# Trauma/Major Health Problems

## Claim Form

**Pages 1–3 to be completed by the insured person.**

We'll assess your claim as quickly as possible. The information you provide will help us do this and make sure our assessment is accurate. Please complete all sections of the form as requested – an incomplete form could delay the assessment of your claim.

- Please have all the policy owners sign and date the declaration page.
- Page 4 has additional space if you run out of room answering these questions, or if you need to provide any information not covered by the questions.
- We encourage you to attach supporting medical records or any other information you have that will help us in assessing your claim.

We're happy to help if you have any queries about this form. Please call us on 0800 808 101, or talk to your adviser.

## A. Your details

Policy number(s)

*Please tick one* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ *Please specify*

Surname

Given names

Home phone number

Date of birth

Business phone number

Email address

Mobile phone number

Residential address

Post Code

Postal address *(if different)*

Post Code

## B. Claim Details

1. Which Trauma Condition are you claiming for? (Please give us as many details as you can)

2. When did you first notice symptoms?
   *Please describe these symptoms below.*

3. Have you ever suffered from this condition or related condition(s) before? ..... Yes ☐ No ☐
*If 'yes' please provide details.*

| Dates | Specific Details |
|---|---|
| | |
| | |
| | |

4. a. Please advise the date you were first treated for this condition.

b. Please advise the name, address and phone number of the doctor you consulted.

c. If this is not your usual doctor please give the name, address and phone number of your usual doctor.

5. Please give details of all treatment you have received for your condition (eg x-rays, blood tests, ECG's, biopsies, etc)

| Dates | Treatment | Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

6. Have you seen any other doctors about your condition? ..... Yes ☐ No ☐
*If 'yes' please give names and addresses.*

| Doctor | Address |
|---|---|
| | |
| | |
| | |

7. Have you lodged, or are you intending to lodge, any claims with any other insurers for your condition? (eg medical, health, etc)..... Yes ☐ No ☐
*If 'yes' please provide details.*

## C. Payment Details

If your claim is accepted, your payment will be made by direct credit. Please provide your bank account details below:

Account name

Account number

BANK BRANCH ACCOUNT NUMBER SUFFIX

Name of Bank and Branch

Signature of Account Holder(s) Sign here Sign here

Please print name(s)

# Privacy Act 1993

This information is being collected and will be held securely by Asteron Life Limited ('Asteron Life') and my adviser. It is intended for use by Asteron Life employees who require access to this information for administering your claim and policy. Under the Privacy Act 1993 you are entitled to request access to and request correction of any personal information about you held by Asteron Life. If you do not supply the information sought your claim may be declined.

In assessing and managing your claim we may need to disclose your personal information to other parties such as claims assessors, loss assessors, reinsurers, medical and financial professionals, judicial or dispute resolution bodies, joint venture partners and Suncorp Group companies.

## Consent and Declaration

I have read and understood and have made the other people named on this form aware of the privacy disclosure statement above. I acknowledge that where information is provided it is with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the person as named on this form.

I hereby declare that the information in this Claim Form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise Asteron Life of any relevant information regarding my claim, Asteron Life may refuse to pay my claim. I understand that I can be prosecuted if I make any fraudulent statements.

## Medical and Information Authority

I hereby authorise any dentist, hospital, doctor or other person who has attended me, to release to Asteron Life Limited ("Asteron Life") or its representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

I hereby authorise any insurer, adviser/broker, accountant, institution, employer, business entity, medical institution, professional board or company, legal professional or entity, to release to Asteron Life or its representatives, all information which Asteron Life requests for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

**Person Insured**

Full name _____ Signature _____ Sign here

Date _____

**Policy Owner(s) 1**

Full name _____ Signature _____ Sign here

Date _____

**Policy Owner(s) 2**

Full name _____ Signature _____ Sign here

Date _____

**Asteron Life**
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Issuer: Asteron Life Limited

## Additional Information