CLAIM FORM

Total and Permanent Disablement 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 Total and Permanent Disablement cover is in place and current for the Life Insured. Then complete **Section 1: Parts A to D**.

Step 2: The Life Insured needs to complete **Section 2: Parts E and F**, then choose which one of the following describes the claim:

- The Life Insured was gainfully employed when the disablement occurred: **Life Insured to complete Section 2: Part G**
- The Life Insured wasn't gainfully employed when the disablement occurred: **Life Insured to complete Section 2: Part H**

Step 3: The Life Insured also needs to complete **Section 2: Parts I to K**. If you are both the Policy Owner and Life Insured, then you must complete all the applicable **Parts A to K**. Our initial assessment is based on the details provided here and the details provided by the Life Insured's Medical Practitioners.

Step 4: If **Section 2: Part G** applies, please send **Section 3: Part L** to the Life Insured's employer to complete, and ask them to return the completed form us.

Step 5: Once **Sections 1 and 2** have been **fully completed**, please forward this form to the Medical Practitioner who predominantly attended to the disabled Life Insured, to complete **Section 4: Parts M, N and O**. Once the Medical Practitioner has completed section 4 the claimant must send the completed claim 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 Life Insured are the same, please skip and 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 (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 in 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 on page 1.

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: / /		Gender:	Male: Female:
Country of birth:		Are you an Australian resident?	Yes No
Language spoken at home:		Is an interpreter required?	Yes No
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

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

Part F: Details of Policy Owner/Life Insured's injury or illness

1.	Please state the exact nature of the injury or illness that caused you to cease work:		
2.	On what date did the injury first occur or did you first become ill? / /		
3.	On what date did you cease work totally? / /		
4.	Please give details of all doctors, physiotherapists, chiropractors etc. consulted by you, including any hospital treatment you may have received in relation to your disability. (If space provided is insufficient, please attach separately.)		
(i)	Doctor's name (usual doctor):		
	Address:		
	Suburb:	State:	Postcode:
	Date of first consultation: / /	Most recent consultation: / /	
(ii)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Date of first consultation: / /	Most recent consultation: / /	
(iii)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Date of first consultation: / /	Most recent consultation: / /	
5.	Have you ever previously suffered from the same or similar illness? Yes No	If yes, please supply details:	
	Date of episode:	Period affected:	Name of attending doctor:
	/ /		
	/ /		
	/ /		
	/ /		

Part G: Policy Owner/Life Insured's occupational details

1.	Name of employer/company:			
	Address:			
	Suburb:		State:	Postcode:
	Phone:	Commencement date: / /		
2.	What was your job title?			
3.	Please describe all your work duties in detail:			% per duty
				Total: 100%
4.	How many hours did you normally work each week?			
5.	On what date did you last work? / /			
6.	If you are submitting this claim more than 12 months after the date on which you last worked please state the reasons for the late lodgement:			
7.	Please state the reasons why you ceased work: (If you have ceased work due to redundancy, resignation or termination please provide a copy of the relevant documentation)			
8.	Please list all of the work duties your disability prevents you from performing:			
9.	Since ceasing work with your employer, have you been able to perform work of any kind? Yes No If yes, please supply details:			

Employer:	Job title:	Period of work:	Part time	Full time	Income earned (before income tax)

10.	Have you applied for any jobs since ceasing work? Yes No If yes, please supply details:			
	Employer:	Job title:	When sought:	Outcome:

Part G: Policy Owner/Life Insured's occupational details (continued)

11.	Are you now able to perform any duties of your prior occupation or any occupation for which you have the necessary education, training and experience? Yes ☐ No ☐ If yes, please list which duties you can perform:		
12.	What level of education do you have? Primary ☐ Secondary ☐ Tertiary ☐		
13.	What qualification or licensing certificates do you have? Please supply details:		
14.	Do you have any other training or skills? Yes ☐ No ☐ If yes, please supply details:		
	Date(s):	Where	Course taken or skill acquired
15.	Please supply details of all previous jobs you have performed and/or enclose a copy of your resume:		
	Employer:	Description of jobs:	Approximate dates:
16.	Please list any work you think you may be able to perform in the future:		
17.	Have you received, or are you entitled to claim any benefits under any insurance policy such as income protection, lump sum total and permanent disablement or trauma, or any benefit such as Worker's Compensation, Compulsory Third Party, Invalid Pension, Sickness benefit, Veterans Affairs benefits or unemployment benefits? (If insufficient space is provided please attach separately.) Yes ☐ No ☐ If yes, please supply details:		
(i)	Claim number:	Type of benefit:	Period:
	Name and company address:		
	Case manager's name:	Case managers phone:	
(ii)	Claim number:	Type of benefit:	Period:
	Name and company address:		
	Case manager's name:	Case managers phone:	
(iii)	Claim number:	Type of benefit:	Period:
	Name and company address:		
	Case manager's name:	Case managers phone:	
18.	Please state your current daily activities:		

Part H: Policy Owner/Life Insured's daily activities

If insufficient space is provided for your answers, please continue on a separate piece of paper and return it with this form.

1.	List any jobs held over the last 5 years, when they finished and why they finished:
2.	Describe the daily activities you usually did prior to disablement. For each day of the week, list the typical activities and the approximate time they took:
	Monday:
	Tuesday:
	Wednesday:
	Thursday:
	Friday:
	Saturday
	Sunday:
3.	What date best separates your old daily activities from your current daily activities? / /
4.	Describe your current daily activities. For each day of the week, list the typical activities and the approximate time they took:
	Monday
	Tuesday:
	Wednesday:
	Thursday:
	Friday:
	Saturday:
	Sunday

Part H: Policy Owner/Life Insured's daily activities (continued)

5.	What pensions do you currently receive and how much are they?	
6.	What other income do you currently receive and for what reasons?	
7.	What level of education do you currently have?	Primary ☐ Secondary ☐ Tertiary ☐
8.	What qualifications do you have? Please supply details:	

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

Part J: 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.

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.

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

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 Hallmark Insurance 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 K: Policy Owner/Life Insured's declaration and consent

I acknowledge:

(a) this Declaration forms part of my claim for a Total and Permanent Disability benefit.

(b) 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 understand that, in order to assess and process my claim for a benefit, Hallmark Insurance may need information about me including but not limited to medical, financial, legal and employment. I consent to Hallmark Insurance obtaining my information about me from medical practitioners that I have consulted at anytime and any that Hallmark Insurance wishes to appoint to examine, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, Hallmark Insurance parent company, other insurance or reinsurance companies, my past and present employers and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also consent to Hallmark Insurance disclosing information about me to any of the organisations mentioned above, insofar as such disclosure is necessary to Hallmark Insurance to perform its functions.

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

Please ensure that all questions have been answered before you proceed further.

Section 3: Employer's statement in connection with a claim for a Total and Permanent Disablement benefit.

Part L: To be completed by an authorised representative of the employer

Name of employer:			
Employee's full name:			
Employee's address:			
Suburb:		State:	Postcode:
Employee's date of birth:		Date joined company:	
1.	Date the employee was last at work:		
2.	Why did the employee cease work?		
3.	Have there been any periods of absence? If so, list the periods and reasons:		
4.	Employee's job title:		
5.	Please list the precise duties performed by the employee:	% per duty	
		Total: 100%	
6.	Number of hours normally worked each week:		
7.	Please list the education, training or qualifications required to perform the job:		
8.	Please list the education, training, qualifications and past experience of the employee, if known:		
9.	Number of people supervised by the employee:		
10.	Is the employee's job still open?		
11.	Do you have any other jobs appropriate to the employee's level of skill and experience?		

Part L: To be completed by an authorised representative of the employer (continued)

12. Did the employee spend any time at work on the following activities:

Activity	Proportion of time spend (%)	Activity	Proportion of time spend (%)	Activity	Proportion of time spend (%)
Driving:		Walking or standing:		Lifting*:	
Climbing:		Crawling or kneeling:		Carrying*:	

*If the employee spent time lifting or carrying, please complete the following table:

Lifting	A: Never	B: Occasional (1/3 of time)	C: Frequent (1/3 to 2/3 of time)	D: Continuous (2/3 or more of time)
Under 7 kgs:				
7 - 19 kgs:				
20 kgs or over:				

Carrying	A: Never	B: Occasional (1/3 of time)	C: Frequent (1/3 to 2/3 of time)	D: Continuous (2/3 or more of time)
Under 7 kgs:				
7 - 19 kgs:				
20 kgs or over:				

13. Have any alternative jobs been offered to the employee? Yes ☐ No ☐
If yes, please give details including job title and date offered including job title and date offered:

14. Describe any previous jobs the employee has done while employed by you. Include time spent in each job:

15. Give details of the gross weekly income the employee was paid at the time of disablement:

16. Give details of any amounts you are currently paying to the employee (e.g. Worker's compensation, salary):

17. Is a claim being made for: **Temporary Disablement?** Yes ☐ No ☐ **Permanent Disablement?** Yes ☐ No ☐

18. Other comments (e.g. any other comments you may have which you believe may be relevant to the assessment):

I declare that I am authorised to answer the above questions on behalf of the employer; and that the responses to the questions on this statement are true.

Signed on behalf of the Employer: Date: ☐☐ / ☐☐ / ☐☐☐☐

Section 4: Total and Permanent Disablement - Confidential Medical Report

This document is to be fully completed by the registered Medical Practitioner treating the Life Insured.

Please note that the information required to be completed in this document is in relation to the Life Insured.

Please note that it is the Life Insured'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.

Part M: Life Insured's details

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

Part N: Questions to be answered by the Life Insured's Medical Practitioner

(Please attach a separate statement if space is insufficient for any answer.)

1.	Please select/state correct relationship: I am the Life Insured's: ☐ Usual doctor ☐ Specialist ☐ Other doctor (please state):		
2.	(a) On what date did you first attend the Life Insured in connection with his/her illness or injuries?		/ /
	(b) On what date did the illness or accident occur?		/ /
	(c) What was the date of your last attendance?		/ /
	(d) Has the Life Insured an appointment to consult you again?		Yes ☐ No ☐
	If yes, please supply an approximate date:		/ /
3.	On what date did the Life Insured become totally and permanently unable to perform all the normal duties of his/her occupation? (or if not working, his/her normal daily activities)		/ /
4.	Please provide details of other doctors seen by the claimant in connection with this disability. Alternatively please provide a complete copy of the patients, clinical notes, medical reports, test results.		
(i)	Name of the Life Insured's usual doctor:		
	Address:		
	Suburb:	State:	Postcode:
	Phone:	Date of first consultation:	/ /
(ii)	Name of doctor:		
	Address:		
	Suburb:	State:	Postcode:
	Phone:	Date of first consultation:	/ /
(iii)	Name of doctor:		
	Address:		
	Suburb:	State:	Postcode:
	Phone:	Date of first consultation:	/ /

Part N: Questions to be answered by the Life Insured's medical practitioner (continued)

5. What is the diagnosis of the illness or injury and how was that diagnosis reached?

6. Please state the history of the illness or injury, including the exact nature and severity of the condition and give particulars of any treatment which has been, including dates where relevant. Please also provide full details and results of any tests performed. Please give full details of the current condition. Alternatively, a complete copy of your clinical notes, test results, reports will be sufficient.

7. Has hospital admission been necessary? Yes ☐ No ☐ If yes, please give name of hospital(s) and relevant dates:

Name of hospital:	Date of admission:	Date of discharge:
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

8. Has surgical treatment been necessary? Yes ☐ No ☐

(a) If yes, please state what operation(s) was/were performed:

Operation:	Date performed:
	/ /
	/ /
	/ /
	/ /

(b) If yes, please supply details of post-operative course:

9. Has the Life Insured suffered from the same or similar or related condition? Yes ☐ No ☐

If no, do you consider the disablement to be connected in any way with a previous illness or injury or unfavourable features of the patient's history? Yes ☐ No ☐

If yes, please provide details including dates, conditions and doctors consulted:

10. In respect of the Life Insured's present illness or injury, have you given any certificate to another insurance company, or in connection with worker's compensation, social security, sick leave benefits from the claimant's employer or for any other reason? Yes ☐ No ☐

If yes, to whom?

Part N: Questions to be answered by the Life Insured's medical practitioner (continued)

11.	What is your understanding of the Life Insured's occupation (or if not working, his/her daily activities) at the time the disability occurred?
12.	At the current time, is the Life Insured capable of performing his/her usual occupation? Yes ☐ No ☐ If no, which work duties/activities is he/she unable to perform or in the case they are unemployed, which daily activities are he/she unable to perform?
	If yes, from what date is he/she fit to return to work (or resume their normal daily activities)? ☐☐ / ☐☐ / ☐☐☐☐
13.	If you do NOT expect the Life Insured to EVER return to his/her usual occupation, do you think he/she will EVER be able to be engaged for a remuneration in any occupation for which he/she is reasonably suited to by education, training or experience (or if he/she wasn't working at the time the disability occurred, do you think he/she will ever be able to resume his/her daily activities?) Yes ☐ No ☐ If no, please give detailed reasons:
	If yes, please list examples of jobs/activities which in your opinion would be appropriate:

Part O: Declaration

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 Hallmark Insurance is obligated under the Privacy Act 1988 to give access to this report.

First name:	Surname:		
Qualifications:			
Address:			
Suburb:		State:	Postcode:
Phone:	Fax:		
Signature:		Date: ☐☐ / ☐☐ / ☐☐☐☐	