Children's Insurance Benefit Claim Form

(Optional Benefit)

- To help ensure you receive a prompt assessment, please complete all the required sections of this form. If you need assistance please call us on **1300 308 578**. Please note however, that a claim cannot be assessed until we receive all original documents.
- Please note that the information required to be completed in this form is in relation to the Child Insured, unless otherwise stated.
- To ensure that the claim can be fully assessed, and to avoid any delays to this process, please ensure that all the questions in this form are thoroughly addressed and answered. Responses such as "refer to doctor", "see above", etc. are not acceptable. Failure to address and answer all questions in this form may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this form 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 question on this form 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 ✗

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
Greenstone Financial Services Pty Ltd
trading as Guardian Insurance
ABN 53 128 692 884, AFSL 343079

Issued by
Hannover Life Re of Australasia Ltd
ABN 37 062 395 484, AFSL 530811
Tower 1, Level 33, 100 Barangaroo Avenue
Sydney NSW 2000
Phone: (02) 9251 6911
Email: hlra@hlra.com.au

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Please return this form to Guardian Insurance, Reply Paid 6728, Baulkham Hills NSW 2153

PART A:
Children's Insurance Serious Injury or Illness Benefit 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 **1300 709 431** Monday to Friday, 8am – 8pm AEST.

Section A – Policyowner's details

Title | First name | Surname

Policy number

Address

Suburb

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 treated 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. What is 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 the Child Insured's usual doctor:

Doctor's name

Address

Phone number

Doctor's Authority – Release of Child Insured's full record

Release a copy of the full record, including consultation notes, held by the Child Insured's Medical Practitioner/Practice.

I declare that I'm legally authorised to:

- submit this claim in relation to the Child Insured; and
- request a copy of the Child Insured's medical records.

I authorise any Medical Practitioner or hospital the Child Insured had attended to release a copy of their full record, including consultation notes, to Hannover Life Re of Australasia Ltd, or to third parties they engage, including asking any Medical Practitioner to provide a report regarding any treatment or advice given to the Child Insured.

I agree to the following:

- Hannover Life Re of Australasia Ltd can collect, use, store and disclose my (and the Child Insured's) personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Hannover Life Re of Australasia Ltd is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name of Child Insured

DD / MM / YYYY
Date of Birth of Child Insured

Claimant's Signature

DD / MM / YYYY
Date

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 HLRA accepts liability for the claim)

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

Child Insured's name

and do hereby discharge the HLRA 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 ✗
Policyowner/Claimant's signature

DD / MM / YYYY
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 Policyowner's identity (e.g. Birth Certificate, Passport, or Driver's Licence).

☐ (If applicable) A completed and signed Medicare Authority Form authorising the release of the Child Insured's 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.

- This section of the form must be completed by the Policyowner.
- If your claim has been approved, 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. We suggest you contact your nominated Credit Union.

SIGN HERE ▶ ✗ Policyowner's signature

DD / MM / YYYY Date

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 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 Benefit Confidential Medical Report

This form 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 form 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 can be fully assessed, and to avoid any delays to this process, please ensure that all the questions in this form are thoroughly addressed and answered. Failure to address and answer all questions in this form may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this form 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 question on this form 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's (Life Insured) 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. What is the date of the first consultation in connection with the current condition? DD / MM / YYYY
5. Please 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		

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, please 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 the 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