CLAIM FORM

Children's Cover - Child Trauma benefit

Privacy Statement

This Privacy Policy Statement explains how St Andrew's Australia Services Pty Ltd ABN 75 097 464 616 (St Andrew's) and its wholly owned subsidiaries and related entities Hallmark Life Insurance Company Ltd ABN 87 008 446 884 and Hallmark General Insurance Company Ltd ABN 82 008 477 647 (collectively referred to as Hallmark Insurance, we or our) collect, store, use and disclose personal information.

We collect personal information so that we can process and administer this claim. Without your information we will not be able to process and administer this claim.

If you provide us with personal information about someone else, you should ensure that you are authorised to do so and agree to inform that person of the contents of this notice.

We exchange your personal information with organisations in the normal operation of our business, for example, with our related companies and agents, coinsurers, reinsurers and with service providers (such as professional advisors, IT support and mailing houses). In relation to your claim, your information may also be exchanged with other parties including ex-employers, government agencies, financiers, insurers, underwriters, claims investigators, other insurance companies, lawyers, recovery agents, hospitals, doctors, medical specialists or other health professionals. We do not send your personal information offshore.

By providing this information you consent to us collecting, using and disclosing information about you in the manner described above.

You also specifically consent to Hallmark Insurance being provided with medical information, including copies of any medical reports, clinical reports or others, from any Doctor who at any time has attended to you or the insured.

The St Andrew's Privacy Policy contains information about how you can have access to your personal information and seek the correction of your personal information, and how you can complain about a breach of the privacy laws that bind us and how your complaint will be handled.

The St Andrew's Privacy Policy is available at www.standrews.com.au. If you have any query in relation to your privacy please contact St Andrew's at customerservice@hallmarkinsurance.com.au or PO Box 7395, Cloisters Square WA 6850

Completion instructions

Step 1: As the Policy Owner, you should first check your most recent policy schedule to make sure that the Children's Cover is in place and current for the injured Insured Child. Then complete **Section 1: Parts A to D**. Note that once the claim is approved, the claim payment will be made to you.

Step 2: The Policy Owner must then complete **Section 2: Parts E to J** on behalf of the Insured Child who has suffered the Child Trauma event. Our assessment is based on the details provided here and the details provided by the Life Insured's Medical Practitioners.

Step 3: Once Sections 1 and 2 have been **fully completed**, please forward this form to the Medical Practitioner who is predominantly attending to the injured Insured Child, to complete **Section 3: Parts K and L**. Once the Medical Practitioner has completed Section 3 the claimant must send the completed claim form back to Let's Insure.

Please return the completed form to Let's Insure. You can either:

1. **Scan & email to claims@letsinsure.com.au (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); or**
2. **Mail to Claims Department, Let's Insure, PO Box 7395, Cloisters Square WA 6850 (please mark the envelope as CONFIDENTIAL).**

Section 1: Policy Owner's details

Part A: Policy Owner's details

Policy Owner:		Policy number:	
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

Please indicate your preferred method of communication with an asterisk (*)

Part B: Policy Owner's authorisation to share information about this claim (optional)

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	

Policy Owner's signature: Date: / /

Part C: Policy Owner's payment authority

Once the claim has been accepted the benefit will be credited to the account below.

Name of bank:	Name of account holder:
BSB number: –	Account number:

Part D: Policy Owner's Declaration

I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim. I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Hallmark Insurance requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner's signature: Date: / /

Section 2: Insured Child's details

Part E: Insured Child's details

Title:	First name:	Surname:
Date of birth:		/ /

Part F: Policy Owner/Insured Child's Trauma claim

Medical details of the Insured Child.

1.	Has the condition occurred resulted in any of the following conditions? (Please tick one)			
	☐ Bacterial Meningitis	☐ Cancer	☐ Encephalitis	☐ Loss of Hearing
	☐ Loss of Sight	☐ Major Head Trauma	☐ Major Burns	☐ Paralysis
	These conditions are defined in your Product Disclosure Statement.			
2.	On what date was the condition first diagnosed?			/ /
3.	On what date did the condition first occur?			/ /
4.	Name of doctor you have predominantly consulted with about the child's claimed condition:			
	Address:			
	Suburb:		State:	Postcode:
	Phone:			
	Date of first consultation? / /		Date of last consultation? / /	
5.	Is the doctor named in (3) above Insured Child's usual doctor?	Yes ☐	No ☐	If 'no', please provide details of usual doctor:
	Doctor's name:			
	Address:			
	Suburb:		State:	Postcode:
	Phone:			

Part G: Legal Guardian's authorisation to share information about Insured Child and consent to obtain a medical report

I hereby declare that I am the legal guardian of the Insured Child.

I have read and carefully considered the questions on this document and all the responses. I have read and consent to the Privacy Statement above.

I hereby consent to Hallmark Insurance being provided with personal information in relation to the Insured Child and medical information, including copies of any medical reports, clinical reports or otherwise, from any Medical Practitioner who at any time has attended the Insured Child concerning anything which affects their physical or mental health, and I hereby agree that a copy of this consent shall have the validity of the original.

First name:	Surname:
Date of birth:	
Legal Guardian's signature:	Date: / /

Part H: Policy Owner/Insured's authorisation to share information about this claim (optional)

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	
Policy Owner/Insured's signature:	Date: / /

Part I: Policy Owner/Insured's consent to obtain a medical report

I hereby consent to Hallmark Insurance being provided with medical information, including copies of any medical reports, clinical reports or otherwise, from any Medical Practitioner who at any time has attended the Insured Child concerning anything which affects their physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

First name:	Surname:
Date of birth:	/ /
Policy Owner/Insured's signature:	Date: / /

Part J: Policy Owner/Insured's declaration

I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim. I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Hallmark Insurance requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner/Insured's signature:	Date: / /

Please have the treating Medical Practitioner complete parts K & L on the following pages.

Section 3: Medical details

This section (Parts K and L) is to be fully completed by the registered treating Medical Practitioner.

Part K: Confidential Medical Report - Child Trauma benefit

Please note that the information required is in relation to the injured Insured Child (patient).

To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this section are fully addressed and answered. Responses such as "refer to specialist", "see above", etc., are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.

If for any reason there is not enough room on this document to provide the details being requested, please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

1. Patient's details

First name:	Surname:		
Address:			
Suburb:	State:	Postcode:	
Date of birth:	/ /		

2. Medical details

a.

Are you the patient's usual Medical Practitioner?	Yes	No	
If yes when did you first start treating the patient?	/ /		
If no, please provide details of usual doctor:			
Doctor's name:			
Address:			
Suburb:	State:	Postcode:	
Phone:			

b. Which of the following conditions has been suffered by your patient? (Please tick one)

☐ Bacterial Meningitis	☐ Cancer	☐ Encephalitis	☐ Loss of Hearing
☐ Loss of Sight	☐ Major Head Trauma	☐ Major Burns	☐ Paralysis

c. What was the date of diagnosis? / /

d. What was the date of the first consultation in connection with the current condition? / /

e. Please fully describe the patient's current condition and prognosis for recovery, relapse or whether the condition is permanent:

f. Please provide the dates and results of any imaging or other tests performed. Alternatively please provide a complete copy of your patients clinical notes.

Date:	Test:	Results:
/ /		
/ /		
/ /		

g. What treatment is currently being undertaken, including surgery and medication, if any:

Part K: Confidential Medical Report - Child Trauma benefit (continued)

h. Please provide the names and addresses of any consulting specialist(s) or medical services the patient has been referred to.

Name:	Speciality or medical service:

i. If the patient has been hospitalised, provide the following details.

Admission date:	Discharge date:	Name of hospital:
/ /		
/ /		
/ /		
/ /		

j. Have you ever treated the patient before for any condition? Yes ☐ No ☐ If 'yes', please supply details.
Alternatively, please provide a complete copy of your patients clinical notes.

Date consulted:	Nature of the condition:
/ /	
/ /	
/ /	
/ /	

k. Please provide details if the patient has a previous history of the current condition, or any impairment likely to be connected with the current condition:

Part L: Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended the above named patient and that all the information supplied by me in this Report is true. I agree that Hallmark Insurance may provide copies of this Report to any medical specialist from whom Hallmark Insurance seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom the Insurer is obligated under the Privacy Act 1988 to give access to this Report.

First name:	Surname:	
Qualifications:		
Address:		
Suburb:	State:	Postcode:
Phone:	Fax:	

Medical Practitioner's signature: Date: / /