guardian INSURANCE™

Guardian Income Protection Insurance Claim Form

- To assist us in ensuring you receive a prompt assessment, please complete all the required sections of this booklet. If you need assistance please call us on **1300 737 697**. 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 document is in relation to the Life 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 questions 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 questions 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 question on this document you are addressing. Please ensure that you sign and date the piece of paper.
- Please note that it is the Policyowner's or Life Insured's responsibility for the payment of all fees associated in the completion of the Specialist Medical Report or Confidential Report.
- If the Policyowner nominated a third party beneficiary for the Final Expenses Insurance benefit (if applicable), in accordance with the Insurance Contracts Act, the proceeds will be paid to the third party. If no nomination has been made, the proceeds will be paid to the Estate.

Filling in this form:

- Use a black or blue pen
- Mark boxes like this ☐ with ✓ or ✗

There are 2 parts to the claim form:

- **Part A** is to be completed by claimant
- **Part B** is to be completed by the registered medical practitioner treating the Life Insured.

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
Level 7, 70 Phillip Street
Sydney NSW 2000
Phone: (02) 9251 6911
Email: hlra@hlra.com.au

H2383 G IP Claim HLRA 04/15

Please return this form to Guardian Insurance Customer Service, PO Box 6728, Baulkham Hills NSW 2153

PART A:
Income Protection Insurance Claim Form

guardian INSURANCE™

Privacy

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

The information we collect will be used to assess and process your claim. The information may also be used if you apply for insurance from us in the future. If you fail to provide us with all or part of the information we require, we will be unable to assess and process your claim. Personal information will be collected from you or, where that is not practicable, from other organisations such as medical practitioners and government agencies.

The information we collect may be disclosed to other organisations, including but not limited to medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation organisations, an organisation that is duly appointed to manage the administration of such insurance policy or interpreters. We are unlikely to send your personal information to any foreign jurisdiction and we take steps to ensure our service providers don't either.

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. You can also obtain the Privacy Policy of HLRA on their website, www.hannoverlifere.com.au. 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 737 697 Monday to Friday, 8:00am – 8:00pm EST.

Section A – Policy Information

Policyowner | Policy number

Section B – Policyowner Details

Title | First name | Surname

Date of birth (DD / MM / YYYY) | Gender: Male | Female

Residential address

Postal address

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

Email

Section C – Income Protection Insurance Claim

1. Injury details

a. Where did this injury occur? (place/address)?

b. What date and time did this injury occur?

c. Please provide a detailed description of how you were injured?

d. Were there any witnesses to your injury, and if so, what are their names and contact details?

e. Did ambulance, first aid officer or police attend following your injury?

No ☐ Yes ☐ ▶ Who attended and what did they do?

f. Was the injury or accident related to your employment?

No ☐ Yes ☐ ▶ How is it related to your employment?

2. Illness details

a. Please describe in detail the illness suffered:

3. General injury or illness details

a. What date did the symptoms of your injury or illness first occur? DD / MM / YYYY

b. Please provide a full description of the symptoms resulting from your injury or illness in the area provided below. If there are more than 5 symptoms please attach a separate sheet with all details in the same format.

Symptom	How often does this symptom occur?	How does this symptom prevent you from working?
1		
2		
3		
4		
5		

c. Have you had this, or a similar injury or illness before?

No ☐ Yes ☐ ▶ Please provide the date and circumstances. DD / MM / YYYY

4. Details of hospitalisation

a. Please provide names and addresses of all the hospitals you were admitted to:

Name of hospital and/or name of doctor consulted in hospital	Admission date	Discharge date
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY

b. If you had an operation, please detail what type of operation it was?

c. What date did you have the operation? DD / MM / YYYY

d. What is the name, address and telephone number of the doctor who performed the operation?

Name	Address	Telephone

5. Details of treatment

a. In date of chronology, please provide full details of all the medical treatment you have received since the onset of your symptoms. If your treatment has included medication, please provide details of the type of medication and dosage.

Medication and treatment	Dosage or medication and frequency of treatment	Doctor prescribing medication and administering treatment (name and address required)	Effect of medication and treatment on symptoms

b. What is the name, address and telephone number of your usual doctor?

Name	Address	Telephone

c. For how long have you been attending your usual doctor?

6. Details of work in your occupation immediately prior to your disability

a. What is your job title/occupation?

b. Please tick the amount of manual labour your occupation involves:

☐ Nil ☐ 1-20% ☐ 21-40% ☐ 41-60% ☐ 61-80% ☐ 81% or more

c. Please list all work duties performed in your occupation immediately prior to your disability. *(Please note that the percentage of working time must equal a total of 100%)*.

Duty	Percentage of Working Time
	%
	%
	%
	%
	%

d. How long have you been undertaking all the above listed work duties prior to your disability?

e. How many hours per week did you spend performing all the above listed duties immediately prior to your disability?

f. Were the duties you were attending prior to your disability any different to your normal work duties? If so, please describe how were they different:

g. Please list all your work duties you are **unable** to perform due to your illness or injury:

h. Please list all your work duties that you are still **able** to perform:

i. Have you stopped work completely?

No ☐ Yes ☐ ▶ What date and time did you stop all work completely?

j. Since completely stopping work have you undertaken any work, regardless whether it is paid work or not?

No ☐ Yes ☐ ▶ Please provide full details of the work that you have undertaken including all the dates, work duties, the number of hours per day worked, and the place of work.

k. If you have not returned to work yet, when do you expect to be able to return to work?

Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

7. Income

a. What was your average weekly income before your disability commenced? $ Per week
(Please provide us with a copy of your payslips immediately prior to your disability)

b. If you have returned to work in a reduced capacity, what is your weekly income? $ Per week
(Please provide a copy of your payslips)

c. Do you have any other source of income?

No ☐ Yes ☐ ▶ Please provide details of the source of income, frequency and gross amount.

Please ensure that all questions have been answered before you proceed further.

8. Declaration and consent

I have read and carefully considered the questions on this document and all the responses are true and correct in relation to me.

I acknowledge this Declaration is part of a claim for a disability benefit and that the making of a false statement may invalidate my claim, 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.

I understand that in order to assess and process my claim for a benefit, HLRA may need information about me including but not limited to medical, financial, legal and employment. I consent to HLRA obtaining information about me from medical practitioners that I have consulted at any time and any that HLRA wishes to appoint to examine me, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, any organisation appointed to manage the administration of such insurance policy, my past and present employers and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also consent to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosure is necessary for HLRA to perform its functions.

SIGN HERE ✗ _____ DD / MM / YYYY

Life Insured's signature — Date

9. Disclosure of information – doctor's authority

For the purpose of assessing my claim for a disability benefit, I [Insert Name] authorise my current medical practitioner, and any other medical practitioner or health professional I have consulted or may consult in the future, or that Hannover Life Re of Australasia Ltd ("HLRA") appoints to examine me, to disclose information about my health and related matters to HLRA. A photocopy of this authorisation will be valid as the original.

SIGN HERE ✗ _____ DD / MM / YYYY

Life Insured's signature — Date

Section D – Policy Discharge

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

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

[Life Insured name], and do hereby discharge HLRA from all liability there under other than for payment of the benefit.

Section E – Declaration

As the Policyowner/Life Insured/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, that if I fail to provide all or part of the information HLRA requires to assess this claim it will not be assessed and processed.

SIGN HERE ✗ _____ DD / MM / YYYY

Signature of Policyowner / Life Insured / Claimant — Date

Section F – 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

Financial institution/ name of bank

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 ✗ Your signature

DD / MM / YYYY Date

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

Section G – 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.

Income Protection Insurance

☐ The original Policy Document and Policy Schedule.

If these documents have been misplaced, please complete the Statutory Declaration

☐ **Go to Section H – Statutory Declaration on page 9**

☐ Either, copies of your individual income tax returns and notice of assessments for the previous 2 financial periods or employer issued pay slips for the same period.

☐ A certified copy of evidence of age (e.g. Birth Certificate, Driver's Licence or Passport)

☐ A completed and signed Medicare Authority form authorising the release of your Medical and Pharmaceutical Benefits Scheme claim information.

Section H – 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 _____ 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 ✗ _____ DD / MM / YYYY

Signature of Policyowner Date

_____ DD / MM / YYYY

Declared at Date

SIGN HERE ✗ _____ DD / MM / YYYY

Before me (Signature of authorised signatory) Date

_____

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.

This page intentionally left blank.

PART B:
Income Protection Insurance Claim Form – Confidential Medical Report

guardian INSURANCE™

This section is to be fully completed by the registered medical practitioner treating the Life Insured.

- Please note that the information required to be completed in this document is in relation to the Life Insured (as indicated below).
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the questions in this section 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. Please ensure that you sign and date the piece of paper.

1. Life Insured's details

First name | Surname

Date of birth (DD / MM / YYYY) | Gender: Male ☐ Female ☐ | Height (cm) | Current weight (kg)

Residential address

2. Medical details

a. Please state the Life Insured occupation/job title:

b. Please detail the date the Life Insured was first ever seen at your medical practice: (DD / MM / YYYY)
(not just for the current medical condition):

c. In the event that the Life Insured was referred to you please detail the name and address of the referring health professional:

First name | Surname

Address

d. What date did the Life Insured consult you in relation to the current medical condition? (DD / MM / YYYY)

e. Please advise the date and nature of the first symptoms related to this condition: (DD / MM / YYYY)

Nature of the first symptoms:

f. Please detail your diagnosis:

g. What process was undertaken in order to come to this diagnosis?
(If tests have been undertaken please attach a copy of all of these)

3. Hospitalisation details

a. If hospitalisation was necessary, please advise:

i) Hospital attended:

ii) Name of treating medical practitioner:

iii) Date admitted: DD / MM / YYYY Date discharged: DD / MM / YYYY

b. Has the insured person ever consulted you, or any other medical practitioner, previously for a similar condition or symptoms? If so, please provide dates and doctors consulted:

Doctor	Consultation date
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY

c. Please detail all the current reported symptoms:

d. What specific effect do these symptoms have on the Life Insured's functional work ability?

e. Please detail the last date the Life Insured received any sort of treatment from you for their current medical condition:

f. What date are you next scheduled to treat the Life Insured? DD / MM / YYYY

g. If you have referred the Life Insured to any other medical professional(s) please detail their name, speciality, address and the date of the referral: *If you have received correspondence from other medical professional please attach a copy to this document.*

Name of medical professional	Speciality	Address	Date
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

h. Please detail what treatment has been provided to date:
If medication has been prescribed please detail the dosage and how often it is to be taken.

I. Is the Life Insured compliant with treatment?

No ☐ Yes ☐ ▶ Please detail on what basis you believe this is the case:

J. Please detail the improvements in symptoms (if any) that have been achieved through the treatment to date:

K. If there has not been any improvements in the symptoms to date please detail the reason(s) for this:

L. Please detail the future treatment planned, and objectives hoped to be achieved through this treatment:

M. Please detail your understanding of the Life Insured usual occupation and specific work duties:

a. Occupation:

b. Details of specific work duties:

N. If the current reported symptoms prevent the Life Insured from undertaking their work duties please detail which work duties they are prevented from undertaking and which symptom(s) is preventing this:

Work duties	Symptoms preventing undertaking work duties

O. In your opinion what date did the Life Insured first become unable to undertake their usual occupation due to injury or illness?

DD / MM / YYYY

P. What date has the Life Insured reported to you that they totally ceased all work? DD / MM / YYYY

Q. Do you consider the Life Insured currently capable of working either full time or part time?

No ☐ Yes ☐ ▶ Please advise from what date, and in what capacity (i.e. full time or part time):

R. If capable of returning to part time work, please advise which duties of their usual occupation the Life Insured is **incapable** of performing?

S. If the Life Insured has not yet returned to work, when do you anticipate they will be able to return:

Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

T. Have you considered, or are you considering, implementing a return to work program or rehabilitation? If so, please provide a copy of the program or details. If not, please detail the reason(s) you don't consider this is an option at this time:

4. Medical practitioner's final comments

a. Please detail all ongoing medical problems, past history or other circumstances which you are aware are affecting the Life Insured's current condition and ability to work in their usual occupation:

b. Have you given any certificate or report to?

Another Insurance Company:	No ☐	Yes ☐
Workers Compensation Insurer:	No ☐	Yes ☐
Centrelink:	No ☐	Yes ☐
Third Party Insurer:	No ☐	Yes ☐
Solicitor:	No ☐	Yes ☐
Any other party:	No ☐	Yes ☐

If you have answered "yes" to any of the above, please detail the name of the organisation you have provided this information to and their address:

c. Please provide us with any other comments you may have to assist the Life Insured to return to good health and return to work:

5. Medical practitioner's declaration and agreement

I hereby certify that I have personally attended the Life Insured named on page 1 and that all the information supplied by me in this Report is true. I agree that the Insurer may provide copies of this Report to any medical specialist from whom Hannover Life Re of Australasia Ltd ("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

✗

Doctor's signature

DD / MM / YYYY

Date