CLAIM FORM

Trauma benefit

Privacy Statement

Let's Insure collects personal information so that we can process and administer this claim on behalf of the insurer St Andrew's Life Insurance Pty Ltd (St Andrew's). Without your information we will not be able to process and administer this claim. The completed claim information will then be sent to St Andrew's to assess the claim. If they require any further information, they will contact you directly or through us. If you have any queries in relation to your claim, please contact Let's Insure in the first instance.

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 this notice.

We exchange your personal information with organisations in the normal operation 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, insurers, underwriters, claims investigators, other insurance companies, lawyers, recovery agents, hospitals, doctors, medical specialists or other health professionals. We do not send your personal information offshore.

By providing this information you consent to us collecting, using and disclosing information about you in the manner described above. You also specifically consent to St Andrew's being provided with medical information, including copies of any medical reports, clinical reports or others, from any Doctor who at any time has attended to you or the insured.

The following Privacy Policies contain information about how you can have access to your personal information and seek the correction of your personal information, and how you can complain about a breach of the privacy laws that bind us and how your complaint will be handled.

The St Andrew's Privacy Policy (also applicable to St Andrew's Australia Services Pty Ltd) is available at **www.standrews.com.au**. If you have any query in relation to your privacy please contact St Andrew's on 1300 363 159, **standrews@standrews.com.au** or PO Box 7395, Cloisters Square WA 6850.

The Let's Insure Privacy Policy is available at **www.letsinsure.com.au**. If you have any query in relation to your privacy please contact Let's Insure:

Phone: 1300 355 355 (Mon - Fri, 9am - 5pm AEST)
Email: customerservice@letsinsure.com.au
Mail: Customer Service; Let's Insure PO Box 1192, Chatswood NSW 2057

Completion instructions

Step 1: As the Policy Owner, you should first check your most recent policy schedule to make sure that the trauma cover is in place and current for the affected Life Insured. Then complete **Section 1: Parts A to D**. Note that once the claim is approved, the claim payment will be made to you.

Step 2: The Life Insured who is suffering the trauma must complete **Section 2: Parts E to I**. If you are both the Policy Owner and Life Insured, then you must complete **all Parts A to I**. Our assessment is based on the details provided here and the details provided by the Life Insured's Medical Specialist.

Step 3: Once Sections 1 and 2 have been **fully completed**, please forward this form to the Medical Specialist who is predominantly attending to the Life Insured, to complete **Section 3: Parts J and K**. Once your Medical Practitioner has completed **Section 3: Parts J and K** please send the whole completed form back to Let's Insure.

Section 1: Policy Owner's details

Only to be completed if the Policy Owner is not the Life Insured. If the Policy Owner and the Life Insured are the same please go to Section 2.

Part A: Policy Owner's details

Policy Owner:		Policy number:	
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

Please indicate your preferred method of communication with an asterisk (*)

Part B: Policy Owner's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	
Policy Owner's signature:	Date: / /

Part C: Policy Owner's 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 D: Policy Owner's declaration

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 St Andrew's requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner's signature:	Date: / /

Section 2: Policy Owner/Life Insured's details

To be completed in full when the Policy Owner and Life Insured are the same individual.

Part E: Policy Owner/Life Insured's details

Title:	First name:	Surname:	
Date of birth: / /		Weight: kg	Height: cm
Occupation:			
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

Please indicate your preferred method of communication with an asterisk (*)

Part F: Policy Owner/Life Insured's Trauma claim

Medical details of the Life Insured will require Medical Specialist details

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

☐ Benign Brain or Spinal Cord Tumor (consultant neurologist)*		☐ Cancer
☐ Coma	☐ Coronary Artery Bypass Surgery	☐ Heart Attack (Cardiologist)*
☐ Heart Valve Surgery	☐ Kidney Failure	☐ Liver Failure
☐ Loss of Hearing	☐ Loss of Independent Living	☐ Loss of Sight (ophthalmologist)*
☐ Loss of Speech	☐ Loss of Use of Limbs	☐ Lung Failure
☐ Major Burns	☐ Major Head Trauma	☐ Major Organ Transplant (Specialist physician)*
☐ Paralysis	☐ Stroke (consultant neurologist)*	
☐ Triple Vessel Coronary Angioplasty for Coronary Artery Disease		

These Trauma events are defined in your Product Disclosure Statement.

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. Include dates and which doctors attended for each previous episode:

4. Name of doctor you have predominantly consulted with about the claimed condition:

Address:		
Suburb:	State:	Postcode:
Phone:		
Date of first consultation? / /	Date of last consultation? / /	

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

Doctor's name:		
Address:		
Suburb:	State:	Postcode:
Phone:		

Part G: Policy Owner/Life Insured's authorisation to share information about this claim (optional)

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	
Policy Owner/Life Insured's signature:	Date: / /

Part H: Policy Owner/Life Insured's consent to obtain a medical report

I hereby consent to St Andrew's and Let's Insure being provided with medical information, including copies of any medical reports, clinical reports or otherwise, from any Medical Specialist who at any time has attended me concerning anything which affects my physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

First name:	Surname:
Date of birth:	/ /
Policy Owner/Life Insured's signature:	Date:

Part I: Policy Owner/Life Insured's declaration

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 St Andrew's requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner/Life Insured's signature:	Date: / /

Please have your treating Medical Specialist complete parts J & K on the following pages.

Section 3: Medical details

This section (Parts J and K) is to be fully completed by the registered treating Medical Specialist.

Part J: Confidential Medical Report - Trauma benefit

Please note that the information required to be completed in this document is in relation to the insured person (patient).

Please note that it is the insured person's responsibility for the payment of all fees associated in the completion of this document.

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.

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.

1. Patient's details

First name:	Surname:		
Address:			
Suburb:		State:	Postcode:

2. Medical details

a. Are you the patient's usual Medical Specialist? Yes ☐ No ☐ If no, please provide details of usual doctor below:

Doctor's name:			
Address:			
Suburb:		State:	Postcode:
Phone:			

b. Which of the following conditions has been suffered by your patient? Will require Medical Specialist details.

☐ Benign Brain n Spinal Cord Tumor (consultant neurologist)*	☐ Cancer	☐ Coma
☐ Coronary Artery Bypass Surgery	☐ Heart Attack (Cardiologist)*	☐ Heart Valve Surgery
☐ Kidney Failure	☐ Liver Failure	☐ Loss of Hearing
☐ Loss of Independent Living	☐ Loss of Sight (ophthalmologist)*	☐ Loss of Speech
☐ Loss of Use of Limbs	☐ Lung Failure	☐ Major Burns
☐ Major Head Trauma	☐ Major Organ Transplant (Specialist physician)*	☐ Paralysis
☐ Stroke (consultant neurologist)*	☐ Triple Vessel Coronary Angioplasty for Coronary Artery Disease	

c. What was the date of diagnosis? ☐☐ / ☐☐ / ☐☐☐☐

d. What was the date of the first consultation in connection with the current condition? ☐☐ / ☐☐ / ☐☐☐☐

e. Please fully describe the patient's current condition and prognosis for recovery, relapse or whether the condition is permanent:

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

Date:	Test:	Results:
☐☐ / ☐☐ / ☐☐☐☐		
☐☐ / ☐☐ / ☐☐☐☐		
☐☐ / ☐☐ / ☐☐☐☐		

g. What treatment is currently being given, including surgery and medication, if any?

Part J: Confidential Medical Report - Trauma benefit (continued)

h. 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:

i. If the patient has been hospitalised, provide the following details.

Admission date:	Discharge date:	Name of hospital:
/ /	/ /	
/ /	/ /	
/ /	/ /	

j. Have you ever treated the patient before for any condition? Yes ☐ No ☐ If 'yes', please supply details.

Date consulted:	Nature of the condition:
/ /	
/ /	
/ /	

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

Part K: Medical Practitioner'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 St Andrew's may provide copies of this Report to any Medical Specialist from whom St Andrew's 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:
Phone:	Fax:		

Medical Practitioner's signature: Date: / /

Please return the completed form to Let's Insure. You can either:

1. Scan and email to claims@letsinsure.com.au (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); or
2. Mail to The Claims Manager, Let's Insure, PO Box 1192, Chatswood NSW 2057 (please mark the envelope as CONFIDENTIAL); or
3. Fax to 1300 361 097 (please address the cover page to The Claims Manager).