swann insurance
protect what you love

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 DISABLEMENT 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 disablement claim form.
- That you (the insured) and a witness have both signed and dated your claim form.
- Your treating Doctor completes pages three (3) and four (4) of your claim form.
- If the date you last worked or the date your injury or illness first occurred is 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 current medical certificate(s) from your Doctor in order for us to maintain continuous payments to your financier. Your medical certificate(s) can be for a maximum period of three (3) months from the date noted on the certificate(s) and must state your exact disability.

****PLEASE NOTE, MEDICAL CERTIFICATES THAT STATE "MEDICAL CONDITION" ARE NOT ACCEPTABLE****

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

G2439-0810 **PRN**_D388

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DISABLEMENT 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.

your personal details

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

ADDRESS POSTCODE TELEPHONE NO. ( )

EMAIL

OCCUPATION AT TIME OF DISABILITY YOUR USUAL OCCUPATION

CURRENT EMPLOYER (OR PREVIOUS EMPLOYER) DATE EMPLOYED FROM / / TO / /

ADDRESS POSTCODE TELEPHONE NO. ( )

ARE YOU CLAIMING WORKERS' COMPENSATION? CLAIM NO.

NO YES STATE INSURER

ADDRESS POSTCODE TELEPHONE NO. ( )

ARE YOU IN RECEIPT OF BENEFITS FROM CENTRELINK?

NO YES TYPE OF BENEFIT

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

your disability details

DATE ON WHICH THE ILLNESS OR INJURY FIRST OCCURRED / / TIME AM/PM YOUR LAST WORKING DAY / /

DESCRIBE THE CIRCUMSTANCES LEADING TO YOUR CURRENT DISABILITY

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

YOUR DOCTOR'S ADDRESS POSTCODE TELEPHONE NO. ( )

DOCTOR AT POLICY COMMENCEMENT DATE ADDRESS POSTCODE

PLEASE STATE THE NAMES AND ADDRESSES OF ALL **OTHER** DOCTORS AND HOSPITALS CONSULTED FOR THIS CURRENT DISABILITY

NAME TELEPHONE NO. ( )

ADDRESS POSTCODE

NAME TELEPHONE NO. ( )

ADDRESS POSTCODE

WAS INJURY CAUSED BY MOTOR VEHICLE ACCIDENT? NO YES POLICE ATTENDED? NO YES

WHEN DID YOU RESUME WORK DUTIES? / / OR WHEN DO YOU EXPECT TO BE FIT FOR SOME WORK DUTIES? / /

your medical history

1. HAVE YOU PREVIOUSLY SUFFERED FROM THIS INJURY OR ILLNESS OR ANY SIMILAR INJURY OR ILLNESS?

NO ☐ YES ☐ ▶ NAME OF DOCTOR — DATE OF CONSULTATION (1) / / — DATE OF CONSULTATION (2) / /

▶ ADDRESS — POSTCODE — TELEPHONE NO. ( )

▶ REASON FOR CONSULT — PERIOD OF DISABILITY FROM / / TO / /

2. HAVE YOU PREVIOUSLY SUFFERED ANY OTHER MAJOR ILLNESS/INJURY UNRELATED TO THIS DISABILITY?

NO ☐ YES ☐ ▶ PLEASE PROVIDE DETAILS OF COMPLAINT

▶ DATE OF OCCURRENCE / / — PERIOD OF DISABILITY (YRS/MTHS/DAYS) YEARS MONTHS DAYS

3. DO YOU TAKE REGULAR MEDICATION FOR ANY ILLNESS OR INJURY?

NO ☐ YES ☐ ▶ PLEASE PROVIDE DETAILS OF MEDICATION AND CONDITION

claims history

HAVE YOU EVER SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY OR ILLNESS?

NO ☐ YES ☐ ▶ PLEASE PROVIDE DETAILS (INCLUDING REFERENCE NUMBER)

NAME OF COMPANY — TELEPHONE NO. ( ) — DATE / /

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 or their agents 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 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.
6. I understand that I may contact Swann Insurance (Aust) Pty Ltd if I wish to update or access my personal information.

SIGNATURE OF INSURED — SIGNATURE OF WITNESS — DATE / /

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

SI-00-00-02-1010-00
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PRN_D466

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MEDICAL CERTIFICATE

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

This certificate must be completed by the qualified and registered Medical Practitioner treating you for your current disablement. In the event of the medical practitioner being unable to answer, from personal knowledge, any of the following questions, this must be stated.
The Certificate is to be completed at the insureds expense and forwarded by the Medical Practitioner to Swann Insurance at the earliest opportunity.

doctor's details

NAME OF ATTENDING DOCTOR

TELEPHONE NO. ( )

INSURED'S NAME

DATE OF BIRTH / /

INSURED'S OCCUPATION

ARE YOU THE INSURED'S USUAL DOCTOR?

NO ☐ YES ☐ FOR HOW LONG YEARS MONTHS

STATE NATURE AND CAUSE OF DISABLEMENT

WHEN DID YOU FIRST TREAT THE INSURED FOR THIS ILLNESS OR INJURY? / /

PLEASE PROVIDE DETAILS OF TREATMENT

PLEASE PROVIDE DETAILS OF ANY MEDICATION

ARE THERE ANY MEDICAL CONDITIONS WHICH HAVE A BEARING ON THIS CURRENT DISABLEMENT?

NO ☐ YES ☐ PLEASE PROVIDE DETAILS

HAS THE INSURED EVER RECEIVED A MEDICAL DIAGNOSIS, TREATMENT, OPERATION OR ATTENTION FOR THIS OR SIMILAR DISABLEMENT OR RELATED CAUSE?

NO ☐ YES ☐ PLEASE SUPPLY THE FOLLOWING DETAILS (provide on a separate page if insufficient space)

DATE	NATURE OF DISABILITY	DATE	NATURE OF DISABILITY
/ /		/ /	
/ /		/ /	
/ /		/ /	

IF NOT BY YOURSELF, NAME AND ADDRESS OF DOCTOR

WHAT IS YOUR PROGNOSIS?

PLEASE PROVIDE DETAILS OF OPERATION(S) IF ANY, AND DATE(S)

HAVE YOU ANY REASON TO:

SUSPECT THAT THE INSURED'S DISABLEMENT HAS RESULTED FROM OR BEEN CONTRIBUTED TO BY THE INFLUENCE OF INTOXICATING LIQUOR OR DRUGS?

NO ☐ YES ☐

TEST FOR HUMAN IMMUNODEFICIENCY VIRUS?

NO ☐ YES ☐ ▶ PLEASE **PROVIDE** RESULTS, INCLUDING TEST RESULTS

SUSPECT THAT THE INSURED'S DISABLEMENT HAS RESULTED FROM OR BEEN CONTRIBUTED TO BY AN INTENTIONALLY SELF-INFLICTED INJURY?

NO ☐ YES ☐

HAS THE INSURED BEEN HOSPITALISED? NO ☐ YES ☐ ▶ NUMBER OF DAYS

HAS THE INSURED BEEN **TOTALLY DISABLED** FROM PERFORMING:

EACH AND EVERY DUTY PERTAINING TO HIS OR HER USUAL OCCUPATION?

NO ☐ YES ☐ ▶ STATE PERIOD: FROM / / TO / /

ANY OTHER GAINFUL OCCUPATION?

NO ☐ YES ☐

IS THE INSURED CAPABLE OF PERFORMING LIGHT OR LIMITED DUTIES?

NO ☐ YES ☐ ▶ STATE PERIOD: FROM / / TO / /

NATURE OF DUTIES

HOURS/DAY AND DAYS/WEEK

IF TOTAL DISABLEMENT HAS CEASED, ON WHAT DATE DID YOU RELEASE THE INSURED TO PERFORM ANY REMUNERATIVE DUTIES?

/ /

IF TOTAL DISABLEMENT STILL EXISTS, ON WHAT DATE IS IT LIKELY TO CEASE?

/ /

please make sure all answers have been answered and printed clearly

SIGNATURE OF MEDICAL PRACTITIONER

DATE / /

QUALIFICATIONS

ADDRESS OF PRACTICE

POSTCODE

TELEPHONE NO. ( )

FACSIMILE NO. ( )

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 LIMITED TOLL FREE TELEPHONE NUMBER: 1300 780 808.

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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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