St Andrew's
AUSTRALIA

TERMINAL ILLNESS CLAIM FORM

Please complete this claim form and return to:

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

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.

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.

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TERMINAL ILLNESS CLAIM FORM

Insured to complete

Details of Insured

1. Claim Number
2. Date of Birth (dd/mm/yy): / /
3. Surname:
4. First Names:
5. Residential Address:
   Suburb/Town:
6. Phone: Home: Mobile:
7. Email:

Personal History

8. What is the medical diagnosis:
9. When did you first become aware of this condition: ..... / /
10. Date of Diagnosis
11. When did you first seek medical treatment for this condition? ..... / /
12. Name and Address of Treating General Practitioner
13. Name and Address of Specialists consulted
14. Have you made a claim for this condition from any other insurance company? ..... Yes ☐ No ☐
    If yes, please provide details – name of insurance company, date of claim, benefit amount

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Authority

I authorise any doctor, hospital, dentist, allied health professional insurer, other person whom I have consulted or has attended to me 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 authorisiation shall be as effective and valid as the original.

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

Name of Insured

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.

Declaration

I declare that the information contained in this statement is true, complete and correct in every detail. I understand that if I do not give full particulars or if I provide incorrect information , my rights to obtain benefits under the policy may be prejudiced.

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

Name of Insured

Checklist – Please ensure all the relevant sections are attached.
Treating Doctor's Section completed and attached

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TERMINAL ILLNESS CLAIM FORM

DOCTOR'S SECTION – insured to pass to Doctor and return

- All questions must be completed by a medical practitioner.
- Any costs associated with the completion of this form are to be met by the patient.
- Please complete and return to the patient.
- A copy of this statement and any other report you provide may be passed to other parties reasonably deemed necessary for the assessment of the patient's claim.

Patient's Name:

Date of birth (dd/mm/yy): / /

Residential Address:

Suburb/Town: State: Postcode:

1. How long have you been treating this patient?

2. Primary Diagnosis:

3. Date of Diagnosis

4. Secondary Diagnosis if (if applicable)

5. Date your patient ceased work due to the diagnosis? ..... / /

6. Please state the objective findings which support your diagnosis

7. Is the patient terminally ill?, this meaning less than 12 months to live?

8. Please list and describe the current symptoms and severity

9. Has the patient been reviewed/assessed by the appropriate specialist? If yes, please provide details of the outcome, details of specialist.

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Additional Details/Comments

Declaration

I certify I have personally attended the above patient and that all the information supplied by me on this patient is true and correct to the best of my knowledge and belief.

Signature of Doctor	✗	Date (dd/mm/yy)	/ /
Doctor Name			
Qualifications			
Surgery Address			
Suburb/Town		State:	Postcode:
Phone		Fax:	
Email Address			