

TERMINAL ILLNESS 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 claim 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.

TERMINAL ILLNESS CLAIM FORM

Insured to complete

Details of Insured

1. Claim Number
2. Date of Birth (dd/mm/yy): / /
3. Surname:
4. First Names:
5. Residential Address:
Suburb/Town:
6. Phone: Home: Mobile:
7. Email:

Personal History

8. What is the medical diagnosis:
9. When did you first become aware of this condition: / /
10. Date of Diagnosis
11. When did you first seek medical treatment for this condition? / /
12. Name and Address of Treating General Practitioner
13. Name and Address of Specialists consulted
14. Have you made a claim for this condition from any other insurance company? Yes No
If yes, please provide details – name of insurance company, date of claim, benefit amount

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;

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 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, 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 Date (dd/mm/yy)

Name of Insured

Checklist – Please ensure all the relevant sections are attached.
Treating Doctor's Section completed and attached

TERMINAL ILLNESS CLAIM FORM

DOCTOR'S SECTION – insured to pass to Doctor and return

- 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): / /

Residential Address:

Suburb/Town: State: Postcode:

1. How long have you been treating this patient?

2. Primary Diagnosis:

3. Date of Diagnosis

4. Secondary Diagnosis if (if applicable)

5. Date your patient ceased work due to the diagnosis? / /

6. Please state the objective findings which support your diagnosis

7. Is the patient terminally ill?, this meaning less than 12 months to live?

8. Please list and describe the current symptoms and severity

9. Has the patient been reviewed/assessed by the appropriate specialist? If yes, please provide details of the outcome, details of specialist.

Additional Details/Comments

Declaration

I 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				