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Life Insurance Total & Permanent Disability Insurance Benefit Claim Form

(Optional Benefit)

- 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 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 ✗

There are 3 parts to the claim form:

- **Part A** is to be completed by claimant.
- **Part B** is to be completed by the Insured's employer.
- **Part C** 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
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Sydney NSW 2000
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H2383 GLI-TPD Claim HLRA 04/15

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

PART A:
Total & Permanent Disability Claim Form

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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 EST.

Section A – Policy Information

Policyowner

Policy number

Section B – Details of Insured

1. Personal information of the Life Insured

Title | First name | Surname

Address

Suburb | State | Postcode

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

Country of birth | Are you an Australian resident? Yes ☐ No ☐

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

Email

Language spoken at home | Is an Interpreter required? Yes ☐ No ☐

2. Employer details

a. Name of employer/company

b. Work address

c. Commencement date DD / MM / YYYY | Telephone

3. Details of your injury or illness

a. If you are submitting this application more than 12 months after the date on which you last worked please state the reasons for the deferral:

b. Please state the reasons why you ceased work:
(If you have ceased work due to Redundancy, Resignation or Termination please provide a copy of the relevant documentation)

c. Please state the exact nature of the injury or illness that caused you to cease work:

d. On what date did the injury occur or did you first become ill? DD / MM / YYYY

e. Please give details of all doctors, physiotherapists, chiropractors etc. consulted by you, including any hospital treatment you may have received in relation to your disability.

Name of doctor	Address	Date of first consultation	Date of most recent consultation

f. Are any of the doctors named in (e) above the usual doctor you attend?

Yes ☐ No ☐ ▶ Please provide details of your usual doctor:

Doctor's name

Address

Phone number

g. Have you ever suffered from the same or similar illness? (please tick)

No ☐ Yes ☐ ▶ Please supply detals

Date of episode	Period off work	Name of attending doctor

4. Occupational details

a. What was your job title?

b. Please describe all your work duties in detail:

c. How many hours did you normally work each week?

d. On what date did you last work? DD / MM / YYYY

e. Please list all of the work duties your disability prevents you from performing:

f. Since ceasing work with your employer have you been able to perform work of any kind?

No ☐ Yes ☐ ▶ Please supply details:

Period of work	Job title	Part time or full time	Income earned (before income tax)

g. Have you applied for any jobs since ceasing work?

No ☐ Yes ☐ ▶ Please supply details:

h. Are you now able to perform any duties of your occupation?

No ☐ Yes ☐ ▶ Please list which duties you can perform:

i. What level of education do you have?

Primary ☐ Secondary ☐ Tertiary ☐

j. What qualification or licencing certificates do you have? Please supply details:

k. Do you have any other training or skills?

No ☐ Yes ☐ ▶ Please supply details:

l. Please supply details of all previous jobs you have performed and/or enclose a copy of your resume:

Employer	Description of job	Approximate dates

m. Please list any work you think you may be able to perform in the future:

n. Have you received, or are you entitled to claim any benefits under any insurance policy such as income protection, lump sum total and permanent disablement or trauma, or any benefit such as Worker's Compensation, Invalid Pension, Sickness benefit, Veterans Affairs benefits or Unemployment benefits?

No ☐ Yes ☐ ▶ Please supply details:

Period	Type of benefit	Name and company address	Case manager and telephone number	Claim number

o. Please state your current daily activities:

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

5. Declaration and consent

I acknowledge;

(a) this Declaration forms part of my claim for a Total and Permanent Disability benefit;

(b) 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.

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 my information about me from medical practitioners that I have consulted at anytime and any that HLRA wishes to appoint to examine, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, 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

6. Disclosure of information – doctor's authority

For the purpose of assessing my claim for a Total and Permanent Disability benefit, I 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 C – 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.

Total & Permanent Disability

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

☐ ▶ **Go to Section G – Statutory Declaration on Page 8**

☐ A certificate of proof of identity/claimant's 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 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 Life Insurance – Total & Permanent Disability Policy (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 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 Hannover Life Re of Australasia Ltd ("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

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

Your signature — Date

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

Section G – 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 ✗ Signature of Policyowner / Life Insured / Claimant — DD / MM / YYYY Date

Declared at — DD / MM / YYYY Date

SIGN HERE ✗ Before me (signature of authorised signatory) — DD / MM / YYYY 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.

PART B:
Employer's Statement in connection with a claim for a Total and Permanent Disablement Benefit

To be completed by an authorised representative of the employer.

Name of employer

Full Name of employee | Date of birth DD / MM / YYYY

Employee's address | Postcode

Date joined company DD / MM / YYYY | Date joined fund DD / MM / YYYY

a. Date the employee was last at work.

b. Why did the employee cease work?

c. Have there been any periods of absence? If so list the periods and reasons.

d. Employee's job title?

e. Precise duties performed by the employee.

f. Number of hours normally worked each week.

g. The education, training or qualifications required to perform the job.

h. The education, training, qualifications and past experience of the employee.

i. Number of people supervised by the employee.

j. Did the employee spend any significant work on the following activities?

Activity	Proportion of time spent (%)	Activity	Proportion of time spent (%)	Activity	Proportion of time spent (%)
Driving		Walking or standing		Lifting or carrying	
Climbing		Crawling or kneeling			

Please turn over to complete this form ▶

k. Did the employee's duties allow him/her to move freely during work hours or was he/she confined to a set space or position?

l. Is the employee's job still open?

m. Do you have any other jobs appropriate to the employee's level of skill and experience?

n. Have any alternative jobs been offered to the employee? If so, please give details.

o. Describe any previous jobs the employee has done while employed by you. Include time spent in each job.

p. Can the employee speak, read, and write English?

Yes ☐ No ☐

q. Give details of the weekly income the employee was paid at the time of disablement.

r. Give details of the annual income the employee was paid prior to disablement.

s. Give details of any amounts you are currently paying to the employee (e.g. Worker's Compensation, salary).

t. Is a claim being made for:

Temporary Disablement? Yes ☐ No ☐ Permanent Disablement? Yes ☐ No ☐

u. Other comments (e.g. any other comments you may have which you believe may be relevant to the assessment of the claim).

I declare that I am authorised to answer the above questions on behalf of the employer; and that the responses to the questions on this Statement are true.

SIGN HERE ✗

Signed on behalf of the employer

DD / MM / YYYY

Date

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PART C:
Total & Permanent Disability Claim Form – Confidential Medical Report

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This document 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.
- 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.

The cost of this report is the claimant's responsibility.

Claimant's family name _____ Given names _____

Date of birth DD / MM / YYYY Occupation _____

Home address _____ Postcode _____

Questions to be answered by the claimant's medical practitioner.

Please attach a seperate statement if space is insufficient for any answer.

1. a) On what date did you first attend the claimant in connection with his/her illness or injuries? DD / MM / YYYY

b) On what date did the illness or accident occur? DD / MM / YYYY

c) What was the date of your last attendance? DD / MM / YYYY

d) Has the claimant an appointment to consult you again? No ☐ Yes ☐ ▶ Approximate date DD / MM / YYYY

2. On what date did the claimant become completely unable to perform all the normal duties of his/her occupation?
DD / MM / YYYY

3. Please provide details of other doctors seen by the claimant in connection with this disability:

Name of doctor	Address	Telephone	Date of first consultation

4. Please state the history of the illness or injury, including the exact nature and severity of the condition and give particulars of any treatment which has been necessary, including dates where relevant. Please also provide full details and results of any tests performed. Please give full details of the current condition.

5. Has hospital admission been necessary? No ☐ Yes ☐ ▶ Please give name of hospital(s) and relevant dates:

Name of hospital	Date of admission	Date of discharge

6. Has surgical treatment been necessary? No ☐ Yes ☐ ▶ a) What operation(s) was/were performed?

Operation	Date performed

b) Post-operative course?

7. Has the claimant suffered from the same or similiar or related condition?

Yes ☐ No ☐ ▶ Do you consider the disablement to be connected in any way with a previous illness or injury or unfavourable features of the patient's history?

No ☐

Yes ☐ ▶ Please provide details:

8. In respect of the claimant's present illness or injury, have you given any certificate to another insurance company, or in connection with Worker's Compensation, Social Security, sick leave benefits from the claimant's employer or for any other reason?

No ☐

Yes ☐ ▶ To whom?

9. At the current time, can the claimant do his/her normal job?

No ☐ ▶ Which work duties is the claimant unable to perform?

Yes ☐ ▶ From what date was he/she fit to return to work? DD / MM / YYYY

10. If you do NOT expect the claimant to EVER return to his/her normal work do you think he/she will EVER be able to do a job for which he/she is reasonably fitted by education, training or experience?

No ☐ ▶ Please give detailed reasons:

Yes ☐ ▶ Please list examples of jobs which in your opinion would be appropriate:

Declaration

I hereby certify that I have personally attended the named patient 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

SIGN HERE ▶ ✗ Signature

DD / MM / YYYY Date