Claim Form
Freedom Protection Plan
Accidental Injury Cover - Part A

Plan Number

Plan Owner (Claimant)

Life Insured (Injured Person)

Claim Type

Important information about completing this form

- This claim form is in 2 parts:
  - **Part A** is to be completed and signed by the Life Insured (except it should be completed by the Plan Owner or any person able to accurately complete the form where the Life Insured is either under 18 years of age or unable to do so due to the nature of their injuries).
  - **Part B** is to be completed and signed by the doctor who is treating the Life Insured for the accidental injury. This report is to be obtained at the cost of the Plan Owner (Claimant).
- 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:

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

☐ **Change of Name:** If the Life Insured's name is currently different to that stated either above (or in the document evidencing their age), a certified copy of the Marriage Certificate, Deed Poll or such other document evidencing the name change.

☐ **Test results and reports:** A copy of any additional test results or reports and any information which may assist us with the assessment of this claim.

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

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

DETAILS OF THE LIFE INSURED'S INJURY

TO BE COMPLETED BY THE LIFE INSURED (except it should be completed by the Plan Owner or any person able to accurately complete the form where the life insured is either under 18 years of age or unable to do so due to the nature of their injuries)

This Part A is completed by (please tick appropriate box):

☐ Life Insured

☐ Plan Owner

☐ Other Person

If other than the Life Insured, please provide name and relationship to the life insured.

Name:

Relationship to Life Insured: Phone No.

1. Please provide full details of the injury.

2. Have you ever had the same or a similar injury or history of any condition that may have contributed to your injury? ☐ **YES** ☐ **NO**
   If "YES", please provide details.

3. Describe the circumstances of the accident causing the injury (including what you were doing when it occurred and where it occurred).

4. Was the injury caused solely by an accident? ☐ **YES** ☐ **NO**
   If "NO", please provide details of any other contributing cause to the injury.

5. When did the accident that gave rise to the injury occur?

6. What date was the injury diagnosed?

7. Was the injury self-inflicted? ☐ **YES** ☐ **NO**
   If "YES", please provide details:

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8. Was the injury sustained whilst you were carrying out the duties of your occupation? ☐ **YES** ☐ **NO**
If "YES", what is your occupation and where were you working at the time of the accident?

9. Were there any witnesses to the accident? ☐ **YES** ☐ **NO**
If "YES", please provide details (including name and contact details):

10. Were any Emergency Services involved?

Police ☐ **YES** ☐ **NO**

Ambulance ☐ **YES** ☐ **NO**

Fire ☐ **YES** ☐ **NO**

Other ☐ **YES** ☐ **NO** If "YES", please specify the service:

11. Were you taken to a hospital following the accident? ☐ **YES** ☐ **NO**
If "YES":
What was the name of the hospital?

Date of admission:

Date of discharge:

12. Please provide details of all medical providers that treated the injury or which were consulted in relation to the injury.

Providers full name	Specialty	Treatment Provided	Date Consulted	Contact Details

13. Do you have anything else you wish to tell us about the injury or the circumstances under which it occurred? ☐ **YES** ☐ **NO**
If "YES", please provide this information here.

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Authorities, Declaration & Consent

TO BE SIGNED BY THE LIFE INSURED (except it should be signed by a parent or legal guardian where the Life Insured is under 18 years of age or a person authorised to act on their behalf where the Life Insured is unable to sign due to the nature of their injuries)

Medical Authority

I hereby authorise any doctor, hospital, therapist or other health professional who has attended me, to release to Swiss Re or its representatives such information 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 me, 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.

Life Insured's Name:

Signature*

Date:

Name of Person signing (if other than Life Insured)

** to be signed by the life insured (or a parent or legal guardian where the life insured is under 18 years of age or a person authorised to sign on their behalf where the life insured is unable to sign due to their injuries).*

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 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

Life Insured's Name:

Signature*

Date:

Name of Person signing (if other than Life Insured)

** to be signed by the life insured (or a parent or legal guardian where the life insured is under 18 years of age or a person authorised to sign on their behalf where the life insured is unable to sign due to their injuries).*

Claim Declaration

I hereby declare that the above statements are true, correct and complete. I also understand that any false or fraudulent statement or concealment of material fact may result in the claim being cancelled or cause a benefit not to be payable.

Signature**

Date:

Name of Person signing (if other than Life Insured)

*** to be signed by the life insured or the person completing Part A of the claim form where the life insured was unable to complete that Part due to being under 18 years of age or due to their injuries.*

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Privacy Disclosure Statement – Use and Disclosure of Personal Information

The purpose of collection personal and sensitive information is to assess the claim. If the information you give to Swiss Re is not complete or accurate, or if you refuse to consent to Swiss Re or its representatives obtaining your 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 you. We reserve the right to charge an administration fee for copying and providing information you request.

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 my personal information (which may include sensitive or health information) to third parties including but not limited to:
  - o Any medical professional, hospital or any other healthcare provider or facility operator that has attended or examined me in order for them to provide to Swiss Re or its representatives full particulars of my medical history (but not limited to) copies of all my patient records, referral letters and reports.
  - o 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.

Signature*

Date:

Name of Person signing (if other than Life Insured)

** to be signed by the life insured (or a parent or legal guardian where the life insured is under 18 years of age or a person authorised to sign on their behalf where the life insured is unable to sign due to their injuries).*

Banking Details

Name: Date of Birth:

Address:

Signature:

Date:

EFT Payment Details

Financial institution:

BSB Number

Account Number

Account Name

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