Make a Trauma 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 TRAUMA 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 trauma claim form.
- That you (the insured) and a witness have both signed and dated your claim 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.

swann insurance
protect what you love

TRAUMA CLAIM FORM

Insurer: Swann Insurance, a trading name of Insurance Australia Limited (IAL) ABN 11 000 016 722 AFS Licence No 227681 trading as Swann Insurance (Swann).
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.

your personal details

TITLE (e.g. MR/MRS) | GIVEN NAMES | SURNAME | DATE OF BIRTH (/ /)

ADDRESS | POSTCODE | TELEPHONE NO. ( )

EMAIL

YOUR USUAL OCCUPATION | CURRENT EMPLOYER (OR PREVIOUS EMPLOYER) | DATE EMPLOYED FROM (/ /) | DATE EMPLOYED TO (/ /)

ADDRESS | POSTCODE | TELEPHONE NO. ( )

EMPLOYER AT POLICY COMMENCEMENT DATE | ADDRESS | POSTCODE

TELEPHONE NO. ( )

ARE YOU CLAIMING WORKERS' COMPENSATION?
NO ☐ YES ☐ ▶ STATE INSURER

tell us about your trauma

WHAT ARE YOU CLAIMING FOR? – Please ✓ tick where applicable

HEART ATTACK ☐ CORONARY ARTERY SURGERY ☐ STROKE ☐ CANCER ☐

WHEN DID YOU FIRST BECOME AWARE OF YOUR CONDITION AND WHAT IS THE NATURE OF YOUR SYMPTOMS?

WHEN DID YOU FIRST ATTEND A DOCTOR OR HOSPITAL FOR YOUR TRAUMA? (/ /)

NAME OF DOCTOR OR HOSPITAL

ADDRESS OF DOCTOR OR HOSPITAL | POSTCODE

your medical history

WHO IS YOUR USUAL DOCTOR?

FOR HOW LONG? YEARS MONTHS

YOUR DOCTOR'S ADDRESS | POSTCODE | TELEPHONE NO. ( )

PLEASE STATE THE NAMES OF ALL DOCTORS AND HOSPITAL CONSULTED FOR THIS CURRENT CONDITION

NAME | TELEPHONE NO. ( )

ADDRESS | POSTCODE

NAME | TELEPHONE NO. ( )

ADDRESS | POSTCODE

NAME | TELEPHONE NO. ( )

ADDRESS | POSTCODE

your medical history (continued)

PLEASE STATE THE DATES AND REASONS FOR ANY CONSULTATIONS WITH YOUR USUAL MEDICAL PRACTITIONER DURING THE LAST 5 YEARS

Date	Reason for consult
/ /	
/ /	
/ /	
/ /	

IF YOU HAVE ATTENDED ANY OTHER DOCTOR OR HOSPITAL DURING THE LAST 5 YEARS, PLEASE LIST DETAILS BELOW

Name of doctor or hospital	Date	Reason for consult
	/ /	
	/ /	
	/ /	
	/ /	

HAVE YOU TAKEN ANY DRUGS OR MEDICATIONS IN THE LAST 5 YEARS? NO ☐ YES ☐ ▶ WHAT TYPE OF DRUGS OR MEDICATIONS?

ARE YOU CURRENTLY RECEIVING ANY TREATMENT/MEDICATION? NO ☐ YES ☐ ▶ PLEASE GIVE FULL DETAILS

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 and/or AMP Life Limited (AMP Life) 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 authorise the creditor to provide Swann and/or AMP Life Limited (AMP Life) with details of my loan for administration of this claim.
6. I/we agree that, by submitting this form the personal information I/we provide to Swann in this form or otherwise may be collected, held, used and disclosed in a manner set out in the Swann Privacy Policy found at www.swanninsurance.com.au/privacy, including for processing this claim.

SIGNATURE OF INSURED	SIGNATURE OF WITNESS	DATE
		/ /

Swann Insurance is a member of the insurance industry's Financial Ombudsman Service Australia (Service). This independent Service is provided to the public at no cost and aims to resolve complaints quickly and informally. However, you should bring your complaint to us first as in most cases, the complaint can be resolved easily. If you are dissatisfied with the outcome of our review, you may then contact the Service for advice and assistance in resolving your complaint.

FINANCIAL OMBUDSMAN SERVICE LIMITED TOLL FREE TELEPHONE NUMBER: 1300 367 287.

For more details on how Swann and AMP Life collect, store, use and disclose your personal information, please read the respective Privacy policies:
Swann Insurance: www.swanninsurance.com.au/privacy or contact 1300 307 926 for a copy of Swann's Privacy Policy.
AMP Life: www.amp.com.au/privacy.

swann insurance
protect what you love

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 (Aust) Pty Ltd 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 ……

SWANN INSURANCE

CORONARY ARTERY BYPASS GRAFT SURGERY MEDICAL CERTIFICATE

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 certificate must be completed by the qualified and registered Medical Practitioner treating you for your current condition. In the event of the medical practitioner being unable to answer, from personal knowledge, any of the following questions, this must be stated.

This Certificate is to be completed at the insured's 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

PLEASE CONFIRM IF YOUR PATIENT HAS UNDERGONE CORONARY ARTERY BYPASS SURGERY.

YES ☐ NO ☐

IF YES, WAS THE SURGERY PERFORMED VIA THORACOTOMY? YES ☐ NO ☐

PLEASE CONFIRM THE DATE THIS PROCEDURE OCCURRED.

PLEASE COMMENT ON AND PROVIDE DETAILS OF ANY ILLNESS, INJURY OR CONDITION THAT HAS CAUSED THIS EVENT. (PLEASE INCLUDE DETAILS OF DIAGNOSIS, TREATMENT AND MEDICATION, INCLUDING DATES PRESCRIBED).

SWANN INSURANCE

CORONARY ARTERY BYPASS GRAFT SURGERY MEDICAL CERTIFICATE

PLEASE MAKE SURE ALL ANSWERS HAVE BEEN ANSWERED AND PRINTED CORRECTLY AND INCLUDE COPY HOSPITAL LETTERS RELATING TO THE CLAIMED CONDITION

SIGNATURE OF MEDICAL PRACTITIONER

DATE

QUALIFICATIONS

ADDRESS OF PRACTICE

POSTCODE

TELEPHONE NO

( )

FACSIMILE NO

( )