guardian INSURANCE™

Living Expenses 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 original documents are received.
- Please note that the information required to be completed in this document is in relation to the Life Insured.
- 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 Life Insured's responsibility for the payment of all fees associated in the completion of the Progress Medical Report.

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
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H3531 G LEI Claim HLRA 05/18

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

PART A:
Guardian Living Expenses 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.hannoverlife.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 AEST.

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 – Type of Claim

Have you suffered from:

☐ An Accident or Injury;

☐ ▶ **Go to Section D – Accident/Injury Details on this Page**

☐ A Sickness;

☐ ▶ **Go to Section E – Sickness Details on Page 3**

Section D – Accident/Injury Details

a. What date and time did this injury occur? (DD / MM / YYYY) (TIME)

b. Please provide a detailed description of how you were injured and where the injury occurred?

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

d. Were you hospitalised?

No ☐ Yes ☐ ▶ What hospital did you attend?

Hospital name	Date admitted	Date discharged

Please supply a copy of your hospital discharge summary.

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

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

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

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

Please ensure that all questions have been answered and proceed to Section G – Claim Details on Page 4.

Section E – Sickness Details

a. Please confirm your diagnosis:

b. What date did the symptoms of your sickness first occur? DD / MM / YYYY

c. Please describe the symptoms you are suffering:

d. Have you had this, or a similar sickness before?

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

Please ensure that all questions have been answered and proceed to Section G – Claim Details on this Page.

Section F – 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?

Section G – Claim Details

Please tick a box that best describes your work status immediately prior to your injury or sickness:

☐ **a.** Aged under 65 years of age and working 20 hours or more per week

☐ **b.** Aged under 65 years of age and not working or working less than 20 hours per week

☐ **c.** Aged 65 or over irrespective of work status

If you have ticked a.

i. What is your usual job title/occupation/duties performed?

ii. Are you unable to attend or engage in your usual occupation? No ☐ Yes ☐

iii. Have you stopped work completely?

No ☐ Yes ☐ ▶ What date and time did you stop all work completely? DD / MM / YYYY TIME

iv. 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.

v. When do you expect to be able to return to work? DD / MM / YYYY

If you have ticked b.

i. Please identify which 3 Domestic Duties you are unable to perform;

- ☐ cleaning the family home (such as using a vacuum cleaner, sweeping with a broom, using a mop, cleaning dishes (automatic or manual));
- ☐ cooking the family meals (such as preparing fresh and frozen food, using an oven, stove or microwave oven);
- ☐ doing the family's laundry (such as loading and unloading a washing machine and hanging out clothes or using a dryer, folding clothes and ironing);
- ☐ shopping for food and household items (such as attending shops or using the phone or internet to purchase food or household items for the family); and
- ☐ where applicable, taking care of dependent children under 16 years of age or in full time secondary education (such as supervising, lifting, transporting, feeding and bathing).

ii. What date did this commence? DD / MM / YYYY

iii. If you have not commenced all your Domestic Duties, when do you expect to be able to undertake these? DD / MM / YYYY

iv. Prior to the disability, who performed these duties and for how many hours per week?

HOURS

v. Following the disability, who performs these duties? Name Contact Number

vi. Is this paid or unpaid assistance?

vii. When do they attend and for how many hours? HOURS

If you have ticked c.

i. Please identify which 2 Activities of Daily Living you are unable to undertake without assistance:

- ☐ Bathing – the ability to wash or shower;
- ☐ Dressing – the ability to put on and take off clothing;
- ☐ Feeding – the ability to get food from a plate into the mouth;
- ☐ Mobility – the ability to get in and out of bed and a chair; and
- ☐ Toileting – the ability to use the toilet including getting on and off.

ii. What date did this commence? DD / MM / YYYY

iii. If you have not commenced all your Activities of Daily Living, when do you expect to be able to undertake these? DD / MM / YYYY

Section H – 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 Living Expenses Insurance 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 ✗

Life Insured's signature

DD / MM / YYYY

Date

Section I – Disclosure of Information – Doctor's Authority

For the purpose of assessing my claim for Living Expenses Insurance, 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 ✗ Life Insured's signature

DD / MM / YYYY Date

Section J – 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 Living Expenses Insurance (details on page 2 of this document), in full satisfaction for all claims whatsoever under the Policy for the Life Insured

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

Section K – 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.

Living Expenses

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

☐ ▶ **Go to Section M – Statutory Declaration on Page 7**

☐ A certificate of proof of identity/claimant's age (e.g. Birth Certificate, Driver's Licence or Passport)

☐ Proof of income for 3 months prior to the disability. Copies of your payslips or a letter from your employer is acceptable. If you are self employed, either a copy of your tax return for the period prior to the disability or copies of your BAS and Profit and Loss Statements for the current period are acceptable.

Section L – 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 M – 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/Life Insured/Claimant — 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.

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PART B:
Guardian Living Expenses Insurance – Confidential Medical Report

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

b. 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

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

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

Nature of the first symptoms:

e. Please detail your diagnosis:

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

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

No ☐ Yes ☐ ▶ Please provide dates and doctors consulted:

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

h. 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 any other medical professionals please attach a copy to this document.

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

i. 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).

j. Is the Life Insured compliant with treatment?

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

k. Please tick a box that best describes the your patient's work status immediately prior to their injury or sickness:

a. Aged under 65 years of age and working 20 hours or more per week ☐

b. Aged under 65 years of age and not working or working less than 20 hours per week ☐

c. Aged 65 or over irrespective of work status ☐

If you have ticked a.

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

a. Occupation:

b. Details of specific work duties:

ii. 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

iii. 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

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

v. 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

If you have ticked b.

i. Please identify which 3 Domestic Duties the Life Insured is unable to perform;

- ☐ cleaning the family home (such as using a vacuum cleaner, sweeping with a broom, using a mop, cleaning dishes [automatic or manual]);
- ☐ cooking the family meals (such as preparing fresh and frozen food, using an oven, stove or microwave oven);
- ☐ doing the family's laundry (such as loading and unloading a washing machine and hanging out clothes or using a dryer, folding clothes and ironing);
- ☐ shopping for food and household items (such as attending shops or using the phone or internet to purchase food or household items for the family); and
- ☐ where applicable, taking care of dependent children under 16 years of age or in full time secondary education such as supervising, lifting, transporting, feeding and bathing);

ii. What date did this commence? DD / MM / YYYY

iii. If the Life Insured has yet to resume their Domestic Duties, when do you expect they will be able to resume? DD / MM / YYYY

If you have ticked c.

i. Please identify which 2 Activities of Daily Living the Life Insured is unable to undertake without assistance:

- ☐ Bathing – the ability to wash or shower;
- ☐ Dressing – the ability to put on and take off clothing;
- ☐ Feeding – the ability to get food from a plate into the mouth;
- ☐ Mobility – the ability to get in and out of bed and a chair; and
- ☐ Toileting – the ability to use the toilet including getting on and off;

ii. What date did this commence? DD / MM / YYYY

iii. If the Life Insured has yet to resume their activities of Daily Living, when do you expect they will be able to resume? DD / MM / YYYY

3. 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 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 ✗

Doctor's signature Date DD / MM / YYYY