Make a Walkaway Claim

Thank you for contacting Swann Insurance

You must have access to a printer in order to access this form. If you do not have access to a printer please contact our office on 1300 657 382 and an alternative will be sent.

HOW TO COMPLETE YOUR WALKAWAY CLAIM FORM

Your claim form must be completed in full. An incomplete form may cause delay in the assessment of your claim.

Please ensure:

For Disablement Claim:

- You (the insured) complete *sections 1, 2, 3 and 4* and your doctor has completed *section 10*

For Involuntary Unemployment Claim:

- You (the insured) complete *sections 1, 2 and 5* and *section 6* is completed by Centrelink/Job Agency and *section 7* is completed by your last employer

For Driver Restrictive Medical Condition:

- You (the insured) complete *sections 1, 2, 3 and 4* and your doctor has completed *section 10*

For International Job Transfer:

- You (the insured) obtain a statement from you employer confirming:
    1. Your international transfer
    2. Your international transfer was not at your request
    3. Your international transfer is for a period of at least 24 consecutive months
    4. Your permanent residence has changed

For Trauma Claim:

- You (the insured) complete *sections 1, 2 and 8*

For Self-employed Bankruptcy Claim:

- You (the insured) supply documentation from your accountant providing details and confirmation of the insolvency of your business

For Employer Approved Leave Of Absence Claim:
(Vehicle return cover not applicable)

- You (the insured) provide evidence from a Medical Practitioner confirming that you have an immediate family member that is suffering a Trauma, or had been medically diagnosed to be at risk of dying within 26 weeks
- You (the insured) provide a statement from your employer confirming your approved leave of absence for 60 consecutive days from your occupation to care for that same immediate family member

For all claims please ensure:

- You (the insured) have ticked the relevant box nominating if you are electing to return the vehicle.
- That you (the insured) and a witness have both signed and dated your claim form.
- If your employment ceased or your disablement occurred more than three (3) months ago, a letter is attached to your claim form detailing the reason(s) for the late lodgement of your claim.

Other useful information

If you have submitted your claim form and it has been accepted by Swann Insurance, we will require you to provide ongoing confirmation of your unemployment or disablement in order for us to maintain continuous payments to your financier.

Please advise us on 1300 657 382 if you return to any form of employment during the period you are claiming for.

It is important that all questions are correctly and fully answered by the policy holder. This will enable Swann Insurance to proceed with the processing of your claim; delays could occur if the claim is completed by someone other than the policy holder or if insufficient information is supplied. If for some reason the policy holder is unable to complete this form, please contact the office to discuss options.

Third Person authority to enquire

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the attached authorisation and return with your completed claim form.

Fax: 1300 657 370
Email: swann.cci.claims@swanninsurance.com.au
Post: Locked Bag 3274
Melbourne VIC 3001

The way we handle your personal information

You agree that, by submitting this claim, the personal information you provide to Swann Insurance for the purposes of making this claim, may be collected, held, used and disclosed in the manner set out in the Swann Insurance Privacy Policy found at www.swanninsurance.com.au/privacy, including for the purposes of the determination and / or settlement of, this claim.

WALKAWAY®
PROTECTION FOR AUTOMOTIVE FINANCING

CLAIM FORM

Insurer: Insurance Australia Limited ABN 11 000 016 722 AFS Licence No 227681 trading as Swann Insurance (Swann Insurance).

All questions must be answered. Please print and indicate where applicable. If insufficient space provided, please write on a separate sheet and attach to the form.

Section 1 - your personal details (complete for all claim types)

TITLE (eg. MR/MRS)		DATE OF BIRTH	/ /
SURNAME		TELEPHONE NO.	
GIVEN NAMES			
ADDRESS		POSTCODE	
E-MAIL		YOUR OCCUPATION	
NAME OF FINANCIER		CURRENT EMPLOYER	
LOAN CONTRACT NO.		ADDRESS	
DATE COMMENCED	/ /		
MONTHLY INSTALMENTS	$	TELEPHONE NO.	
		EMPLOYED FROM / /	TO / /

Section 2 - basis of claim – (describe the circumstances of your claim)

Have you elected to return your vehicle voluntarily to the selling dealer? **YES** ☐ **NO** ☐

Type of claim (please tick relevant box) ***For all claims please provide us with a copy of your last loan statement.***

Disability	☐	Complete Sections 1, 2, 3, and 4 – and your doctor to complete Section 10.
Involuntary unemployment	☐	Complete Sections 1, 2, and 5 – and ensure Section 6 is completed by Centrelink/job agency and Section 7 by your last employer.
Driver restrictive medical condition	☐	Complete Sections 1, 2, 3, and 4 – and your doctor to complete Section 10.
International job transfer	☐	Please obtain a statement from your employer confirming: • your international transfer, and • your international transfer was not at your request, and • your international transfer is for a period of at least 24 consecutive months, and • your permanent residence is changed.
Trauma	☐	Complete Sections 1, 2, and 8.
Self-employed bankruptcy	☐	Please obtain documentation from your accountant providing details and confirmation of the insolvency of your business.
Employer approved leave of absence (Vehicle return cover not applicable)	☐	Please obtain: • evidence from a Medical practitioner confirming that you have an immediate family member that is suffering a Trauma, or had been medically diagnosed to be at risk of dying within 26 weeks, and • a statement from your employer confirming your approved leave of absence for 60 consecutive days from your occupation to care for that same immediate family member.

IMPORTANT – PLEASE ENSURE SECTION 9 – DECLARATION - IS READ, SIGNED AND WITNESSED.

Section 3 – your disability details

DATE THE ILLNESS OR INJURY FIRST OCCURRED / / TIME LAST WORKING DAY / /

DESCRIBE CIRCUMSTANCES LEADING TO YOUR CURRENT DISABILITY

WHO IS YOUR USUAL DOCTOR?		FOR HOW LONG? YEARS:	MONTHS:
YOUR DOCTOR'S ADDRESS		TELEPHONE NO.	
DOCTOR AT POLICY COMMENCEMENT DATE			
ADDRESS		TELEPHONE NO.	

PLEASE STATE NAMES AND ADDRESSES OF ALL OTHER DOCTORS AND HOSPITALS CONSULTED FOR THIS CURRENT DISABILITY

NAME	ADDRESS	Postcode	TELEPHONE NO.

WAS THE INJURY CAUSED BY A MOTOR VEHICLE ACCIDENT? ☐ POLICE ATTENDED? ☐

Section 4 – your medical history

HAVE YOU PREVIOUSLY SUFFERED FROM THIS INJURY OR ILLNESS OR ANY SIMILAR INJURY OR ILLNESS?

NO ☐ YES ☐ ▶ DOCTOR | CONSULTATIONS / / / /

ADDRESS | Postcode

CONSULTED FOR | Phone:

PERIOD OF DISABILITY - FROM | TO

DO YOU TAKE REGULAR MEDICATION FOR ANY ILLNESS OR INJURY?

NO ☐ YES ☐ ▶ PLEASE PROVIDE DETAILS OF MEDICATION AND CONDITION

Section 5 – your unemployment details

ON WHAT BASIS WERE YOU EMPLOYED AT LOAN COMMENCEMENT?

- FULL TIME ☐
- CASUAL ☐
- PART TIME ☐
- CONTRACT ☐
- SEASONAL ☐
- TEMPORARY ☐

WHAT WAS YOUR REASON FOR LEAVING THIS EMPLOYMENT?

- RESIGNED ☐
- RETRENCHED ☐
- DISMISSED ☐
- END OF CONTRACT ☐
- MADE REDUNDANT ☐
- TEMPORARY ☐
- OTHER (please explain) ☐

NAME OF EMPLOYER PRIOR TO LAST EMPLOYMENT

ADDRESS

Postcode

TELEPHONE NO.

OCCUPATION

EMPLOYED FROM / / TO / /

Section 6 – certificate of Centrelink / job agency

IS THE CLAIMANT REGISTERED AS A JOB SEEKER? NO ☐ YES ☐

IF THE CLAIMANT IS RECEIVING JOB SEARCH ALLOWANCE / UNEMPLOYMENT BENEFITS, PLEASE COMPLETE THE FOLLOWING:

THIS IS TO CERTIFY THAT (FULL NAME)

OF (ADDRESS)

AS REGISTERED AS BEING UNEMPLOYED ON / / | ALLOWANCE / BENEFITS OF $ | PER

WERE GRANTED FROM / / AND HAVE BEEN PAID TO / /

IF THE CLAIMANT IS NOT RECEIVING JOB SEARCH ALLOWANCE / UNEMPLOYMENT BENEFITS, PLEASE ADVISE THE REASON WHY:

SIGNATURE OF AUTHORISED OFFICER

DATE / /

BRANCH STAMP

Section 7 – employer's declaration (to be completed by last employer)

I DECLARE THAT:

NAME OF EMPLOYEE (FULL NAME)

WAS EMPLOYED BY (COMPANY NAME)

FROM / / TO / / ON THE FOLLOWING BASIS (TICK APPROPRIATE BOX BELOW)

FULLTIME ☐ CASUAL ☐ PART TIME ☐ CONTRACT ☐ SEASONAL ☐ TEMPORARY ☐

FOR AVERAGE HOURS / WEEK WORKED

AND EMPLOYMENT WAS TERMINATED DUE TO: SHORTAGE OF WORK ☐ EMPLOYEE CEASED VOLUNTARILY ☐

MISCONDUCT ☐ ▶ REASON:

SIGNATURE | POSITION / TITLE | COMPANY STAMP IF AVAILABLE

DATE / /

Section 8 – your trauma details

WHAT ARE YOU CLAIMING FOR?		WHEN DID YOU FIRST BECOME AWARE OF YOUR CONDITION?		/ /	
HEART ATTACK		WHAT WERE THE SYMPTOMS?			
CORONARY ARTERY SURGERY					
STROKE		WHEN WERE YOU FIRST SEEN FOR THE TRAUMA?			
CANCER		DOCTOR/HOSPITAL		TELEPHONE	
		ADDRESS			
WHO IS YOUR USUAL DOCTOR?		FOR HOW LONG?	YEARS:	MONTHS:	
YOUR DOCTOR'S ADDRESS			TELEPHONE NO.		

PLEASE STATE NAMES AND ADDRESSES OF ALL OTHER DOCTORS AND HOSPITALS CONSULTED FOR THIS CURRENT OR RELATED CONDITION

NAME	ADDRESS	Postcode	TELEPHONE NO.

ARE YOU CURRENTLY RECEIVING ANY TREATMENT/MEDICATION? NO ☐ YES ☐ ▶ PLEASE GIVE FULL DETAILS BELOW

Section 9 – declaration

I hereby declare that:

1. I am the person insured by this policy and referred to in the foregoing particulars.
2. The above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy, whether the answers have been written by me or by any other person on my behalf. (To the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.)
3. I am fully aware and agree that any false statements and particulars made by me on this form or any further declarations will result in my claim being denied. (I agree that my right to any Benefit shall be forfeited if I make any false declaration or statement in support of my claim, including any further declaration which Swann Insurance may require.)
4. I authorise any hospital, institution or medical practitioner who has treated or examined me or any person, company or firm who has employed me, or any organisation through which I have claimed compensation, to provide Swann Insurance any information it may request in respect of any trauma, illness, injury, medical history, treatment or advice received by me. A photocopy of this authority can be acted upon as if it were the original. (I authorise the Centrelink / Job Agency or any person or firm who has employed me, to furnish to Swann Insurance any information it may request in respect of my employment and unemployment.)
5. I authorise the creditor to provide Swann Insurance and/or with details of my loan for administration of this claim.
6. I agree that, by submitting this form the personal information I provide to Swann Insurance in this form or otherwise may be collected, held, used and disclosed in a manner set out in the Swann Insurance Privacy Policy found at www.swanninsurance.com.au/privacy, including for processing this claim.
7. I consent to Swann Insurance disclosing my personal information to other insurers, an insurance reference service, its service providers and/or advisers, any third party with whom I have been dealing in respect of this insurance and who referred me to Swann Insurance, Walkaway Canada Incorporated, Walkaway Australia Pty Ltd, and any other third party as permitted or required by law. I consent to Swann Insurance also disclosing my personal information to and/or collecting additional information about me, from investigators or legal advisers.

NAME OF INSURED		NAME OF WITNESS		
SIGNATURE OF INSURED		SIGNATURE OF WITNESS		DATE / /

If an issue has not been resolved to your satisfaction, you can lodge a complaint with the Australian Financial Complaints Authority, or AFCA. AFCA provides fair and independent financial services complaint resolution that is free to consumers.

Website: www.afca.org.au
Email: info@afca.org.au
Telephone: 1800 931 678 (free call)
In writing to: Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001

For more details on how Swann Insurance and AMP Life collect, store, use and disclose your personal information, please read the respective Privacy policies:
Swann Insurance: www.swanninsurance.com.au/privacy or contact 1300 307 926 for a copy of the Swann Insurance Privacy Policy.
AMP Life: www.amp.com.au/privacy.

Insurance Australia Limited ABN 11 000 016 722 AFS Licence No 227681 trading as Swann Insurance (Swann Insurance).
Locked Bag 3274 Melbourne VIC 3001 t 1300 657 382 f 1300 657 370 e swann.cci.claims@iag.com.au

Section 10 – medical certificate

IMPORTANT - This certificate must be completed by the qualified and registered Medical Practitioner treating you for your current disablement. In the event of the Medical Practitioner being unable to answer, from personal knowledge, any of the following questions, this must be stated. The Certificate is to be completed at the insured's expense and forwarded by the Medical Practitioner to Swann Insurance at the earliest opportunity.

Doctor's details

NAME OF ATTENDING DOCTOR

TELEPHONE NO.

Insured's details

NAME

DATE OF BIRTH / /

OCCUPATION

ARE YOU THE INSURED'S USUAL DOCTOR? NO ☐ YES ☐ ▶ FOR HOW LONG? YEARS: MONTHS:

STATE THE NATURE AND CAUSE OF DISABILITY

WHEN DID YOU FIRST TREAT THE INSURED FOR THIS ILLNESS OR INJURY? / /

PLEASE PROVIDE TREATMENT DETAILS

HAS THE INSURED EVER RECEIVED A MEDICAL DIAGNOSIS, TREATMENT, OPERATION OR ATTENTION FOR THIS OR SIMILAR DISABLEMENT OR RELATED CAUSE? NO ☐ YES ☐ ▶ PLEASE SUPPLY THE FOLLOWING DETAILS

DATE	NATURE OF DISABILITY	DATE	NATURE OF DISABILITY
/ /		/ /	
/ /		/ /	
/ /		/ /	

IF NOT BY YOURSELF, NAME AND ADDRESS OF DOCTOR

DO YOU SUSPECT THAT THE INSURED'S DISABLEMENT HAS RESULTED FROM OR BEEN CONTRIBUTED TO BY:

THE INFLUENCE OF INTOXICATING LIQUOR OR DRUGS? NO ☐ YES ☐

AN INTENTIONALLY SELF-INFLICTED INJURY? NO ☐ YES ☐

HAS THE INSURED BEEN TOTALLY DISABLED FROM PERFORMING:

EACH AND EVERY DUTY PERTAINING TO HIS OR HER USUAL OCCUPATION? NO ☐ YES ☐ ▶ STATE PERIOD FROM / / TO / /

ANY OTHER GAINFUL OCCUPATION NO ☐ YES ☐

IS THE INSURED CAPABLE OF PERFORMING LIGHT OR LIMITED DUTIES? NO ☐ YES ☐ ▶ STATE PERIOD FROM / / TO / /

NATURE OF DUTIES

HOURS per DAY AND DAYS per WEEK

IF TOTAL DISABLEMENT HAS CEASED, ON WHAT DATE DID YOU RELEASE THE INSURED TO PERFORM ANY REMUNERATIVE DUTIES? / /

IF TOTAL DISABLEMENT STILL EXISTS, ON WHAT DATE IS IT LIKELY TO CEASE? / /

please make sure all answers have been answered and printed clearly

SIGNATURE OF MEDICAL PRACTITIONER

DATE / /

QUALIFICATIONS

ADDRESS OF PRACTICE Postcode

TELEPHONE NO.

swann insurance
protect what you love

Third Person Authority to make and receive claims enquiries in relation to my claim

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the following authorisation and return with your completed claim form.

I , _____ (name) of

_____ (address),

freely give permission for:

Name: _____

Address: _____

Contact Ph. No.: _____

to contact and be contacted by Swann Insurance to discuss information relating to and about my disablement claim, (number _____).

I know that I may request a copy of this authorisation. I agree that a copy of this authorisation shall be as valid as the original.

I understand that this authorisation shall be valid until my claim is processed and finalised, and that I have a right to revoke this authorisation by written notification to Swann Insurance.

Signed by ……

Print name ……...

Dated ……

Witness signature ……..……..……..……..

Print name ……..……..……...

Dated ……