St Andrew's
AUSTRALIA

LIFE
CLAIM FORM

Please complete this claim form and return to:

The Claims Department
St Andrew's Australia
PO Box 7395
Cloisters Square 6850

IMPORTANT INFORMATION

1. The issue of this claim form is not an admission of liability
2. It is a condition of your policy that you provide a fully completed claim form as quickly as possible (within 120 days of the claim commencement date). A delay in submitting this form may prejudice your entitlement to a claim.
3. Please ensure that all questions are fully answered to avoid any delay in the handling of your claim.
4. If you do not complete all relevant sections of your claim form we may have to return it to you to be fully completed and your claim may be delayed.
5. It may be necessary during the period of your claim for a company representative to call you.
6. It is important that you notify us of any change in circumstances during your claim at the earliest opportunity.
7. If there is not enough room within the form to provide your responses please attach any documentation/word document that will aid us in assessing your claim.

A certified copy of the birth certificate and death certificate must be provided.
If you have any queries regarding your claim you can contact St Andrew's on
Ph: 1300 653 751 or fax 1300 552 695 or email: claims@standrews.com.au.

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LIFE CLAIM FORM

(to be completed by the person making the claim on behalf of the deceased)

Details of Life Insured

1. Claim Number(s)
2. Date of Birth (dd/mm/yy): / /
3. Surname:
4. First Names:
5. Residential Address:

   Suburb/Town:
6. Date of Death (dd/mm/yy): / /
7. Cause of Death:
8. Did the deceased leave a valid Will? ☐ Yes ☐ No
9. Is there any intention to apply for Probate or Letters of Administration? ☐ Yes ☐ No
10. If there is a will, who is the Executor of the will?

    ☐ Solicitor ☐ Public Trustee ☐ Trustee company ☐ Other
11. Please provide the following details for the Executor of the will:

    Name of organisation

    Contact person's name:

    Address:

    Suburb / Town: Postcode

    Daytime phone number:

    Mobile Number:

    Email address:
12. Details of person lodging the claim - Please provide the following details:

    Name:

    Relationship to deceased:

    Address:

    Suburb / Town:

    Phone number:

    Email address:
13. Doctors Details - Please provide the following details of the deceased's General Practitioner:

    Name of deceased GP:

    Name of clinic:

    Address:

    Suburb / Town:

    Phone number:

    Email address:

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Representative Consent and Declaration

I (please print name) _____

of (address) _____

herby declare that I am over 18 years of age and that I am the may be legally entitled to claim the proceeds of the said policy being the * _____ of the deceased.

* insert relationship to insured – eg father, husband, wife, brother.

I declare that the information contained in this statement is true, complete and correct in every detail. I acknowledge my responsibility for the completeness and accuracy of the information, whether the answers have been written, entered or provided by myself or by any person on my behalf. I understand and agree that if I make any false or fraudulent statements or fail to advise St Andrews of any relevant information regarding the claim, St Andrew's may be unable to assess the claim and may proceed to cancel the claim.

I agree copies of this consent and declaration have the validity of the original.

Signature of Representative ✗ Date (dd/mm/yy) / /

Name of Representative

Authority

I (insert the name of the representative) _____ on behalf of the deceased (insert name of deceased) _____ authorise any doctor, hospital, dentist, allied health professional insurer, other persons whom the deceased has consulted or attended to and other insurance companies to release to:

- St Andrews, and/or
- Its Authorised representative;

all information with respect to any illness, accident or injury, medical consultation, prescriptions or treatment and copies of all hospital records or medical records, reports or notes.

I agree that a photocopy or a scanned, electronic copy of this authorisation shall be as effective and valid as the original.

Signature of Representative ✗ Date (dd/mm/yy) / /

Name of Representative

Privacy Policy Statement

We collect your personal information so that we can process your claim, identify you for inquiries you may have, and tell you about our products and services. With respect to your claim, we will need to collect sensitive information related to your health.

By providing your information, you consent to us:

1. collecting, using and disclosing your information in accordance with our Privacy Policy; and
2. disclosing your information to third parties (such as insurers, medical professionals and ex-employers) in relation to your claim.

Our Privacy Policy can be found at www.standrews.com.au, and describes how we deal with your personal information. Please refer to our Privacy Policy for how you can access and correct your information, and for our complaints procedure.

You may contact our Privacy Officer on 1300 363 159 or standrews@standrews.com.au during normal business hours (and to opt-out of marketing). If you provide us with personal information about someone else, please ensure you have their consent to do so.