MAKE A TERMINAL ILLNESS 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 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 CGU 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

CGU SEE IT THROUGH.

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

backed by iag

CGU SEE IT THROUGH.

TERMINAL ILLNESS CLAIM

STATEMENT OF CLAIM – TERMINAL ILLNESS BENEFIT

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 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.

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

D D / M M / Y Y

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 D D / M M / Y Y

3. State the exact nature of your illness

4. When did you first attend a doctor or hospital for this illness? Date D D / M M / Y Y

Name of doctor or hospital

Address of doctor or hospital Postcode

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

Name of doctor

Address Postcode

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

Specialist's name

Address Postcode

Specialist's name

Address Postcode

Specialist's name

Address Postcode

7. Did you 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. Have you made or do you intend to make, any other claim against CGU 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

CGU SEE IT THROUGH.

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

backed by iag

CGU SEE IT THROUGH.

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 interest of your patient it would be appreciated if you would treat this matter as urgent.

Upon completion please send this form direct to:

CGU GPO Box 2177, Melbourne, VIC 3001

Please note that AMP Life Limited or CGU are not responsible for any fee for the completion of this form.

1. Name of Patient

Title | Surname | Given name(s) | Date of birth D D / M M / Y Y

2. Address

Street number and name

Town/Suburb | State | Postcode

3. Diagnosis

Date of diagnosis D D / M M / Y Y

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)
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			
D D / M M / Y Y			

Other comments

Signature

Date

D D / M M / Y Y

Name (block capitals)

Qualifications

Provider number

Address

Postcode

CGU SEE IT THROUGH.

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

backed by iag

CGU SEE IT THROUGH.

AUTHORITIES

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 in the state of

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 Terminal Illness Cover under the

Policy number:

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

Authorised representative signature

Date D D / M M / Y Y

Please return completed form to: CGU Insurance, GPO Box 2177, Melbourne, VIC 3001 Fax: 1800 032 535

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

If you 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 phone no: _____

to contact and be contacted by CGU Insurance to discuss information relating to and about this disablement 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 the 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** _____

CGU SEE IT THROUGH.

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

backed by iag

CCI0067 REV2 08/17