CLAIM FORM

let's INSURE

Terminal Illness 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 on 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 life insurance (including terminal illness) cover is in place and current for the terminally ill Life Insured. 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 Life Insured who is suffering the terminal illness must complete Section 2: Parts E to I. If you are both the Policy Owner and Life Insured, then you must complete all Parts A to I. Our assessment is based on the details provided here and the details provided by the Life Insured's Medical Specialist.

Step 3: Once Sections 1 and 2 have been fully completed, please forward this form to the Medical Specialist who is predominantly attending to the terminally ill Life Insured, to complete Section 3: Parts J and K. Once your Medical Practitioner has completed Section 3: Parts J and K please send the whole completed form back to us.

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 PO Box 7395, Cloisters Square WA 6850 (please mark the envelope as CONFIDENTIAL).**

Section 1: Policy Owner's details

Only to be completed if the Policy Owner is not the Life Insured. If the Policy Owner and the Life Insured are the same, please go to Section 2.

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

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: Policy Owner/Life Insured's details

To be completed in full when the Policy Owner and Life Insured are the same individual.

Part E: Policy Owner/Life Insured's details

Title:	First name:	Surname:	
Date of birth: / /		Weight: kg	Height: cm
Occupation:			
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

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

Part F: Policy Owner/Life Insured's Terminal Illness claim

1.	What condition are you claiming for? (Please give as many details as you can.)		
2.	What treatment have you received for your condition?		
3.	Date the symptoms first began: / /		
4.	Please provide details of the doctor you are predominantly consulting with about your terminal illness:		
	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Phone:		
	Date of first consultation: / /	Date of last consultation: / /	
5.	Have you ever had similar symptoms prior to this period? Yes No If 'yes', please give details and dates of the doctor or hospital that treated you:		
	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Phone:		
	From: / /	To: / /	

Part F: Policy Owner/Life Insured's Terminal Illness claim (continued)

6.	Please give details of your usual doctor:		
	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
7.	Please give details of all other doctors you have consulted for your current condition.		
(i)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Dates of consultation:		
(ii)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Dates of consultation:		
(iii)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Dates of consultation:		

Part G: Policy Owner/Life Insured's authorisation to share information about this claim

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/Life Insured's Signature: Date: / /

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

Consent wording (for living adults)
Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes

Through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- Preparing a general report and/or a report about a specific condition;
- Accessing and releasing your records in SafeScript;
- Releasing your hospital patient notes;
- Releasing the results of any investigations they have done; and/or
- Releasing correspondence with other health providers.

Part H: Policy Owner/Life Insured's consent to obtain a medical report (continued)

Authority 2 explanatory notes

Through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- They will be unable to, or did not, provide the report within 4 weeks; or
- The report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

IMPORTANT NOTICE: You MUST complete Medical Authority 1 OR Medical Authority 1 & Medical Authority 2.

Medical Authority 1

To release any of my health information except the consultation notes held by my General Practitioner/Practice.

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to St Andrew's and Let's Insure, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Hallmark Insurance asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- Hallmark Insurance can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Hallmark Insurance is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

First name:	Surname:

Policy Owner/Life Insured's Signature: Date: / /

Medical Authority 2

To release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances.

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Hallmark Insurance or to third parties they engage, only if Hallmark Insurance has asked them for a report on my health and either:

- The General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- The report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- Hallmark Insurance can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Hallmark Insurance is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

First name:	Surname:

Policy Owner/Life Insured's Signature: Date: / /

Part I: Policy Owner/Life 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/Life Insured's Signature: Date: / /

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

Section 3: Medical details

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

Part J: Confidential Medical Report – Terminal Illness benefit

Please note that the information required to be completed in this document is in relation to the insured person (patient).

Please note that it is the insured person's responsibility for the payment of all fees associated in the completion of this document.

In order 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 document are fully addressed and answered.

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.

1. Patient's details

First name:	Surname:		
Address:			
Suburb:		State:	Postcode:

2. Medical details

a. Are you the patient's usual Medical Specialist? Yes ☐ No ☐ If no, please provide details of usual doctor below:

Doctor's name:			
Address:			
Suburb:		State:	Postcode:
Phone:			

b. What is the diagnosis of the condition? Please fully describe the patient's terminal illness and expected quality and time of remaining life. (Please attach copies of any test results confirming the diagnosis and severity.)

c. On what date did the current condition commence? ☐☐ / ☐☐ / ☐☐☐☐

d. Date of the first consultation in connection with the current condition: ☐☐ / ☐☐ / ☐☐☐☐

e. Provide the dates and results of any X-rays, ECG, blood pressure or other tests performed. Alternatively, please supply a complete copy of your patients clinical notes, test results, reports.

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

f. What treatment is currently being given, including surgery and medication, if any:

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

Name:	Specialty or medical service:

Part J: Confidential Medical Report – Terminal Illness benefit (continued)

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

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

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

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

j. 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. Include dates and which doctors attended for each previous episode. Alternatively, please supply a complete copy of your patients clinical notes.

Part K: 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 Practitioner 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:	/ /