# Make an AXA Terminal Illness 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 TERMINAL ILLNESS 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 parts A and B of your terminal illness claim form.
- Your treating Doctor completes part C of your claim form.
- That you (the insured) have signed and dated your claim form.
- That you (the insured) have completed the Authorities form.

**Other useful information**

**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.

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# Terminal Illness Claim

## Statement of Claim – Terminal Illness Benefit

**Please complete Parts A and B then return to:**

**Swann Insurance, Locked Bag 3274, Melbourne, VIC 3001**

**Privacy – Use of disclosure of personal information**

The privacy of your personal information is important to you and also to AMP Life and Swann Insurance (We). The purpose of collecting your information is to assess your claim. If the information you give us is not complete or accurate, we may not be able to provide you with the full benefits of your policy.

In assessing and managing your claim, We may need to disclose your personal information to other parties, such as claim assessors, loss assessors, re-insurers, medical and financial professionals, judicial or dispute resolution bodies, government authorities and AXA Group companies.

You are entitled to request reasonable access to information We have about you. We reserve the right to charge an administration fee for collating the information you request.

For more details on how We collect, store, use and disclose your personal information, please read our 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.

## Part A – To be completed by policy owner

**1** Policy Number

**2** Policy owner name

**3** I wish to formally request consideration for a Terminal Illness Benefit. ☐ Yes ☐ No

**4** Value of the policy or $

Signature: Date / /

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## Part B – To be completed by insured or representative

**1** Title | Surname | Given name(s) | Maiden name

**2** Private address

Street number and name | Town/Suburb | State | Postcode

Home phone ( ) | Work phone ( ) | Mobile

Occupation | Date of birth

**3** State the exact nature of your illness

**4** When did you first attend a doctor or hospital for this Illness?

Date

Name of doctor or hospital

Address of doctor or hospital

**5** Give the name and address of your usual general medical practitioner if different from above.

Name of doctor

Address

**6** State names and addresses of all specialist(s) you are currently attending for this illness

Specialist's name

Address

Specialist's name

Address

Specialist's name

Address

Specialist's name

Address

**7** Have you attended any medical practitioner during the last five years for any other reason? ☐ Yes ☐ No

If 'Yes', then give the dates, names and addresses of all such medical practitioners attended during the last five years and the reasons for the consultations

| Date | Name and address of doctor | Reason |
|---|---|---|
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**8** Have you made or do you intend to make, any other claim against AMP Life in respect of this illness or any other illness or injury?

☐ Yes ☐ No

If 'Yes', then give details and dates of claim.

| Date | Type of claim. | Policy Number |
|---|---|---|
| / / | | |
| / / | | |
| / / | | |

I have read and understood the Privacy Disclosure Statement contained in the section headed "Privacy - Use and disclosure of personal information". I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement

| Signature | Date |
|---|---|
| | / / |

## Terminal Illness Benefit Medical Certificate

## Part C – To be completed by the current treating doctor.

Your patient is applying for a Terminal Illness benefit which involves an early payment from a life insurance policy to help with immediate financial needs.

**In the interests of your patient it would be appreciated if you would treat this matter as urgent.**

**Upon completion please send this form direct to:**

**Swann Insurance, Locked Bag 3274, Melbourne VIC 3001**

**Please note that AMP Life or Swann Insurance are not responsible for any fee for the completion of this form.**

**1** Name of Patient

Title | Surname | Given name(s) | Date of Birth

**2** Address

Street number and name | Town/Suburb | State | Postcode

**3** Diagnosis

Date of diagnosis

What is the current status of the disease?

What treatment has been employed to date?

What treatment is planned for the future?

How long do you expect your patient to live? _____ months

Please advise of any other illnesses suffered by the patient in the last five years (if necessary please attach a separate sheet)

| Date | Disease | Duration (if known) | Name of Medical Attendant (if known) |
|---|---|---|---|
| / / | | | |
| / / | | | |
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| / / | | | |
| / / | | | |
| / / | | | |

Other comments

Signature

Date: / /

Name (block capitals)

Qualifications

Provider number

Address

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# Authorities

## Medical authority

I hereby authorise Medicare or any doctor, hospital, dentist or other person who has attended me, to release to AMP Life or Swann Insurance, all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Name

Member's signature

X

Date

/ /

## Accountant authority

I hereby authorise my accountant/financial adviser to release to Swann Insurance or its representatives, all information which AMP Life requests for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Name

Insured's signature

X

Date

/ /

## Authority to release information

I (Name) Born on the day of 19

Residingat

Postcode In the state of

(Name of work comp/work care/disability insurer)

Hereby authorise and direct

Claim number:

(Postal address of work comp/work care/disability insurer)

Of

**To release:**

To AMP Life or Swann Insurance, any medical or other information to which I would be entitled under the freedom of information act, any other acts of parliament and under general law, in relation to any claims I have made to the insurer; and to me a complete copy of all the medical information you have released to AMP Life or Swann Insurance. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

This request is made to enable AMP Life to fully assess a claim made by me in relation to Total and Permanent Disablement Cover under the

Policy number:

Dated on this day of Year

Insured's signature

X

Date

/ /

Please return completed form to:

**Swann Insurance**
**Locked Bag 3274**
**Melbourne, VIC 3001**
**Fax: 1300 657 370**



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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 ……