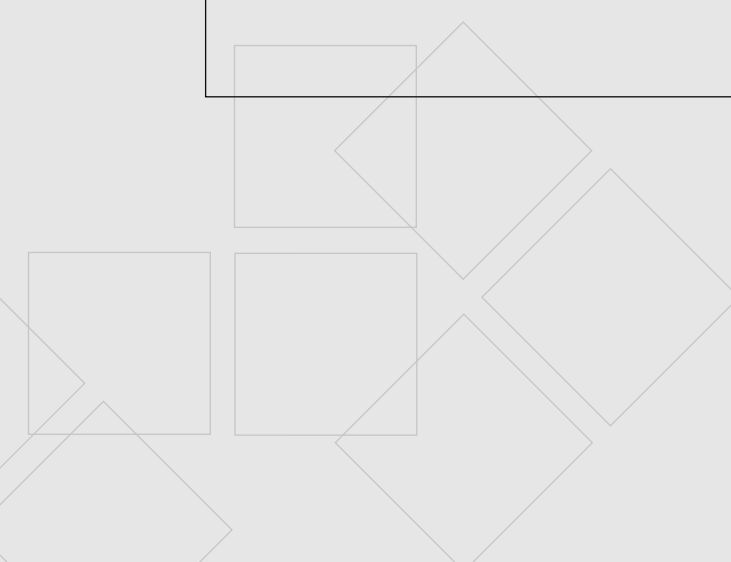
Part-time (dd/mm/yy) Full Time (dd/mm/yy)

Hours able to work per week

If only **Part Time**, please list the specific usual occupational duties the patient is currently able to perform.

Duties	Hours per week

Total hours per week



11. Have you, or are you, completing forms or reports for any other organisation (e.g. insurance company, Workers' Compensation Insurer, Motor Accident compensation, Centrelink or any other litigation claim) or the employer in respect of the patient? Yes No
If **yes**, please provide details.

Additional Details/Comments

Declaration

I hereby certify I have personally attended the above patient and that all the information supplied by me on this patient is true and correct to the best of my knowledge and belief.

Signature of Doctor	X	Date (dd/mm/yy)	/ /
Doctor Name			
Qualifications			
Surgery Address			
Suburb/Town		State:	
		Postcode:	
Phone		Fax:	
Email Address			

St Andrew's means St Andrew's Insurance (Australia) Pty Ltd ABN 89 075 044 656 AFSL 239649 or St Andrew's Life Insurance Pty Ltd ABN 98 105 176 243 AFSL 281731, as applicable to your policy.



Left blank intentionally.