

## Make a Trauma Claim

### Thank you for contacting Swann Insurance

You must have access to a printer in order to access this form. If you do not have access to a printer please contact our office on 1300 657 382 and an alternative will be sent.

#### HOW TO COMPLETE YOUR TRAUMA CLAIM FORM

**Your claim form must be completed in full. An incomplete form may cause delay in the assessment of your claim.**

#### Please ensure:

- You (the insured) complete pages one (1) and two (2) of your trauma claim form.
- That you (the insured) and a witness have both signed and dated your claim form.

#### Other useful information

**It is important that all questions are correctly and fully answered by the policy holder.** This will enable Swann Insurance to proceed with the processing of your claim; delays could occur if the claim is completed by someone other than the policy holder or if insufficient information is supplied. If for some reason the policy holder is unable to complete this form, please contact the office to discuss options.

#### Third Person authority to enquire

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the attached authorisation and return with your completed claim form.

Fax: 1300 657 370

Email: [swann.cci.claims@swanninsurance.com.au](mailto:swann.cci.claims@swanninsurance.com.au)

Post: Locked Bag 3274

Melbourne VIC 3001

Insurer: **Swann Insurance (Aust) Pty Ltd** ABN 80 000 886 680.

All questions must be answered.

Please print and indicate  where applicable. If insufficient space provided, please write on a separate sheet and attach to the form.

**your personal details**

TITLE (eg. MR/MRS) GIVEN NAMES SURNAME DATE OF BIRTH  
    / /

ADDRESS TELEPHONE NO.  
 POSTCODE  ( )

EMAIL

YOUR USUAL OCCUPATION CURRENT EMPLOYER (OR PREVIOUS EMPLOYER) DATE EMPLOYED FROM DATE EMPLOYED TO  
   / /  / /

ADDRESS TELEPHONE NO.  
 POSTCODE  ( )

EMPLOYER AT POLICY COMMENCEMENT DATE ADDRESS  
  POSTCODE

TELEPHONE NO. ARE YOU CLAIMING WORKERS' COMPENSATION?  
 ( ) NO  YES  STATE INSURER

**tell us about your trauma**

WHAT ARE YOU CLAIMING FOR? – Please  tick where applicable

HEART ATTACK  CORONARY ARTERY SURGERY  STROKE  CANCER

WHEN DID YOU FIRST BECOME AWARE OF YOUR CONDITION AND WHAT IS THE NATURE OF YOUR SYMPTOMS?

WHEN DID YOU FIRST ATTEND A DOCTOR OR HOSPITAL FOR YOUR TRAUMA? NAME OF DOCTOR OR HOSPITAL  
 / /

ADDRESS OF DOCTOR OR HOSPITAL  
 POSTCODE

**your medical history**

WHO IS YOUR USUAL DOCTOR? FOR HOW LONG?  
 YEARS MONTHS

YOUR DOCTOR'S ADDRESS TELEPHONE NO.  
 POSTCODE  ( )

PLEASE STATE THE NAMES OF ALL DOCTORS AND HOSPITAL CONSULTED FOR THIS CURRENT CONDITION

NAME TELEPHONE NO.  
  ( )

ADDRESS  
 POSTCODE

NAME TELEPHONE NO.  
  ( )

ADDRESS  
 POSTCODE

NAME TELEPHONE NO.  
  ( )

ADDRESS  
 POSTCODE

## your medical history (continued)

PLEASE STATE THE DATES AND REASONS FOR ANY CONSULTATIONS WITH YOUR USUAL MEDICAL PRACTITIONER DURING THE LAST 5 YEARS

Date	Reason for consult
<input type="text" value="/ /"/>	<input type="text"/>
Date	Reason for consult
<input type="text" value="/ /"/>	<input type="text"/>
Date	Reason for consult
<input type="text" value="/ /"/>	<input type="text"/>
Date	Reason for consult
<input type="text" value="/ /"/>	<input type="text"/>

IF YOU HAVE ATTENDED ANY OTHER DOCTOR OR HOSPITAL DURING THE LAST 5 YEARS, PLEASE LIST DETAILS BELOW

Name of doctor or hospital	Date	Reason for consult
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>
Name of doctor or hospital	Date	Reason for consult
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>
Name of doctor or hospital	Date	Reason for consult
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>
Name of doctor or hospital	Date	Reason for consult
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text"/>

HAVE YOU TAKEN ANY DRUGS OR MEDICATIONS IN THE LAST 5 YEARS? NO  YES  WHAT TYPE OF DRUGS OR MEDICATIONS?

<input type="text"/>
<input type="text"/>
<input type="text"/>

ARE YOU CURRENTLY RECEIVING ANY TREATMENT/MEDICATION? NO  YES  PLEASE GIVE FULL DETAILS

<input type="text"/>
<input type="text"/>
<input type="text"/>

## declaration

I hereby declare that:

1. I am the person insured by this policy and referred to in the foregoing particulars.
2. The above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy, whether the answers have been written by me or by any other person on my behalf.
3. I am fully aware and agree that any false statements and particulars made by me on this form or any further declarations will result in my claim being denied.
4. I authorise any hospital, institution or medical practitioner who has treated or examined me or any person or firm who has employed me, or any firm through which I have claimed compensation to provide Swann Insurance (Aust) Pty Ltd and/or The National Mutual Life Association of Australasia Ltd. (National Mutual) any information it may request in respect of any trauma, illness, injury, medical history, treatment or advice received by me. A photocopy of this authority can be acted upon as if it were the original.
5. I authorise the creditor to provide Swann Insurance (Aust) Pty Ltd and/or The National Mutual Life Association of Australasia Ltd. (National Mutual) with details of my loan for administration of this claim.
6. I consent to Swann Insurance (Aust) Pty Ltd and/or The National Mutual Life Association of Australasia Ltd. (National Mutual) using my personal information I have provided on this form for the purpose of processing my claim. I understand that if I choose not to provide the required details, this is my choice, however, Swann Insurance (Aust) Pty Ltd may not be able to process my claim.

SIGNATURE OF INSURED

SIGNATURE OF WITNESS

DATE

*Swann Insurance is a member of the insurance industry's independent Financial Ombudsman Service (Service). This Service is provided to the public at no cost and aims to resolve claims complaints quickly and informally if Swann Insurance is unable to resolve your complaint. You should first take your complaint up with Swann. In most cases, the problem will be resolved easily. If you are not satisfied with the outcome you may contact the Financial Ombudsman Service Limited in your state for advice and assistance in resolving your claim.*

**FINANCIAL OMBUDSMAN SERVICE LIMITED TOLL FREE TELEPHONE NUMBER: 1300 780 808.**

### Third Person Authority to make and receive claims enquiries in relation to my claim

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the following authorisation and return with your completed claim form.

I, \_\_\_\_\_ (name) of  
\_\_\_\_\_ (address),

freely give permission for:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Ph. No.: \_\_\_\_\_

to contact and be contacted by Swann Insurance (Aust) Pty Ltd to discuss information relating to and about my disablement claim, (number \_\_\_\_\_).

I know that I may request a copy of this authorisation. I agree that a copy of this authorisation shall be as valid as the original.

I understand that this authorisation shall be valid until my claim is processed and finalised, and that I have a right to revoke this authorisation by written notification to Swann Insurance.

Signed by .....

Print name .....

Dated .....

Witness signature .....

Print name .....

Dated .....