TERMINAL ILLNESS CLAIM FORM

Please complete this claim form and return to:

AU
The Claims Department
Hallmark Insurance
PO Box 7395
Cloisters Square 6850

NZ
The Claims Department
Hallmark Insurance
PO Box 108022
Newmarket Auckland 1146

If you have any queries regarding your claim, please contact us on AU: 1800 800 230 or NZ: 0800 220 999 or claims@hallmarkinsurance.com.au

IMPORTANT INFORMATION

1. Providing this claim form is not an admission of liability.
2. Without the information required on this form and as detailed in the cover letter, we will be unable to process your claim.
3. This could result in a delay on making a decision on liability.
4. If you are having any difficulties completing this claim form, please contact us on the number or email noted above.
5. If any question is not relevant to your circumstances please write N/A.
6. It may be necessary during the period of your claim for an insurance Specialist to call you.
7. It is important that you notify us of any change in circumstances during your claim at the earliest opportunity, such as a return to employment.
8. If there is not enough room within the form to provide your responses please attach any documentation that will assist us in assessing your claim.

There are two parts to this form, Insured (your) section and Treating Medical Practitioners section.
You may not need to complete all questions. Please review carefully.

TERMINAL ILLNESS CLAIM FORM

Insured to complete

Details of Insured

1. Policy Number / Loan Number or Account Number:

2. Date of Birth (dd/mm/yy): / /

3. Surname:

4. First Names:

5. Residential Address:

   Suburb/Town State: Postcode:

   Country:

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

Non-medical Authority
(Note: A separate Medical Authority is included on page 6.)

I authorise any other insurance company, which I have made a claim under for this condition, and my most recent employer to release to: Hallmark Insurance Company Ltd information requested by Hallmark to assess and manage my claim.

I agree that a photocopy or a scanned, electronic copy of this authorisation 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.hallmarkinsurance.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 at customerservice@hallmarkinsurance.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 completed and attached.

☐ Insured Section (including Non-medical and Medical Authorities)

IMPORTANT NOTICE:

- You MUST complete the Non-medical Authority set out above on this page 3.
- You MUST also complete Medical Authority 1
  OR Medical Authority 1 and Medical Authority 2 on page 6.

☐ Doctor's Section (including attachments)

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, Hallmark, 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.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms.

This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

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.

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, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Hallmark 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 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 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.

Name

Signature ✘

Date (dd/mm/yy) / /

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, or to third parties they engage, only if St Andrew's 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 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 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.

Name

Signature ✘

Date (dd/mm/yy) / /

AU
The Claims Department
Hallmark Insurance
PO Box 7395
Cloisters Square 6850

NZ
The Claims Department
Hallmark Insurance
PO Box 108022
Newmarket Auckland 1146

Authorised Third Party (ATP) Confirmation - Claim

By completing this form, you authorise Hallmark General Insurance Company Ltd and Hallmark Life Insurance Company Ltd (collectively known as Hallmark Insurance) to disclose and discuss information relating to claims on your policy to the person nominated below. We will only provide information to the ATP on: claim approval, claim decline decision (not reasoning behind decision), claim wait periods, any claim information requested and/or payment amounts and schedule of payments.

You must ensure the ATP is aware of our Privacy Policy and agrees to their personal information being collected, used and disclosed accordingly. Our Privacy Policy can be found at www.hallmarkinsurance.com.au.

My personal details.

Name: _____

Signed by: _____ Date: / /

My authorised person's details.

Name: _____

Address: _____

_____

_____

Date of birth: / / Relationship with person named above: _____

Left blank intentionally.
Use to add additional information or separate here to provide the Dr's Section to your GP.

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.

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			