swann insurance
protect what you love

Make an Unemployment 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 UNEMPLOYMENT 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 the front page and the first box on the second page of your unemployment claim form.
- That you (the insured) and a witness have both signed and dated your claim form.
- Centrelink completes the “Certificate of Centrelink/Job agency” section on your claim form.
- Your last employer completes the “Employer’s Declaration” section of your claim form. If you experience difficulties in completing this section, please attach a copy of your “Employment Separation” certificate to your claim from.
- If your employment ceased more than three (3) months ago, a letter is attached to your claim form detailing the reason(s) for the late lodgement of your claim.

Other useful information

If you have submitted your claim form and it has been accepted by Swann Insurance, we will require you to provide ongoing confirmation of your unemployment in order for us to maintain continuous payments to your financier.

Please advise us on 1300 657 382 if you return to any form of employment during the period you are claiming for.

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
Post: Locked Bag 3274
Melbourne VIC 3001

G2433-0810 **PRN**_D382

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INVOLUNTARY UNEMPLOYMENT CLAIM FORM

Insurer: **Swann Insurance (Aust) Pty Ltd** ABN 80 000 886 680.
All questions must be answered.
Please print and indicate ✓ where applicable. If there is insufficient space, please write on a separate sheet and attach to this form.

IMPORTANT NOTE

Please ensure that you have answered all questions relating to yourself and arrange for Centrelink/Job Agency Certificate and Employers Declaration to be completed. Please note that an incomplete claim form will cause delay in assessment.
Please forward your completed claim form to Swann Insurance within 14 days of the occurrence.
Please notify Swann Insurance when you recommence employment.

your personal details

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

ADDRESS POSTCODE

E-MAIL TELEPHONE NO. ( )

NAME AND DATE OF BIRTH OF ANY OTHER PERSON LISTED ON POLICY

claimant's statement

NAME OF LAST EMPLOYER ADDRESS POSTCODE

TELEPHONE NO. ( ) OCCUPATION DATE EMPLOYED FROM / / TO / /

ON WHAT BASIS WERE YOU EMPLOYED AT POLICY COMMENCEMENT DATE?

FULL TIME ☐ CASUAL ☐ PART TIME ☐ CONTRACT ☐ SEASONAL ☐ TEMPORARY ☐

WHAT WAS YOUR REASON FOR LEAVING THIS EMPLOYMENT?

RESIGNED ☐ RETRENCHED ☐ DISMISSED ☐ END OF CONTRACT ☐ MADE REDUNDANT ☐ TEMPORARY ☐

OTHER ☐ PLEASE GIVE EXPLANATION

NAME OF EMPLOYER PRIOR TO LAST EMPLOYMENT ADDRESS POSTCODE

TELEPHONE NO. ( ) OCCUPATION DATE EMPLOYED FROM / / TO / /

ON WHAT BASIS WERE YOU EMPLOYED AT POLICY COMMENCEMENT DATE?

FULL TIME ☐ CASUAL ☐ PART TIME ☐ CONTRACT ☐ SEASONAL ☐ TEMPORARY ☐

WHAT WAS YOUR REASON FOR LEAVING THIS EMPLOYMENT?

RESIGNED ☐ RETRENCHED ☐ DISMISSED ☐ END OF CONTRACT ☐ MADE REDUNDANT ☐ TEMPORARY ☐

OTHER ☐ PLEASE GIVE EXPLANATION

declaration

I hereby declare that:

1. I am the person insured by Swann Insurance (Aust) Pty Ltd and referred to in the foregoing particulars.
2. I agree that if I have made, or in any further declaration which Swann Insurance (Aust) Pty Ltd may require of me, shall make, any false declaration or statement in support of my claim my right to any Benefit shall be forthwith forfeited.
3. I authorise the Centrelink/Job Agency or any person or firm who has employed me, to furnish to Swann Insurance (Aust) Pty Ltd any information it may request in respect of my employment and unemployment.
4. To the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.
5. I consent to Swann Insurance (Aust) Pty Ltd 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 up your complaint 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 TOLL FREE TELEPHONE NUMBER: 1300 780 808.

certificate of centrelink/job agency

IS THE CLAIMANT REGISTERED AS A JOBSEEKER? NO ☐ YES ☐

IF THE CLAIMANT IS RECEIVING JOB SEARCH ALLOWANCE/UNEMPLOYMENT BENEFITS, PLEASE COMPLETE THE FOLLOWING:

THIS IS TO CERTIFY THAT (FULL NAME)

OF (ADDRESS)

WAS REGISTERED AS BEING UNEMPLOYED ON (DATE) / / ALLOWANCE/BENEFITS OF $

PER WERE GRANTED FROM (DATE) / / AND HAVE BEEN PAID TO (DATE) / /

IF THE CLAIMANT IS NOT RECEIVING JOB SEARCH ALLOWANCE/UNEMPLOYMENT BENEFITS, PLEASE ADVISE THE REASON WHY

SIGNATURE OF AUTHORISED OFFICER

BRANCH STAMP

DATE / /

employers declaration (to be completed by the last employer)

NAME OF EMPLOYEE

DATE EMPLOYED FROM / / TO / /

ON WHAT BASIS WERE THEY EMPLOYED?

FULL TIME ☐ CASUAL ☐ PART TIME ☐ CONTRACT ☐ SEASONAL ☐ TEMPORARY ☐ AVERAGE HOURS/WEEK WORKED

EMPLOYMENT WAS TERMINATED DUE TO: MISCONDUCT ☐ ▶ REASON

SHORTAGE OF WORK ☐ EMPLOYEE CEASED WORK VOLUNTARILY ☐

SIGNATURE

POSITION

COMPANY NAME (PLEASE AFFIX COMPANY STAMP IF AVAILABLE)

Swann Insurance (Aust) Pty Ltd ABN 80 000 886 680 AFS Licence No. 238292
Locked Bag 3274 Melbourne VIC 3001 **t** 1300 657 382 **f** 1300 657 370 **e** swann.cci.claims@swanninsurance.com.au

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PRN_D465

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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 ………………………………………………………………………………………

Swann Insurance (Aust) Pty Ltd ABN 80 000 886 680

Locked Bag 3274 Melbourne VIC 3001 **t** 1300 657 382 **f** 1300 657 370 **e** swann.cci.claims@swanninsurance.com.au

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