

Make a Life 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 LIFE CLAIM FORM

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

Please ensure:

- You (the Next of Kin/Estate) complete the first box on the front page and the first box on the back of the life claim form.
- That you (the Next of Kin/Estate) have signed and dated the Life claim form.
- The regular medical attendants statement has been completed by the deceased's treating Doctor.
- The claim estimate and certificate has been completed by the relevant financial institution.

Other useful information

It is important that all questions are correctly and fully answered by the Next of Kin /Estate. This will enable Swann Insurance to proceed with the processing of the claim; delays could occur if insufficient information is supplied.

******* A COPY OF THE DEATH CERTIFICATE MUST BE ATTACHED TO THE CLAIM FORM *******

Third Person authority to enquire

If you wish to provide authority for another person to discuss the 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.

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.

IMPORTANT NOTE

A certified copy of the complete Death Certificate must accompany this Claim Form.
On accident cases, a copy of the Coroner's Statement may be sent as Proof of Death.

details of insured person and loan agreement

NAME OF INSURED PERSON	DATE OF BIRTH	AGE AT DEATH
<input type="text"/>	<input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/>	<input type="text"/>

ADDRESS

POSTCODE

NAME OF LENDER	POLICY NO.
<input type="text"/>	<input type="text"/>

DATE OF COMMENCEMENT OF LOAN AGREEMENT	ACCOUNT NO.	DATE OF DEATH
<input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/>	<input type="text"/>	<input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/>

TYPE OF POLICY	ORIGINAL AMOUNT INSURED
<input type="text"/>	\$ <input type="text"/>

IS THERE AN UNEMPLOYMENT / DISABLEMENT CLAIM PENDING?

NO YES NAME OF INSURER

claim estimate

- NUMBER OF MONTHS EXPIRED (Determined by difference between Date of Commencement of Finance Agreement and Date of Death.)
- NUMBER OF INSURED MONTHS REMAINING (Determined by difference between Original Term of Contract and number of months expired from 1 above.)
- BALANCE AT DATE OF DEATH (Including interest)

			\$ <input type="text"/>
LESS REBATE OF UNEARNED INTEREST (If applicable)	LESS ARREARS (61 DAYS AND OVER) (If applicable)		
\$ <input type="text"/>	+	\$ <input type="text"/>	= \$ <input type="text"/>
SUB TOTAL			\$ <input type="text"/>
CALCULATED CLAIM ESTIMATE			\$ <input type="text"/>

* PLEASE ATTACH LOAN REPAYMENT HISTORY FOR MONTH OF INSURED'S DEATH

certificate

I HEREBY CERTIFY THAT THE ANSWERS ABOVE ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE AND I HAVE NOT WITHHELD ANY RELEVANT INFORMATION.

NAME OF LENDER	TELEPHONE NO.
<input type="text"/>	() <input type="text"/>

MANAGER'S SIGNATURE	DATE
<input type="text"/>	<input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/>

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

certificate of identity of deceased by next of kin

NAME OF DECEASED	DATE OF BIRTH	AGE
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text" value="YEARS"/>

ADDRESS

POSTCODE

1. STATE RELATIONSHIP TO DECEASED

2. WHAT WAS HIS/HER OCCUPATION?

3. DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/>

4. NAME OF DECEASED'S REGULAR DOCTOR?	SINCE WHEN?
<input type="text"/>	<input type="text" value="/ /"/>

DOCTOR'S ADDRESS

POSTCODE

DID THE DECEASED EVER CONSULT A SPECIALIST?

NO YES WHEN?

I believe that the deceased is the same person as the Insured under a Policy issued by Swann Insurance and, to the extent permitted by law, I authorise any hospital, institution or medical practitioner who has treated or examined the deceased to provide Swann Insurance with any medical information it may request.

I have not withheld any relevant information.

DATE	SIGNED	PLEASE PRINT NAME
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/>

ADDRESS	TELEPHONE NO.
<input type="text"/>	<input type="text" value="()"/>
POSTCODE <input type="text"/>	

regular medical attendant's statement — must be completed

ARE YOU THE DECEASED'S USUAL MEDICAL ATTENDANT?

NO YES SINCE WHEN?

CAUSE OF DEATH

DATE OF FIRST TREATMENT	ONSET OF SYMPTOMS
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>

SIGNATURE OF MEDICAL PRACTITIONER	DATE
<input type="text"/>	<input type="text" value="/ /"/>

QUALIFICATIONS	TELEPHONE NO.
<input type="text"/>	<input type="text" value="()"/>

ADDRESS OF PRACTICE

POSTCODE

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