Claimant's statement

ZURICH

This form is to be completed by the life insured and the policy owner.
To avoid delays check that all questions have been answered fully.
Please use BLOCK LETTERS.

Policy Number

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 / /

Address State Postcode

Contact numbers Home ( ) Mobile

Fax ( ) Email

2 Diagnosis

Date symptoms first noticed / /

Please provide details of the symptoms that prompted you to seek medical attention

When did you first seek medical advice / / Date condition diagnosed / /

Name of practitioner who diagnosed this condition

Address State Postcode

Details of diagnosis

Have you previously had the same or a similar condition? Yes ◯ No ◯ If 'Yes', please provide details

Zurich Australia Limited ABN 92 000 010 195, AFSLN 232510. 5 Blue Street North Sydney NSW 2060.

2 Diagnosis (continued)

Have you undergone any special tests (eg ECG, blood tests) prior to or after the onset of this condition? Please attach copies of any relevant test results.

Date	Name of doctor	Address	Test performed
/ /			
/ /			
/ /			
/ /			

3 Consultations

Name of your usual doctor

Address State Postcode

Contact number

Medical practitioners consulted for this condition

Date	Name of doctor	Address	Contact number
/ /			
/ /			
/ /			
/ /			

Details of hospitalisation for this condition

Date	Date discharged	Name of hospital	Address
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

Details of all medical practitioners consulted in the last five years

Date	Name	Address	Contact number	Reason
/ /				
/ /				
/ /				
/ /				

4 Claims and insurance history

Do you have similar insurance cover? Yes ◯ No ◯ If 'Yes', please provide details

Name of company	Policy number	Date	Amount of cover
		/ /	$
		/ /	$
		/ /	$
		/ /	$

Have you lodged a claim for this condition with any other company? Yes ◯ No ◯ If 'Yes', please provide details

5 Additional information

6 Payment details

Preferred method of claim payment ◯ Cheque ◯ Direct credit

Direct credit details

Please provide bank account details where you would like the funds to be deposited. Please note that the account must be in the name of the policy owner.

Name of financial institution

Branch address State Postcode

Account name

Bank/State/Branch (BSB number) | | | | – | | | | Account Number | | | | | | | | | |

7 Declaration and authority

I declare that the statements I have made on this form are true and correct in every particular. I also understand that any false statement, concealment of material facts, or omission may result in the policy being cancelled or cause a benefit not to be payable.

I authorise any Hospital, Physician, or any other person who has attended me, any other insurance company, my employer or accountant, to provide to Zurich Australia Limited any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatments and copies of all hospital or medical and financial records. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Name of life insured

Signature of life insured Date

✗ / /

Name of policy owner

Signature of policy owner Date

✗ / /

Name of witness

Signature of witness 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