

# Children's Insurance Claim Form

## (Optional benefit)

- To help ensure you receive a prompt assessment, please complete all the required sections of this form. If you need assistance, please call **1300 307 297**. Please note however, that a claim cannot be assessed until all original documents are received.
- Please note that the information required to be completed in this form is in relation to the Child Insured, unless otherwise stated.
- To ensure that the claim can be fully assessed, and to avoid any delays to this process, please ensure that all the questions in this form are thoroughly addressed and answered. Responses such as "refer to doctor", "see above", etc. are not acceptable. Failure to address and answer all questions in this form may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this form 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 question on this form you are addressing. Please ensure that you sign and date the piece of paper.

### Filling in this form:

- Use a black or blue pen
- Mark boxes like this  with ✓ or ✗
- Where you see a box like this ▶ follow the instructions after the right arrow.

There are two parts to the claim form:

#### For Serious Injury or Illness:

- **Part A** is to be completed by the Policyowner/Claimant.
- **Part B** is to be completed by the registered Medical Practitioner treating the Child Insured.

#### For Death :

- **Part A** is to be completed by the Policyowner/Claimant.

#### Distributed by

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# PART A: Children's Insurance Serious Injury or Illness Claim Form



## Privacy Collection Notice

In this form, "we", "us", or "our" refers to Greenstone Financial Services Pty Ltd ("GFS"), St Andrew's Life Insurance Pty Ltd ("St Andrew's") and Hannover Life Re of Australasia Ltd ("HLRA"). We collect and handle personal information about you on behalf of St Andrew's who are the issuer of your policy, and HLRA who administer and assess your claim on behalf of St Andrew's, in compliance with the Privacy Act 1988 (Cth). All information collected throughout the claims process by any of us may be shared with all those companies.

## Collection and 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 collect it from a third party such as our related bodies corporate, authorised administrators, 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.

By providing this information, you specifically consent to GFS, HLRA, and St Andrew's being provided with medical information (including copies of any medical reports, clinical reports, or others) from any Doctor who at any time has attended to you or the insured.

## 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, Philippines, and France.

## Access correction and complaints

You can read more about how GFS collects, uses, and discloses your personal information in their Privacy Policy (including how to complain about a breach of the Privacy Principles) which is available on their website at [greenstone.com.au/privacy-policy.html](http://greenstone.com.au/privacy-policy.html) or you can request a copy by calling GFS at **02 8886 8300** or emailing [privacy@greenstone.com.au](mailto:privacy@greenstone.com.au).

HLRA's Privacy Policy is also available at [hannover-re.com/1094181/australia\\_lh\\_privacy](http://hannover-re.com/1094181/australia_lh_privacy) (or by contacting HLRA using the details set out in this form or emailing [privacyofficer@hlra.com.au](mailto:privacyofficer@hlra.com.au)). It outlines HLRA's personal information handling practices, including details on how you can seek access or correction of the personal information that HLRA hold about you, how to complain if you believe HLRA has breached the Australian privacy laws and HLRA's complaint handling processes.

St Andrew's Privacy Policy (also applicable to St Andrew's Australia Services Pty Ltd) can be found at [standrews.com.au/privacy](http://standrews.com.au/privacy) and describes how St Andrew's deals with your personal information, how you can have access to and seek correction of your personal information, how you can complain about a breach of the privacy laws that bind us, and how your complaint will be handled. If you have any query in relation to your privacy or if you wish to lodge a complaint, please contact St Andrew's on **1300 363 159** or email [customerservice@standrews.com.au](mailto:customerservice@standrews.com.au).

If you wish to gain access to your information (including correcting or updating it), have a complaint about a breach of your privacy or have any other query relating to privacy, please call **1300 367 325** Monday to Friday, 8am – 8pm (AEST).

## Section A – Policyowner's details

Title	<input type="text"/>	First name	<input type="text"/>	Surname	<input type="text"/>
Policy number	<input type="text"/>				
Residential address	<input type="text"/>				

Postal address

Phone (home)  (work)  (mobile)

Email

## Section B – Child Insured’s details

First name  Surname

Date of birth  Weight  Height

## Section C – Type of claim

This is a claim for:

- Death  **Complete Sections D, F, G, H, I**
- Serious Injury or Illness  **Complete Sections E, F, G, H, I**

## Section D – Death Insurance claim

### 1. Child Insured’s details

Name of Child Insured  Date of death

Cause of death

### 2. Claimant’s details

I am the:  Nominated Beneficiary  Policyowner  Relative  Executor  Other

Title  First name  Surname

Residential Address

Postal Address

Phone (home)  (work)  (mobile)

Email

Relationship to Child Insured

SIGN HERE

Policyowner/Claimant’s signature

Date

### 3. Authority to release information

I, , as Executor/Administrator/Guardian of

hereby authorise any physician, clinic, hospital, institution or insurance company to supply upon request to HLRA, on a confidential basis all details of any medical test, treatment or history that it may reasonably request.

A photocopy of this declaration shall be treated as valid an authority as the original.

**NOTE: This authority is to be completed by the Executor/Administrator/Guardian and a copy of the relevant legal documents must be provided (e.g. Will, Letter of Administration, Power of Attorney).**

SIGN HERE

Executor/Administrator/Guardian’s signature

Date

## Section E – Accidental Serious Injury or Illness claim details

1. Has the injury or illness that occurred resulted in any of the following conditions? Please tick one.

- Benign Tumour of the Brain or of the Spinal Cord     Blindness     Cancer     Chronic Kidney Failure     Deafness  
 Diagnosis of a Terminal Illness     Encephalitis     Major Head Trauma     Major Organ Transplant  
 Meningitis (and/or Meningococcal Disease)     Paralysis     Severe Burns     Total and Permanent Loss of Use of One Limb

2. On what date did the symptoms or injury first occur?

DD / MM / YYYY

3. What is the date a diagnosis was made of the Child Insured's condition?

DD / MM / YYYY

4. Has the Child Insured previously had the same or similar condition or symptoms?

No  Yes   Please provide full details:

5. The doctor the Child Insured first consulted about the claimed condition:

Name

Address

Phone number

Date of first consultation

DD / MM / YYYY

Date of last consultation

DD / MM / YYYY

6. Is the doctor named in Question 5 the usual doctor the Child Insured attends?

Yes  No   Please provide details of the Child Insured's usual doctor:

Doctor's name

Address

Phone number

### Doctor's Authority – Release of Child Insured's full record

Release a copy of the full record, including consultation notes, held by the Child Insured's Medical Practitioner/Practice.

I declare that I'm legally authorised to:

- submit this claim in relation to the Child Insured; and
- request a copy of the Child Insured's medical records.

I authorise any Medical Practitioner or hospital the Child Insured had attended to release a copy of their full record, including consultation notes, to Hannover Life Re of Australasia Ltd, or to third parties they engage, including asking any Medical Practitioner to provide a report regarding any treatment or advice given to the Child Insured.

I agree to all of the following:

- Hannover Life Re of Australasia Ltd can collect, use, store and disclose my (and the Child Insured's) personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles;
- This Authority is valid only while Hannover Life Re of Australasia Ltd is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover; and
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name of Child Insured

DD / MM / YYYY

Date of Birth of Child Insured

Claimant's Signature

DD / MM / YYYY

Date

SIGN HERE



X

Policyowner/Claimant's signature

DD / MM / YYYY

Date

### Section F – Policy discharge

**(Please note this section of the form will only be used if St Andrew's accepts liability for the claim)**

I/We hereby request payment of the benefit payable for the Insurance Policy (full details on page 2 of this form), in full satisfaction for all claims whatsoever under the Policy for the Child Insured

Child Insured's name

and do hereby discharge St Andrew's from all liability thereunder other than for payment of the benefit.

**Please ensure that all questions have been answered before you proceed further. If you fail to do so we will be unable to assess and process your claim.**

## Section G – Declaration

As the Policyowner/Claimant, 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, and that if I fail to provide all or part of the information **Hannover Life Re of Australasia Ltd (“HLRA”)** requires to assess this claim, it will not be assessed and processed.

SIGN HERE

X

Policyowner/Claimant’s signature

DD / MM / YYYY

Date

## Section H – Checklist

**Certified copies of the relevant documentation related to this claim are attached as follows:**

### What is a certified copy?

This is a signed photocopy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, accountant, solicitor, doctor, bank manager or police officer. It means you keep the original.

### Children’s Insurance

- The original Policy Document and Policy Schedule.  
If these documents have been misplaced, please complete the Statutory Declaration

**Go to Section J – Statutory declaration on Page 6**

- A certified copy of proof of the Child Insured’s identity (e.g. Birth Certificate, Passport, or Driver’s Licence).
- A certified copy of proof of the Policyowner’s identity (e.g. Birth Certificate, Passport, or Driver’s Licence).
- (If applicable) A completed and signed Medicare Authority Form authorising the release of the Child Insured’s Medical and Pharmaceutical Benefits Scheme claim information.
- (If applicable) A certified copy of proof of the Child Insured’s death (e.g. Death Certificate) and certified copies of any Police and/or Coroner’s Report.

## Section I – Direct credit authority

**Completing the details below will assist us in getting your claim payment to you as quickly as possible.**

This section of the form must be completed by the Policyowner.

If your claim is approved, the Benefit Amount payable will be credited to the account below.

BSB number (branch number)  -  Account number

Account name

Name of bank/  
financial institution

Branch name/  
location of financial institution

NB. If your account is held with a Credit Union, it may take longer for the Benefit Amount payable to be cleared. May we suggest you contact your nominated Credit Union.

SIGN HERE

X

Policyowner’s signature

DD / MM / YYYY

Date

## Section J – Statutory declaration

I, (insert name, address and occupation)

Name

Address

Occupation

do solemnly and sincerely declare that I am the legal owner/beneficial owner of Policy number

Policy number

("Policy") on the life/lives of

Child Insured's name

issued by St Andrew's Life Insurance Pty Ltd ("St Andrew's").

I have satisfied myself by exhaustive enquiry that for the above Policy, none of the members of my family or my solicitor has any knowledge of the Policy documents' whereabouts nor have they been disposed of by me or to the best of my knowledge by any other person, nor are the Policy documents held by my bank or any other person for safekeeping or lodgement.

The Policy documents have been lost in the following circumstances:

I have not assigned, mortgaged or otherwise dealt with the above Policy in any way and there is no lien on it.

I undertake to return the previous Policy documents to St Andrew's should they be found.

I make this solemn declaration by virtue of the Statutory Declarations Act 1959 as amended and subject to the penalties provided by the Act for the making of false statements in statutory declarations, conscientiously believing that the statements contained in this declaration are true in every particular.

SIGN HERE

X

Policyowner/Claimant's signature

DD / MM / YYYY

Date

Declared at

DD / MM / YYYY

Date

SIGN HERE

X

Before me (authorised signatory's signature)

DD / MM / YYYY

Date

Full name

Occupation/title

**NOTE 1** – A person who willfully makes a false statement in a statutory declaration under the Statutory Declarations Act 1959 as amended is guilty of an offence against the Act, the punishment for which is a fine not exceeding \$200 or imprisonment for a term not exceeding six months or both if the offence is prosecuted summarily, or imprisonment for a term not exceeding four years if the offence is prosecuted upon indictment.

**NOTE 2** – A statutory declaration under the Statutory Declarations Act 1959 as amended may be made only before a Chief Police, Resident or Special Magistrate; Stipendiary Magistrate or any Magistrate in respect of whose office an annual salary is payable; a Justice of the Peace; a person authorised under any law in force in Australia or its Territories to take affidavits; a person appointed under the Statutory Declarations Act 1959 as amended or under a State Act to be a Commissioner for Declarations; a person appointed as a Commissioner for Declarations under the Statutory Declarations Act 1959, or under that Act as amended, and holding office immediately before the commencement of the Statutory Declarations Act 1959; a Notary Public; a person before whom a statutory declaration may be made under the law of the State in which a declaration is made; or a person appointed to hold, or act in, the office in a country or place outside Australia of Australian Consul-General, Consul, Vice-Consul, Trade Commissioner, Consular Agent, Ambassador, High Commissioner, Minister, Head of Mission, Commissioner, Charge D'Affaires, or Counsel, or Secretary or Attache at an Embassy, High Commissioner's office, Legation or other post.

# PART B: Children's Insurance Serious Injury or Illness Claim Form – Confidential Medical Report



**This form is to be fully completed by the registered Medical Practitioner treating the Child Insured.**

- Please note that the information required to be completed in this form is in relation to the Child Insured.
- Please note that it is the Policyowner's responsibility for the payment of all fees associated in the completion of this form.
- In order to ensure that the claim can be fully assessed, and to avoid any delays to this process, please ensure that all the questions in this form are thoroughly addressed and answered. Failure to address and answer all questions in this form may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this form 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 question on this form you are addressing. Please ensure that you sign and date the piece of paper.

## Section A – Child Insured's details

First name  Surname

Date of birth

Residential address

## Section B – Child Insured's medical details

1. Are you the Child Insured's usual medical attendant? Yes  No
2. What is the exact diagnosis of the condition? Please attach copies of all pathology, test results, etc. that confirm the diagnosis.

3. What is the date of diagnosis?
4. What is the date of the first consultation in connection with the current condition?
5. Please provide the dates and results of any X-rays, ECG, blood pressure or other tests performed.

Date	Test	Results
<input type="text" value="DD / MM / YYYY"/>		
<input type="text" value="DD / MM / YYYY"/>		
<input type="text" value="DD / MM / YYYY"/>		
<input type="text" value="DD / MM / YYYY"/>		

6. What treatment is currently being given (including surgery and medication) if any?
- 

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

Name	Address	Specialty or medical service



8. If the Child Insured has been hospitalised, provide the following dates.

Admission date	Discharge date	Name of hospital
DD / MM / YYYY	DD / MM / YYYY	
DD / MM / YYYY	DD / MM / YYYY	
DD / MM / YYYY	DD / MM / YYYY	
DD / MM / YYYY	DD / MM / YYYY	

9. Have you ever treated the Child Insured before for any condition?

No  Yes   Please supply details.

Date consulted	Nature of the condition
DD / MM / YYYY	
DD / MM / YYYY	
DD / MM / YYYY	
DD / MM / YYYY	

10. Please provide details if the Child Insured has a previous history of the current condition, or any impairment likely to be connected with the current condition.

### Section C – Medical Practitioner’s declaration and agreement

I hereby certify that I have personally attended to the Child Insured and that all the information supplied by me in this Report is true. I agree that Hannover Life Re of Australasia Ltd (“HLRA”) may provide copies of this Report to any medical specialist from whom HLRA 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 HLRA is obligated under the Privacy Act 1988 to give access to this Report.

Name

Qualifications

Address

Telephone  Facsimile

Email

**SIGN HERE** 

Medical Practitioner’s signature Date