MAKE A TRAUMA 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 (1800 CGU CCI) and one 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 the claim.

Please ensure:

- you (the insured) complete pages one (1), two (2) and three (3) 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 CGU 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 1800 032 535
EMAIL cciclaims@cgu.com.au
POST GPO Box 2177 Melbourne VIC 3001

CCI0054 REV6 07/19

GPO BOX 2177 Melbourne VIC 3001
T 1800 CGU CCI (1800 248 224)
F 1800 032 535
E cciclaims@cgu.com.au

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

TRAUMA CLAIM FORM

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

Your personal details

Title | Name of Insured Person | Date of birth (D D / M M / Y Y)

Address | Postcode

Telephone number | Email

Your usual occupation | Current employer (or previous employer)

Date employed from (D D / M M / Y Y) | Date employed to (D D / M M / Y Y) | Telephone number

Address | Postcode

Employer at Policy commencement date | Telephone number

Address | Postcode

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? (D D / M M / Y Y) | Name of doctor or hospital

Address of doctor or hospital | Postcode

Your medical history

Who is your casual doctor? | For how long? Years Months

Your doctor's address | Postcode

Please state the dates and reasons for any consultations with your usual medical practitioner during the last 5 years

Date	Reason for consult
D D / M M / Y Y	
D D / M M / Y Y	
D D / M M / Y Y	

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
	D D / M M / Y Y	
	D D / M M / Y Y	
	D D / M M / Y Y	

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 CGU Insurance and/or AMP Life Limited 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 CGU Insurance and/or AMP Life Limited 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 CGU Insurance and/or AMP Life Limited in this form or otherwise may be collected, held, used and disclosed in the manner set out in the CGU Privacy Policy found at www.cgu.com.au/privacy, including for processing this claim.

Signature of insured	Print name	Date
		D D / M M / Y Y

Signature of witness	Print name	Date
		D D / M M / Y Y

CGU Insurance is a member of the insurance industry's independent Australian Financial Complaints Authority (AFCA). This Service is provided to the public at no cost and aims to resolve claims complaints quickly and informally if CGU Insurance is unable to resolve your complaint. You should first take your complaint up with CGU. In most cases, the problem will be resolved easily. If you are not satisfied with the outcome you may contact the Australian Financial Complaints Authority in your state for advice and assistance in resolving your claim.

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 CGU Insurance to discuss information relating to and about my Trauma 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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Insurer
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trading as CGU Insurance

STROKE MEDICAL CERTIFICATE

Insurance Australia Limited ABN 11 000 016 722 trading as CGU 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 CGU Insurance at the earliest opportunity.

Doctor's details

Name of attending doctor

Telephone number

Insured's name

Date of birth D D / M M / Y Y

Insured's occupation

Are you the insured's usual doctor

No ☐ Yes ☐ For how long? Years Months

Please confirm your patient's specific diagnosis

What was the date of diagnosis?

D D / M M / Y Y

Please confirm if the diagnosis has resulted in infarction of brain tissue, with associated deficits. Please provide full details.

Has the infarction of brain tissue been caused by violent, accidental, external or visible means?

No ☐ Yes ☐ If yes, please provide further details.

Is there any evidence of permanent functional impairment? Please elaborate.

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).

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

Print name

Date D D / M M / Y Y

Qualifications

Address of practice

Postcode

Telephone number

Facsimile number

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