MAKE A LIFE CLAIM

THANK YOU FOR CONTACTING CGU 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 1800 248 224 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 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 CGU 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 your claim on your behalf, please complete the attached authorisation and return with your completed claim form.

FAX 1800 032 535
EMAIL cciclaims@cgu.com.au
POST GPO Box 2177 Melbourne VIC 3001

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E cciclaims@cgu.com.au

CGU SEE IT THROUGH.

Insurer
Insurance Australia Limited
ABN 11 000 016 722 AFSL 227681
trading as CGU Insurance.

backed by iag

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LIFE CLAIM

STATEMENT OF CLAIM – LIFE BENEFIT

Insurance Australia Limited ABN 11 000 016 722 trading as CGU Insurance

Please complete Parts A and B then return to: CGU Insurance GPO Box 2177, 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 Limited and CGU. 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 AMP 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.

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 Terminal Illness Benefit

Yes ☐ No ☐

4. Value of the policy or $

Signature

Date D D / M M / Y Y

CCI0066 REV2 08/17

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Part B – To be completed by representative of estate

1. Title Surname

Given Name(s) Maiden name

2. Address

Postcode

Home phone number Work phone number Mobile

Occupation Date of birth D D / M M / Y Y

3. State the exact cause of death

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

Date D D / M M / Y Y

Name of doctor or hospital

Address of doctor or hospital

Postcode

5. When did the deceased first attend a doctor or hospital for this illness? (if applicable)

Name of doctor

Address

Postcode

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

Specialist's name

Address

Postcode

Specialist's name

Address

Postcode

Specialist's name

Address

Postcode

7. Did the deceased attend any medical practitioner during the last five years for any other reason?

No ☐ Yes ☐ 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
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		

8. Has the deceased made, any other claim in respect of this illness or any other illness or injury?

No ☐ Yes ☐ If 'Yes', then give details and dates of claim.

Date	Type of claim	Policy number
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		

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 D D / M M / Y Y

I believe that the Deceased is the same person as the Life Insured under a Policy issued by CGU and I authorise any hospital,institution or medical practitioner who has treated or examined the deceased to provide CGU with any medical information it may request.

I have not withheld any relevant information.

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AUTHORITIES

Insurance Australia Limited ABN 11 000 016 722 trading as CGU Insurance

Medical authority

I hereby authorise Medicare or any doctor, hospital, dentist or other person who has attended me, to release to CGU or its representatives, 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

Date D D / M M / Y Y

Accountant authority

I hereby authorise my accountant/financial adviser to release to CGU or its representatives, all information which is requested 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

Date D D / M M / Y Y

Authority to release information

I Born on the day of 1 9

Residing at

Postcode

Hereby authorise and direct (Name of work comp/work care/disability insurer)

Claim number:

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

Postcode

To release:

To CGU or its representatives, 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 CGU or its representatives. 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 CGU to fully assess a claim made in relation to Life Cover under the

Policy number:

Dated on this **day of** **Year**

Authorised representative

Date D D / M M / Y Y

Please return completed form to: CGU Insurance, GPO Box 2177, Melbourne, VIC 3001

THIRD PERSON AUTHORITY TO MAKE AND RECEIVE CLAIMS ENQUIRIES IN RELATION TO MY CLAIM

If you (the Next of Kin/Estate) wish to provide authority for another person to discuss this claim on your behalf, please complete the following authorisation and return with the completed claim form.

I, _____ (name)

of _____ (address),

freely give permission for:

Name: _____

Address: _____

Contact Ph. No: _____

to contact and be contacted by CGU Insurance to discuss information relating to and about this claim.

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 CGU Insurance.

Signed by _____

Print name _____ Dated _____

Witness signature _____

Print name _____ Dated _____

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