Claim Form

WeProtect

Accidental Serious Injury Benefit

Privacy Collection Notice

This Privacy Collection Notice outlines how Hannover Life Re of Australasia Ltd ("Hannover", "we", "us" or "our") collects and handles your personal information in compliance with the Privacy Act 1988 (Cth).

Collection & Use

We collect personal information such as identification information and policy details and sensitive information such as health details. Generally, we collect this information so that we can provide our products and services to you and manage, administer, develop and improve our business, including to assess and process your application for insurance, and assess any claims made by you or on your behalf. We generally collect this information directly from you but may on occasions collect it from a third party such as our related bodies corporate, professional advisers or from publicly available information. If you do not provide us with all or part of the personal information we require, we may be unable to provide such services to you.

Disclosure

The information you provide us will be collected by us and may be disclosed to third parties that help us deliver and improve our products and services (including other insurance / reinsurance companies, legal practitioners, medical practitioners, health service providers, hospitals, legal tribunals and courts, dispute resolution bodies, investigators/investigation organisations, third parties authorised by you, any current or former employer, our parent company and other related bodies corporate, professional advisers such as accountants or lawyers or other consultants, service providers that assist us in carrying out our business activities, trustees of superannuation funds, administrators of superannuation funds, an organisation appointed by the trustees of a superannuation fund to receive or give information, interpreters and regulatory bodies, government agencies, law enforcement agencies or, as required, other persons authorised or permitted by law) or as required by law.

Overseas Disclosure

We may disclose your personal information to parties located in other countries, including to our related bodies corporate. The countries in which these recipients may be located will vary from time to time, but may include Germany, Canada, Japan, New Zealand, Hong Kong, United Kingdom, United States of America, India, China, Korea, Malaysia, South Africa, Bermuda, Ireland, Sweden and France.

Access, Correction & Complaints

Our Privacy Policy which is available at https://www.hannover-re.com/1094181/australia_lh_privacy (or, by contacting us using the details set out in the 'Contact Us' section below) outlines our personal information handling practices, including details on how you can seek access or correction of the personal information that we hold about you, how to complain if you believe we have breached the Australian privacy laws and our complaint handling processes.

Contact Us

You may contact Hannover as follows:
The Privacy Officer. Hannover Life Re of Australasia Ltd. Tower 1, Level 33, 100 Barangaroo Avenue SYDNEY NSW 2000
Telephone: (02) 9251 6911 **Facsimile:** (02) 9251 6862 **Email:** privacyofficer@hlra.com.au

Completion instructions

Step 1: As the Policy Owner, you should first check your most recent policy schedule to make sure that the Accidental Serious Injury cover is in place and current for the injured Life Insured. Then complete **Section 1: Parts A to E**. Note that once the claim is approved, the claim payment will be made to you.

Step 2: The Life Insured who has suffered the injury must complete **Section 2: Parts F to I**. If you are both the Policy Owner and Life Insured, then you must complete **all Parts A to I**. Our assessment is based on the details provided here and the details provided by the Life Insured's medical practitioners.

Step 3: Once Sections 1 and 2 have been fully completed, please forward this form to the Medical Practitioner who has predominantly attended to the injured Life Insured, to complete **Section 3: Parts J and K**. Once your Medical Practitioner has completed **Section 3: Parts J and K** please send the whole completed form back to WeProtect.

Section 1: Policy Owner's details

Only to be completed if the Policy Owner is not the Life Insured. If the Policy Owner and the Life Insured are the same please go to Section 2.

Part A: Policy Owner details

Policy Owner:		Policy number:	
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

Please indicate your preferred method of communication with an asterisk (*)

Part B: Policy Owner's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	

Policy Owner's signature: Date: / /

Part C: Policy Owner's payment authority

Once the claim has been accepted the benefit will be credited to the account below.

Name of bank:	Name of account holder:
BSB number: –	Account number:

Part D: Policy Owner's declaration

I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim. I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Hannover requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner's signature: Date: / /

Section 2: Policy Owner/Life Insured's details

To be completed in full when the Policy Owner and Life Insured are the same individual.

Part E: Policy Owner/Life Insured's details

Title:	First name:	Surname:	
Date of birth: / /		Weight: kg	Height: cm
Occupation:			
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

Please indicate your preferred method of communication with an asterisk (*)

Part F: Policy Owner/Life Insured's Accidental Serious Injury claim

Medical details of the Life Insured.

1. Has the injury occurred resulted in any of the following conditions? (Please tick one)

☐ Loss of Hearing	☐ Coma	☐ Major Burns	☐ Loss of Use of Limbs
☐ Loss of Speech	☐ Paralysis	☐ Major Head Trauma	☐ Blindness

These conditions are defined in your Product Disclosure Statement.

2. On what date did the injury first occur? / /

3. Where (including the address) did the injury occur?

Address:

Suburb: | State: | Postcode:

4. Please provide a comprehensive description of how the injury occurred, including the names and contact details of all witnesses.

Witness name: | Phone:

Witness name: | Phone:

5. Name of doctor you have predominantly consulted with about the claimed condition:

Address:

Suburb: | State: | Postcode:

Phone:

Date of first consultation: / / | Date of last consultation: / /

6. Is the doctor named in (5) above your usual doctor? Yes ☐ No ☐ If 'no', please provide details of usual doctor:

Doctor's name:

Address:

Suburb: | State: | Postcode:

Phone:

Part G: Policy Owner/Life Insured's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	

Policy Owner/Life Insured's signature: Date: / /

Part H: Policy Owner/Life Insured's declaration

I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim. I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Hannover requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner/Life Insured's signature: Date: / /

Please have the treating Medical Practitioner complete parts I & J on the following pages.

Section 3: Medical details

This section (Parts I and J) is to be fully completed by the registered treating Medical Practitioner.

Part I: Confidential Medical Report - Accidental Serious Injury benefit

Please note that the information required is in relation to the injured Life Insured (patient).

To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this section are fully addressed and answered. Responses such as "refer to doctor", "see above", etc, are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.

If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

1. Patient's details

First name:	Surname:	
Address:		
Suburb:	State:	Postcode:

2. Medical details

a. Are you the patient's usual Medical Practitioner? Yes ☐ No ☐ If 'no', please provide details of usual doctor:

Doctor's name:		
Address:		
Suburb:	State:	Postcode:
Phone:		

b. Which of the following conditions has been suffered by your patient? (Please tick one)

☐ Loss of Hearing	☐ Coma	☐ Major Burns	☐ Loss of Use of Limbs
☐ Loss of Speech	☐ Paralysis	☐ Major Head Trauma	☐ Blindness

c. What was the date of diagnosis? ☐☐ / ☐☐ / ☐☐☐☐

d. What was the date of the first consultation in connection with the current condition? ☐☐ / ☐☐ / ☐☐☐☐

e. Please fully describe the patient's current condition and prognosis for recovery, relapse or whether the condition is permanent:

f. Provide the dates and results of any X-rays or other tests performed. Alternatively please provide a complete copy of the patients clinical notes, tests results, reports.

Date:	Test:	Results:
☐☐ / ☐☐ / ☐☐☐☐		
☐☐ / ☐☐ / ☐☐☐☐		
☐☐ / ☐☐ / ☐☐☐☐		

g. What treatment is currently being given, including surgery and medication, if any:

h. Please provide the names and addresses of any consulting specialist(s) or medical services the patient has been referred to.

Name:	Speciality or medical service:

Part I: Confidential Medical Report - Accidental Serious Injury benefit (continued)

i. If the patient has been hospitalised, provide the following details. Alternatively provide a complete copy of the patients clinical notes.

Admission date:	Discharge date:	Name of hospital:
/ /	/ /	
/ /	/ /	
/ /	/ /	
/ /	/ /	

j. Have you ever treated the patient before for any condition? Yes No If 'yes', please supply details.
Alternatively provide a complete copy of the patients clinical notes.

Date consulted:	Nature of the condition:
/ /	
/ /	
/ /	
/ /	
/ /	

k. Please provide details if the patient has a previous history of the current condition, or any impairment likely to be connected with the current condition. Alternatively supply a complete copy of the patients clinical notes.

Part J: Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended the above named patient and that all the information supplied by me in this Report is true. I agree that Hannover may provide copies of this Report to any Medical Practitioner from whom Hannover seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom the Insurer is obligated under the Privacy Act 1988 to give access to this Report.

First name:	Surname:		
Qualifications:			
Address:			
Suburb:		State:	Postcode:
Phone:	Fax:		
Medical Practitioner's signature:		Date: / /	

Please return the completed form to Hannover. You can either:

1. Scan and email to **groupclaims@hlra.com.au** (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); or
2. Fax to **+61 2 9251 6862**; or
3. Mail to Hannover Life Re of Australasia Ltd, Tower 1, Level 33, 100 Barangaroo Avenue, Sydney, NSW, 2000.