Make a Fee Secure or Bill Protect 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 section of the life claim form.
- The regular medical attendants statement has been completed by the deceased's treating Doctor.
- That you (the Next of Kin/Estate) have signed and dated the Life claim form.
- You (the Next of Kin/Estate) have supplied a copy of the death certificate or a copy of the coroner's statement.

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 authorization 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.

swann insurance
protect what you love

LIFE 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.

IMPORTANT NOTE

This form must be completed and submitted with a copy of the Death Certificate. On accident cases, a copy of the Coroner's Statement may be sent as Proof of Death.

certificate of identity of deceased by next of kin

NAME OF DECEASED

DATE OF BIRTH / /

AGE YEARS

ADDRESS

POSTCODE

STATE RELATIONSHIP TO DECEASED

WHAT WAS HIS/HER OCCUPATION?

DATE OF DEATH / /

PLACE OF DEATH

CAUSE OF DEATH

NAME OF DECEASED'S REGULAR DOCTOR?

SINCE WHEN? / /

DOCTOR'S ADDRESS

POSTCODE

DID THE DECEASED EVER CONSULT A SPECIALIST?

NO ☐ YES ☐ WHEN?

IS THERE A DISABLEMENT CLAIM PENDING?

NO ☐ YES ☐ NAME OF INSURER

I believe that the deceased is the same person as the Insured under a Policy issued by Swann Insurance and 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

ADDRESS

POSTCODE

TELEPHONE NO. ( )

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 / /

SIGNATURE OF MEDICAL PRACTITIONER

DATE / /

ADDRESS OF PRACTICE

POSTCODE

TELEPHONE NO. ( )

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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 ……