# Children's Insurance (Optional Benefit) Claim Form

- To help ensure you receive a prompt assessment, please complete all the required sections of this booklet.
- If you need assistance please call **1300 306 775**. Please note however, that a claim cannot be assessed until all original documents are received.
- Please note that the information required to be completed in this document is in relation to the Child Insured, unless otherwise stated.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the relevant items in this document 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.

## Filling in this form:

- Use a black or blue pen.
- Mark boxes like this ☐ with ✓ or ✗
- Where you see a box like this ☐▶ follow the instructions after the right arrow.

There are two parts to the claim form.

**For Serious Injury or Illness:**

- **Part A** is to be completed by the Policyowner/Claimant.
- **Part B** is to be completed by the registered Medical Practitioner treating the Child Insured.

**For Death :**

- **Part A** is to be completed by the Policyowner/Claimant.

**Distributed by**
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trading as Australian Seniors Insurance Agency
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**Please return this form to Australian Seniors, Reply Paid 6728, Baulkham Hills, NSW 2153**

# PART A: Children's Insurance Serious Injury or Illness Claim Form

## Privacy Collection Notice

Greenstone Financial Services Pty Ltd ("GFS", "we", "us" or "our") collects and handles personal information about you on behalf of Hannover Life Re of Australasia Ltd ("HLRA") in compliance with the Privacy Act 1988 (Cth). All information collected throughout the claims process by GFS or HLRA will be shared with both companies.

### Collection and use

We collect personal information such as identification information and policy details and sensitive information such as health details. Generally, we collect this information so that we can provide our products and services to you and manage, administer, develop and improve our business, including to assess and process your application for insurance, and assess any claims made by you or on your behalf. We generally collect this information directly from you but may collect it from a third party such as our related bodies corporate, authorised administrators, professional advisers or from publicly available information. If you do not provide us with all or part of the personal information we require, we may be unable to provide such services to you.

### Disclosure

The information you provide us will be collected by us and may be disclosed to third parties that help us deliver and improve our products and services (including other insurance/reinsurance companies, legal practitioners, Medical Practitioners, health service providers, hospitals, legal tribunals and courts, dispute resolution bodies, investigators/investigation organisations, third parties authorised by you, any current or former employer, our parent company and other related bodies corporate, professional advisers such as accountants or lawyers or other consultants, service providers that assist us in carrying out our business activities, trustees of superannuation funds, administrators of superannuation funds, an organisation appointed by the trustees of a superannuation fund to receive or give information, interpreters and regulatory bodies, government agencies, law enforcement agencies or, as required, other persons authorised or permitted by law) or as required by law.

### Overseas disclosure

We or HLRA may disclose your personal information to parties located in other countries, including to our related bodies corporate. The countries in which these recipients may be located will vary from time to time, but may include Germany, Canada, Japan, New Zealand, Hong Kong, United Kingdom, United States of America, India, China, Korea, Malaysia, South Africa, Bermuda, Ireland, Sweden and France.

### Access correction and complaints

You can read more about how we collect, use and disclose your personal information in our Privacy Policy, including how to complain about a breach of the Privacy Principles, which is available on our website or you can request a copy by contacting us.

HLRA's Privacy Policy is also available at hannover-re.com/1094181/australia_lh_privacy (or, by contacting HLRA using the details set out in this form or emailing privacyofficer@hlra.com.au). It outlines HLRA's personal information handling practices, including details on how you can seek access or correction of the personal information that HLRA hold about you, how to complain if you believe HLRA has breached the Australian privacy laws and HLRA's complaint handling processes.

If you wish to gain access to your information (including correcting or updating it), have a complaint about a breach of your privacy or have any other query relating to privacy, please call **1800 004 005** Monday to Friday, 8am – 8pm AEST.

## Section A – Policyowner's Details

Title | First name | Surname

Policy number

Residential address

Postal address

Phone (home) | (work) | (mobile)

Email

## Section B – Child Insured's details

First name | Surname

Date of birth (DD / MM / YYYY) | Weight | Height

## Section C – Type of Claim

This is a claim for:

Death ☐ ▶ **Complete Sections D, F, G, H, I**

Serious Injury or Illness ☐ ▶ **Complete Sections E, F, G, H, I**

## Section D – Death Insurance Claim

### 1. Child Insured's details

Name of Child Insured | Date of death (DD / MM / YYYY)

Cause of death

### 2. Claimant's details

I am the: ☐ Nominated Beneficiary ☐ Policyowner ☐ Relative ☐ Executor ☐ Other

Title | First name | Surname

Residential Address

Postal Address

Phone (home) | (work) | (mobile)

Email

Relationship to Child Insured

SIGN HERE ✗

Policyowner/Claimant's signature | Date (DD / MM / YYYY)

### 3. Authority to release information

I, (Print name in full), as Executor / Administrator / Guardian of (Print name in full) 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, (e.g. Will, Letter of Administration, Power of Attorney).**

SIGN HERE ✗

Executor/Administrator/Guardian's signature | Date (DD / MM / YYYY)

## Section E – Accidental Serious Injury or Illness Claim details

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

☐ Benign Tumour of the Brain or of the Spinal Cord ☐ Blindness ☐ Cancer ☐ Chronic Kidney Failure ☐ Deafness
☐ Diagnosis of a Terminal Illness ☐ Encephalitis ☐ Major Head Trauma ☐ Major Organ Transplant
☐ Meningitis (and/or Meningococcal Disease) ☐ Paralysis ☐ Severe Burns ☐ Total and Permanent Loss of Use of One Limb

2. On what date did the symptoms or injury first occur? DD / MM / YYYY

3. The date a diagnosis was made of the Child Insured's condition? DD / MM / YYYY

4. Has the Child Insured previously had the same or similar condition or symptoms? No ☐ Yes ☐ ▶ Please provide full details:

5. The doctor the Child Insured first consulted about the claimed condition:

Name

Address

Phone number

Date of first consultation DD / MM / YYYY Date of last consultation DD / MM / YYYY

6. Is the doctor named in Question 5. the usual doctor the Child Insured attends? Yes ☐ No ☐ ▶ Please provide details of your usual doctor:

Doctor's name

Address

Phone number

**7. Disclosure of information – doctor's authority**

For the purpose of assessing Name of child (my child's) claim, I authorise our current Medical Practitioner, and any other Medical Practitioner or health professional we have consulted or may consult in the future, or that Hannover Life Re of Australasia Ltd ("HLRA") appoints to examine my child, to disclose information about his/her health and related matters to HLRA.

A photocopy of this authorisation will be valid as the original.

SIGN HERE ✗ Policyowner/Claimant's signature DD / MM / YYYY Date

## Section F – Policy Discharge

**(Please note this section of the form will only be used if the Insurer accepts liability for the claim)**

☐ I/We hereby request payment of the benefit payable for the Insurance Policy (full details on page 2 of this document), in full satisfaction for all claims whatsoever under the Policy for the Child Insured

Child Insured's name

and do hereby discharge the Insurer from all liability there under other than for payment of the benefit.

**Please ensure that all questions have been answered before you proceed further If you fail to do so we will be unable to assess and process your claim.**

## Section G – Declaration

As the Policyowner/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, and that if I fail to provide all or part of the information **Hannover Life Re of Australasia Ltd ("HLRA")** requires to assess this claim, it will not be assessed and processed.

SIGN HERE ✗ _____ DD / MM / YYYY

Policyowner/Claimant's signature Date

## Section H – Checklist

**Certified copies of the relevant documentation related to this claim are attached as follows:**

**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.

### Children's Insurance

☐ The original Policy Document and Policy Schedule
If these documents have been misplaced, please complete the Statutory Declaration

☐ ▶ **Go to Section J – Statutory Declaration on Page 6**

☐ A certified copy of proof of the Child Insured's identity (e.g. Birth Certificate, Passport, or Driver's Licence).

☐ A certified copy of proof of the Claimant's identity (e.g. Birth Certificate, Passport, or Driver's Licence).

☐ (If applicable) A completed and signed Medicare Authority form authorising the release of your Medical and Pharmaceutical Benefits Scheme claim information

☐ (If applicable) A certified copy of proof of the Child Insured's death (e.g. Death Certificate) and certified copies of any Police and/or Coroner's Report.

## Section I – Direct Credit Authority

**Completing the details below will assist us in getting your claim payment to you as quickly as possible.**

- Once your claim has been assessed, the Benefit Amount payable will be credited to the account below.

BSB number (branch number) ☐☐☐ – ☐☐☐ Account number ☐☐☐ ☐☐☐ ☐☐☐

Account name _____

Name of bank/ financial institution _____

Branch name/ location of financial institution _____

NB. If your account is held with a Credit Union, it may take longer for the Benefit Amount payable to be cleared. May we suggest you contact your nominated Credit Union.

SIGN HERE ✗ _____ DD / MM / YYYY

Policyowner/Claimant's signature Date

- If you don't have an Australian bank account, we will make any claim payment by cheque.

## Section J – Statutory Declaration

I, (insert name, address and occupation) Name

Address

Occupation

do solemnly and sincerely declare that I am the legal owner/beneficial owner of Policy number Policy number

("Policy") on the life/lives of Child Insured's name
issued by Hannover Life Re of Australasia Ltd ("HLRA").

I have satisfied myself by exhaustive enquiry that for the above Policy, none of the members of my family or my solicitor has any knowledge of the Policy documents' whereabouts nor have they been disposed of by me or to the best of my knowledge by any other person, nor are the Policy documents held by my bank or any other person for safekeeping or lodgement.

The Policy documents have been lost in the following circumstances:

I have not assigned, mortgaged or otherwise dealt with the above Policy in any way and there is no lien on it.

I undertake to return the previous Policy documents to HLRA should they be found.

I make this solemn declaration by virtue of the Statutory Declarations Act 1959 as amended and subject to the penalties provided by the Act for the making of false statements in statutory declarations, conscientiously believing that the statements contained in this declaration are true in every particular.

SIGN HERE ✗

Policyowner/Claimant's signature — Date: DD / MM / YYYY

Declared at — Date: DD / MM / YYYY

SIGN HERE ✗

Before me (authorised signatory's signature) — Date: DD / MM / YYYY

Full name

Occupation/title

**NOTE 1** – A person who willfully makes a false statement in a statutory declaration under the Statutory Declarations Act 1959 as amended is guilty of an offence against the Act, the punishment for which is a fine not exceeding $200 or imprisonment for a term not exceeding six months or both if the offence is prosecuted summarily, or imprisonment for a term not exceeding four years if the offence is prosecuted upon indictment.

**NOTE 2** – A statutory declaration under the Statutory Declarations Act 1959 as amended may be made only before a Chief Police, Resident or Special Magistrate; Stipendiary Magistrate or any Magistrate in respect of whose office an annual salary is payable; a Justice of the Peace; a person authorised under any law in force in Australia or its Territories to take affidavits; a person appointed under the Statutory Declarations Act 1959 as amended or under a State Act to be a Commissioner for Declarations; a person appointed as a Commissioner for Declarations under the Statutory Declarations Act 1959, or under that Act as amended, and holding office immediately before the commencement of the Statutory Declarations Act 1959; a Notary Public; a person before whom a statutory declaration may be made under the law of the State in which a declaration is made; or a person appointed to hold, or act in, the office in a country or place outside Australia of Australian Consul-General, Consul, Vice-Consul, Trade Commissioner, Consular Agent, Ambassador, High Commissioner, Minister, Head of Mission, Commissioner, Charge D'Affaires, or Counsel, or Secretary or Attache at an Embassy, High Commissioner's office, Legation or other post.

# PART B: Children's Insurance Serious Injury or Illness Claim Form – Confidential Medical Report

**This document is to be fully completed by the registered Medical Practitioner treating the Child Insured.**

- Please note that the information required to be completed in this document is in relation to the Child Insured.
- Please note that it is the Policyowner's responsibility for the payment of all fees associated in the completion of this form.
- In order 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 document are fully addressed and answered. 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.

## Section A – Child Insured's Details

First name _____ Surname _____

Date of birth DD / MM / YYYY

Residential address _____

## Section B – Child Insured's Medical Details

1. Are you the Child Insured's usual medical attendant? Yes ☐ No ☐
2. What is the exact diagnosis of the condition? (Please attach copies of all pathology, test results, etc that confirm the diagnosis).

3. What is the date of diagnosis? DD / MM / YYYY
4. Date of the first consultation in connection with the current condition: DD / MM / YYYY
5. Provide the dates and results of any X-rays, ECG, blood pressure or other tests performed.

| Date | Test | Results |
|---|---|---|
| DD / MM / YYYY | | |
| DD / MM / YYYY | | |
| DD / MM / YYYY | | |
| DD / MM / YYYY | | |

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

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

| Name | Address | Specialty or medical service |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

8. If the Child Insured has been hospitalised, provide the following dates:

| Admission date | Discharge date | Name of hospital |
|---|---|---|
| DD / MM / YYYY | DD / MM / YYYY | |
| DD / MM / YYYY | DD / MM / YYYY | |
| DD / MM / YYYY | DD / MM / YYYY | |
| DD / MM / YYYY | DD / MM / YYYY | |

9. Have you ever treated the Child Insured before for any condition? No ☐ Yes ☐ ▶ Please supply details

| Date consulted | Nature of the condition |
|---|---|
| DD / MM / YYYY | |
| DD / MM / YYYY | |
| DD / MM / YYYY | |
| DD / MM / YYYY | |

10. Please provide details if the Child Insured has a previous history of the current condition, or any impairment likely to be connected with the current condition.

## Section C – Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended to the above named Child Insured and that all the information supplied by me in this Report is true. I agree that Hannover Life Re of Australasia Ltd ("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 HLRA is obligated under the Privacy Act 1988 to give access to this Report.

Name

Qualifications

Address

Telephone

Facsimile

Email

SIGN HERE ▶ ✗

Medical Practitioner's signature

DD / MM / YYYY

Date