# Claim Form
# Freedom Protection Plan
# Accidental Death Cover

| | |
|---|---|
| Plan Number: | |
| Plan Owner: | |
| Life Insured (Deceased): | |
| Nominated Beneficiaries: | |

## Important information about completing this form

- This claim form is to be completed and signed by:
  1. The Plan Owner **(where the deceased Life Insured is NOT the Plan Owner).**

  **OR**

  2. A representative of the deceased's estate **(where the deceased Life Insured is also the Plan Owner).**

  **OR**

  3. A representative of a nominated beneficiary **(where the deceased Life Insured is also the Plan Owner and beneficiaries have been nominated).**
- Please answer all the questions fully to ensure that the claim is assessed as quickly as possible. Answers left blank or not fully completed may delay the assessment of the claim.
- False statements or failure to advise Swiss Re Life & Health Australia Limited (**"Swiss Re"**) of any relevant information may lead to Swiss Re declining your claim.
- If you have any questions regarding the completion of this form, please contact Freedom Insurance on **1300 88 44 88.**

## Documentation Required

- The following additional documents must accompany this form:

☐ **Death Certificate:** A certified copy of the deceased's death certificate.

☐ **Evidence of Age:** A certified copy of evidence of the deceased's age (Birth Certificate or current Passport).

☐ **Change of Name:** If the deceased's name at the date of death is different to that stated either above or in the Death Certificate (or the document evidencing their age), a certified copy of the Marriage Certificate, Deed Poll or other document evidencing the name change is required.

☐ **Police and/or Coroner's Report**: A certified copy of any Police and / or Coroner's Report.

☐ **Other Information:** Any other information which Freedom Insurance has specifically asked you to provide.

☐ **Will:** A copy of the deceased's will (if any) is required where the Plan Owner is the deceased and either no nominated beneficiary has been named or any of the nominated beneficiaries named are under 18 years of age.

☐ **Probate or Letters of Administration:** Where Probate has been granted or Letters of Administration have been issued, please provide a certified copy (only required where the Plan Owner is the deceased and no nominated beneficiary has been named).

**Please tick the documents you are providing. If any of these documents are not immediately available, please complete the remainder of the form and tell us below when the required documents will be available**.

**Please return the completed forms and required documents to Freedom Insurance:**
**By Mail: Freedom Insurance Claims, GPO Box 3553 Sydney NSW 2001**
**By Email: claims@freedominsurance.com.au**

## PART A - CLAIMANT INFORMATION

I am submitting this claim form as:

- ☐ Plan Owner
- ☐ A Relative of the Deceased – you will also need to complete **Part D – Estate Details**
- ☐ Executor/Administrator – you will also need to complete **Part D – Estate Details**
- ☐ Nominated Beneficiary (or representative of a nominated beneficiary where under 18 years of age)

**Claimant's Details** (only complete If **NOT** the Plan Owner)

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Surname: Date of Birth:

Given Name(s):

Residential Address:

State: Postcode:

Home Phone: Business Phone:

Mobile Phone: Email:

Relationship to Deceased:

## PART B - INJURY DETAILS

1. Date of death:
2. What was the cause of death:
3. Place of death (Town, City, Country):
4. What injuries were sustained by the deceased in the accident?

5. Was death caused solely by the injuries sustained in the accident described above? ☐ **YES** ☐ **NO**

   If "NO", please provide details of any other contributing cause of death?

6. Has the deceased ever had the same or a similar injury or history of any condition that may have contributed to the injuries or their death? ☐ **YES** ☐ **NO**

   If "YES", please provide details.

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7. Was the injury sustained whilst the deceased was carrying out the duties of their occupation? ☐ **YES** ☐ **NO**

If "YES", what was the deceased occupation at the date of death and where was the deceased working at the time of the accident?

8. Were the injuries self-inflicted? ☐ **YES** ☐ **NO**

If "YES", please provide details.

9. Please advise the name and address of the deceased's usual doctor/medical clinic.

Name:

Address:

State: Postcode:

## PART C - ACCIDENT DETAILS

10. When did the accident occur? Date: ☐ **AM** ☐ **PM**

11. Where did the accident occur?

12. Please describe the circumstances of the accident causing the injuries (including what the deceased was doing when it occurred).

13. Were there any witnesses to this accident? ☐ **YES** ☐ **NO**

If "YES", please provide their names and contact details.

14. Were any Emergency Services involved?

| | | | | | |
|---|---|---|---|---|---|
| Police | ☐ **YES** | ☐ **NO** | Ambulance | ☐ **YES** | ☐ **NO** |
| Fire | ☐ **YES** | ☐ **NO** | Other | ☐ **YES** | ☐ **NO** |

If "YES" for "Other", please specify the service.

15. Was the deceased taken to a hospital following the accident? ☐ **YES** ☐ **NO**

If "YES": What was the name of the hospital?

Date of admission: Date of discharge (if applicable):

16. Do you have anything else you wish to tell us about the circumstances of the accident or how the injuries occurred? ☐ **YES** ☐ **NO**

If "YES", please provide this information here.

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## PART D - ESTATE DETAILS

**Only complete this where required by Part A**

17. Who is handling the Estate of the deceased? ☐ CLAIMANT ☐ ANOTHER PERSON

If "ANOTHER PERSON", please provide details of the person(s).

### Person 1

Name:

Address:

State: Postcode: Phone:

### Person 2

Name:

Address:

State: Postcode: Phone:

18. Did the deceased leave a will? ☐ **YES** ☐ **NO**

If "YES", please provide details of the Executor(s) of the deceased's will. (Indicate Person 1 or 2 if same person as described in question 17).

### Executor 1

Name:

Address:

State: Postcode: Phone:

### Executor 2

Name:

Address:

State: Postcode: Phone:

19. Has anyone applied to a court for Grant of Probate or Letters of Administration in relation to the deceased's estate? ☐ **YES** ☐ **NO**

If "YES", please provide details of the person who applied for the Grant of Probate or Letters of Administration (if known).

Name:

Residential Address:

State: Postcode: Phone:

Relationship to the deceased:

**If Probate has been granted or Letters of Administration have been issued, please provide a certified copy.**

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# PART E - AUTHORITIES, DECLARATION & CONSENT

## To be signed by the Claimant

| Deceased's Name | Claimant's Name | Claimant's Relationship to Deceased |
|---|---|---|
| | | |

## Medical Authority

I hereby authorise any doctor, hospital, therapist or other health professional who has attended the deceased to release to Swiss Re or its representatives such information relating to the deceased which Swiss Re requires for the purpose of assessing this claim, with respect to any sickness or injury, medical history, consultation, medication or treatment received by the deceased, together with copies of any and all relevant medical records. A copy of this authority shall be regarded as valid as the original signed authority.

Claimant's Signature:

Date:

## Information Authority

I hereby authorise any insurer, employer, accountant or other relevant holder of information to release to Swiss Re or its representatives such information relating to the deceased which Swiss Re requires for the purpose of assessing this claim. A copy of this authority shall be regarded as valid as the original signed authority.

Claimant's Signature:

Date:

## Claim Declaration

I hereby declare that the statements made in this claim form are true, correct and complete. I also understand that any false or fraudulent statement or the concealment of material fact may result in Swiss Re Life & Health Australia Limited declining your claim.

Claimant's Signature:

Date:

## Privacy Disclosure Statement – Use and Disclosure of Personal Information

The purpose of collecting personal and sensitive information is to assess the claim. If the information given to Swiss Re is not complete or accurate, or if we are not able to obtain a valid consent to Swiss Re or its representatives obtaining the deceased's personal information from third parties, we may not be able to assess entitlements to benefits and provide the services under the insurance. You are entitled to request reasonable access to the information we hold about the deceased. We reserve the right to charge an administration fee for copying and providing information you request.

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## Authority and Consent

- I have read and understood the Privacy Disclosure statement above.
- I hereby authorise and consent to Swiss Re or its representatives providing the deceased's personal information (which may include sensitive or health information) to third parties, including but not limited to:
    - Any medical professional, hospital or any other healthcare provider or facility operator that has attended or examined the deceased in order for them to provide to Swiss Re or its representatives full particulars of the deceased's medical history (including but not limited to) copies of all patient records, referral letters and reports.
    - Any claims assessor, investigator, medical professional, hospital or healthcare provider or facility operator, employer, insurance reference service, credit reference service, legal or accounting firm, auditor, consultant, other insurance company or reinsurer for the purpose of producing a report in respect of this claim.

Claimant's Signature:

Date:

## Banking Details

Name: Date of Birth:

Address:

Signature:

Date:

**EFT Payment Details**

Financial institution:

BSB Number

Account Number

Account Name

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