

Make a Fee Secure or Bill Protect 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 LIFE 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 Next of Kin/Estate) complete the first section of the life claim form.
- The regular medical attendants statement has been completed by the deceased's treating Doctor.
- That you (the Next of Kin/Estate) have signed and dated the Life claim form.
- You (the Next of Kin/Estate) have supplied a copy of the death certificate or a copy of the coroner's statement.

Other useful information

It is important that all questions are correctly and fully answered by the Next of Kin /Estate. This will enable Swann Insurance to proceed with the processing of the claim; delays could occur if insufficient information is supplied.

******* A COPY OF THE DEATH CERTIFICATE MUST BE ATTACHED TO THE CLAIM FORM *******

Third Person authority to enquire

If you wish to provide authority for another person to discuss the claim on your behalf, please complete the attached authorization 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

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.

IMPORTANT NOTE

This form must be completed and submitted with a copy of the Death Certificate. On accident cases, a copy of the Coroner's Statement may be sent as Proof of Death.

certificate of identity of deceased by next of kin

NAME OF DECEASED	DATE OF BIRTH	AGE
<input type="text"/>	<input type="text" value="/ /"/>	<input type="text" value="YEARS"/>

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

STATE RELATIONSHIP TO DECEASED
<input type="text"/>

WHAT WAS HIS/HER OCCUPATION?
<input type="text"/>

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/>

NAME OF DECEASED'S REGULAR DOCTOR?	SINCE WHEN?
<input type="text"/>	<input type="text" value="/ /"/>

DOCTOR'S ADDRESS	POSTCODE
<input type="text"/>	<input type="text"/>

DID THE DECEASED EVER CONSULT A SPECIALIST?

NO YES WHEN?

IS THERE A DISABLEMENT CLAIM PENDING?

NO YES NAME OF INSURER

I believe that the deceased is the same person as the Life Insured under a Policy issued by Swann Insurance (Aust) Pty Ltd and I authorise any hospital, institution or medical practitioner who has treated or examined the deceased to provide Swann Insurance (Aust) Pty Ltd with any medical information it may request. I have not withheld any relevant information.

DATE	SIGNED	PLEASE PRINT NAME
<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/>

ADDRESS	POSTCODE	TELEPHONE NO.
<input type="text"/>	<input type="text"/>	<input type="text" value="()"/>

regular medical attendant's statement — must be completed

ARE YOU THE DECEASED'S USUAL MEDICAL ATTENDANT?

NO YES SINCE WHEN?

CAUSE OF DEATH
<input type="text"/>

DATE OF FIRST TREATMENT	ONSET OF SYMPTOMS	SIGNATURE OF MEDICAL PRACTITIONER	DATE
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text" value="/ /"/>

ADDRESS OF PRACTICE	POSTCODE	TELEPHONE NO.
<input type="text"/>	<input type="text"/>	<input type="text" value="()"/>

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