Make an AXA 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.

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Life Claim

Statement of Claim – Life 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 representative of estate

1 Policy Number

2 Policy owner name

3 I wish to formally request consideration for a Life Benefit. ☐ Yes ☐ No

4 Value of the policy or $

Signature: Date / /

G2443 PRN_L596

Part B – To be completed by representative of estate

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 cause of death

4 When did the deceased first attend a doctor or hospital for this illness? (If applicable)

Date

Name of doctor or hospital

Address of doctor or hospital

5 Give the name and address of the deceased's usual general medical practitioner if different from above.

Name of doctor

Address

6 State names and addresses of all specialist(s) the deceased attended for this illness

Specialist's name

Address

Specialist's name

Address

Specialist's name

Address

Specialist's name

Address

7 Did the deceased attend 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 Has the deceased made, any other claim 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
	/ /

I believe that the Deceased is the same person as the Life 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.

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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 r 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 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 ……