

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 DISABLEMENT 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 insured) complete pages one (1) and two (2) of your disablement claim form.
- That you (the insured) and a witness have both signed and dated your claim form.
- Your treating Doctor completes pages three (3) and four (4) of your claim form.
- If the date you last worked or the date your injury or illness first occurred is 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 current medical certificate(s) from your Doctor in order for us to maintain continuous payments to your financier. Your medical certificate(s) can be for a maximum period of three (3) months from the date noted on the certificate(s) and must state your exact disability.

****PLEASE NOTE, MEDICAL CERTIFICATES THAT STATE "MEDICAL CONDITION" ARE NOT ACCEPTABLE****

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.

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 there is insufficient space, please write on a separate sheet and attach to this form.

your personal details

TITLE (e.g. MR/MRS)	SURNAME	GIVEN NAMES	DATE OF BIRTH
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

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

EMAIL

OCCUPATION AT TIME OF DISABILITY	YOUR USUAL OCCUPATION
<input type="text"/>	<input type="text"/>

CURRENT EMPLOYER (OR PREVIOUS EMPLOYER)	DATE EMPLOYED
<input type="text"/>	FROM <input type="text"/> / <input type="text"/> / <input type="text"/> TO <input type="text"/> / <input type="text"/> / <input type="text"/>

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

ARE YOU CLAIMING WORKERS' COMPENSATION?	CLAIM NO.
NO <input type="checkbox"/> YES <input type="checkbox"/> STATE INSURER <input type="checkbox"/>	<input type="text"/>

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

ARE YOU IN RECEIPT OF BENEFITS FROM CENTRELINK?	TYPE OF BENEFIT
NO <input type="checkbox"/> YES <input type="checkbox"/>	<input type="text"/>

NAME AND DATE OF BIRTH OF ANY OTHER PERSON LISTED ON POLICY

your disability details

DATE ON WHICH THE ILLNESS OR INJURY FIRST OCCURRED	TIME	YOUR LAST WORKING DAY
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> AM/PM <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

DESCRIBE THE CIRCUMSTANCES LEADING TO YOUR CURRENT DISABILITY

WHO IS YOUR USUAL DOCTOR?	FOR HOW LONG?
<input type="text"/>	YEARS <input type="text"/> MONTHS <input type="text"/>

YOUR DOCTOR'S ADDRESS	TELEPHONE NO.
<input type="text"/> POSTCODE <input type="text"/>	<input type="text"/> (<input type="text"/>) <input type="text"/>

DOCTOR AT POLICY COMMENCEMENT DATE	ADDRESS
<input type="text"/>	<input type="text"/> POSTCODE <input type="text"/>

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

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

ADDRESS	POSTCODE
<input type="text"/>	<input type="text"/>

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

ADDRESS	POSTCODE
<input type="text"/>	<input type="text"/>

WAS INJURY CAUSED BY MOTOR VEHICLE ACCIDENT? NO YES POLICE ATTENDED? NO YES

WHEN DID YOU RESUME WORK DUTIES? / / OR WHEN DO YOU EXPECT TO BE FIT FOR SOME WORK DUTIES? / /

your medical history

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

NO

YES

NAME OF DOCTOR

DATE OF CONSULTATION (1)

DATE OF CONSULTATION (2)

ADDRESS

TELEPHONE NO.

POSTCODE

REASON FOR CONSULT

PERIOD OF DISABILITY

FROM

TO

2. HAVE YOU PREVIOUSLY SUFFERED ANY OTHER MAJOR ILLNESS/INJURY UNRELATED TO THIS DISABILITY?

NO

YES

PLEASE PROVIDE DETAILS OF COMPLAINT

DATE OF OCCURRENCE

PERIOD OF DISABILITY (YRS/MTHS/DAYS)

YEARS

MONTHS

DAYS

3. DO YOU TAKE REGULAR MEDICATION FOR ANY ILLNESS OR INJURY?

NO

YES

PLEASE PROVIDE DETAILS OF MEDICATION AND CONDITION

claims history

HAVE YOU EVER SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY OR ILLNESS?

NO

YES

PLEASE PROVIDE DETAILS (INCLUDING REFERENCE NUMBER)

NAME OF COMPANY

TELEPHONE NO.

DATE

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.
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.
4. I authorise any hospital, institution or medical practitioner who has treated or examined me or any person or firm who has employed me, or any firm through which I have claimed compensation to provide Swann Insurance or their agents 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.
5. I/we agree that, by submitting this form the personal information I/we 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.
6. I understand that I may contact Swann Insurance if I wish to update or access my personal information.

SIGNATURE OF INSURED

SIGNATURE OF WITNESS

DATE

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 there is insufficient space, please write on a separate sheet and attach to this form.

IMPORTANT NOTE

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 insureds 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 NAME

DATE OF BIRTH

INSURED'S OCCUPATION

ARE YOU THE INSURED'S USUAL DOCTOR?

NO YES
 FOR HOW LONG YEARS MONTHS

STATE NATURE AND CAUSE OF DISABLEMENT

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

PLEASE PROVIDE DETAILS OF TREATMENT

PLEASE PROVIDE DETAILS OF ANY MEDICATION

ARE THERE ANY MEDICAL CONDITIONS WHICH HAVE A BEARING ON THIS CURRENT DISABLEMENT?

NO YES PLEASE PROVIDE 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 (provide on a separate page if insufficient space)

DATE	NATURE OF DISABILITY	DATE	NATURE OF DISABILITY
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>

IF NOT BY YOURSELF, NAME AND ADDRESS OF DOCTOR

WHAT IS YOUR PROGNOSIS?

PLEASE PROVIDE DETAILS OF OPERATION(S) IF ANY, AND DATE(S)

Empty text box for operation details and dates.

HAVE YOU ANY REASON TO:

SUSPECT THAT THE INSURED'S DISABLEMENT HAS RESULTED FROM OR BEEN CONTRIBUTED TO BY THE INFLUENCE OF INTOXICATING LIQUOR OR DRUGS?

NO YES

TEST FOR HUMAN IMMUNODEFICIENCY VIRUS?

NO YES PLEASE PROVIDE RESULTS, INCLUDING TEST RESULTS

SUSPECT THAT THE INSURED'S DISABLEMENT HAS RESULTED FROM OR BEEN CONTRIBUTED TO BY AN INTENTIONALLY SELF-INFLICTED INJURY?

NO YES

HAS THE INSURED BEEN HOSPITALISED? NO YES NUMBER OF DAYS

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

Empty text box for nature of duties.

HOURS/DAY AND DAYS/WEEK

Empty text box for hours/day and days/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

Empty text box for signature.

DATE

/ /

QUALIFICATIONS

Empty text box for qualifications.

ADDRESS OF PRACTICE

Empty text box for address of practice.

POSTCODE

TELEPHONE NO.

()

FACSIMILE NO.

()

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

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