Death claim form

ZURICH

This form is to be completed by the person or persons legally entitled to claim the policy proceeds.

To avoid delays, check that all questions have been answered fully.

Please use BLOCK LETTERS.

Policy Number/s

Claim Reference Number

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any Personal or Sensitive Information ('Information'), you should know the following information.

We collect, use, process and store personal information and, in some cases, Sensitive Information about you in order to comply with our legal obligations and in order to assess your claim ('purposes').

Where relevant for this purpose, we will disclose this information (other than sensitive information such as health information) to your adviser (and the licensed dealer or broker he or she represents), affiliates of the Zurich Insurance Group Ltd, to other insurers and reinsurers, to our agents, contractors, service providers and administrators, doctors and where we are required or permitted to by law.

Where relevant, to assess your claim, we will also disclose personal information, including sensitive information such as health information to medical practitioners, other health professionals, other insurers and reinsurers, legal representatives and other consultants. By signing this claim form, you consent to those organisations and other professionals collecting, and us disclosing sensitive information about you for this purpose.

If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of your claim may be delayed or we may not accept the claim.

Zurich may obtain Information from government offices and third parties to assess a claim.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your Information to, a list of countries in which recipients of your Information are likely to be located, details of how you can access or correct the Information we hold about you or make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 132 687 or email us at privacy.officer@zurich.com.au

1 Life insured details

Title Surname

Given names

Date of birth / / Place of birth (city/state/country)

Address State Postcode

Date of death / / Place of death (city/state/country)

Cause of death

If death was caused by illness, when was the illness first diagnosed / /

If death resulted solely from bodily injury, please indicate how this happened?

Motor vehicle accident ◯ Suicide ◯ Homicide ◯

Other accident ◯ Please provide details

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2 Consultations

Name of life insured's usual doctor

Address State Postcode

Contact number

Name of doctor who first diagnosed illness

Address State Postcode

Contact number

List the names and addresses of all doctors who attended the life insured, that are known to you.

Doctor's name	Address	Date	Illness
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

3 Information about the estate

(a) Did the Life Insured have a Will? Yes ◯ No ◯

(i) If 'Yes', who are the Executors?

Is an application for Probate being made? Yes ◯ No ◯

Has Probate been granted? Yes ◯ No ◯ If 'Yes', to whom?

(ii) If no Will was left, are Letters of Administration being applied for? Yes ◯ No ◯ If 'Yes', by whom?

(b) In what capacity do you make the claim? Executor ◯ Administrator ◯ Policy Owner ◯ Beneficiary ◯

Please advise your relationship to the life insured

4 Declaration and authority (to be signed by every claimant)

I declare that as the person(s) legally entitled to claim and receive the proceeds of the Policy on the death of:

.....

I have read and understand all the statements, questions and answers shown above and to the best of my knowledge and belief, those statements and answers are true and complete in every particular.

I, the undersigned, authorise any hospital, physician or insurance company, employer or association to furnish to Zurich Australia Limited, or to any other representative, any and all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

Claimant 1

Name .....

Address ..... State ..... Postcode .....

Contact number .....

Signature ✗ ..... Date / /

Name of witness .....

Signature ✗ ..... Date / /

Claimant 2

Name .....

Address ..... State ..... Postcode .....

Contact number .....

Signature ✗ ..... Date / /

Name of witness .....

Signature ✗ ..... Date / /

Claimant 3

Name .....

Address ..... State ..... Postcode .....

Contact number .....

Signature ✗ ..... Date / /

Name of witness .....

Signature ✗ ..... Date / /

Any questions?

Call 131 551 or email: life.claims@zurich.com.au

Please return completed form to:

Zurich Australia Limited
Life Risk Claims
Locked Bag 994
North Sydney NSW 2059