Total & Permanent Disability Insurance Claim Form

(Optional Benefit)

- To help ensure you receive a prompt assessment, please complete all the required sections of this booklet. If you need assistance, please call **1300 513 483**. 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 document is in relation to the Life Insured, unless otherwise stated.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the relevant items in this document are fully addressed and answered. Responses such as "refer to doctor", "see above", etc., are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this document 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 item on this document 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 ✗

There are 3 parts to the claim form:

- **Part A** is to be completed by the Life Insured.
- **Part B** is to be completed by the Life Insured's employer.
- **Part C** is to be completed by the registered Medical Practitioner treating the Life Insured.

Distributed by
Greenstone Financial Services Pty Ltd
on behalf of Kogan Life Insurance
ABN 53 128 692 884, AFSL 343079

Issued by
Hannover Life Re of Australasia Ltd
ABN 37 062 395 484, AFSL 530811
Tower 1, Level 33
100 Barangaroo Avenue
Barangaroo NSW 2000
Phone: (02) 9251 6911
Email: hlra@hlra.com.au

H7142_Kogan_TPD_Claims_10/22

Please return this form to Kogan Life Insurance, Reply Paid 6728, Baulkham Hills, NSW 2153

PART A: Total & Permanent Disability Claim Form

Privacy Collection Notice

Greenstone Financial Services Pty Ltd ("GFS", "we", "us" or "our") collects and handles personal information about you on behalf of Hannover Life Re of Australasia Ltd ("HLRA") in compliance with the Privacy Act 1988 (Cth). All information collected throughout the claims process by GFS or HLRA will be shared with both 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.

Overseas disclosure

We or HLRA 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 and France.

Access correction and complaints

You can read more about how we collect, use and disclose your personal information in our Privacy Policy, including how to complain about a breach of the Privacy Principles, which is available on our website or you can request a copy by contacting us.

HLRA's Privacy Policy is also available at 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). 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.

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 513 484** Monday to Friday, 8am – 8pm AEST.

Section A – Policy Information

Policyowner | Policy number

Section B – Details of the Life Insured

Applicable only to policies including the Total & Permanent Disability Insurance Option.

1. Personal information of the Life Insured

Title | First name | Surname

Residental address

Postal address

Date of birth (DD / MM / YYYY) | Gender: Male | Female | Height (cm) | Weight (kg)

Country of birth | Are you an Australian resident? Yes | No

Phone (home) | (work) | (mobile)

Email

Language spoken at home | Is an Interpreter required? Yes | No

2. Employer details

a. Name of employer/company

b. Work address

c. Commencement date (DD / MM / YYYY) | Telephone

3. Details of your injury or illness

a. If you are submitting this application more than 12 months after the date on which you last worked, please state the reasons for the deferral:

b. Please state the reasons why you ceased work (If you have ceased work due to Redundancy, Resignation or Termination, please provide a copy of the relevant documentation):

c. Please state the exact nature of the injury or illness that caused you to cease work:

d. On what date did the injury occur or did you first become ill? (DD / MM / YYYY)

e. Please give details of all doctors, physiotherapists, chiropractors etc. consulted by you, including any hospital treatment you may have received in relation to your disability.

Name of doctor	Address	Date of first consultation	Date of most recent consultation
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

f. Are any of the doctors named in (e) above the usual doctor you attend? Yes ☐ No ☐ ▶ Please provide details of your usual doctor:

Doctor's name

Address

Phone number

g. Have you ever suffered from the same or similar illness? (Please tick.) No ☐ Yes ☐ ▶ Please supply details:

Date of episode	Period off work	Name of attending doctor
DD / MM / YYYY		
DD / MM / YYYY		
DD / MM / YYYY		
DD / MM / YYYY		

4. Occupational details

a. What was your job title?

b. Please describe all your work duties in detail:

c. How many hours did you normally work each week?

d. On what date did you last work? DD / MM / YYYY

e. Please list all of the work duties your disability prevents you from performing:

f. Since ceasing work with your employer, have you been able to perform work of any kind? No ☐ Yes ☐ ▶ Please supply details:

Period of work	Job title	Part time or full time	Income earned (before income tax)

g. Have you applied for any jobs since ceasing work? No ☐ Yes ☐ ▶ Please supply details:

h. Are you now able to perform any duties of your occupation? No ☐ Yes ☐ ▶ Please list which duties you can perform:

i. What level of education do you have? Primary ☐ Secondary ☐ Tertiary ☐

j. What qualification or licencing certificates do you have? Please supply details:

k. Do you have any other training or skills? No ☐ Yes ☐ ▶ Please supply details:

l. Please supply details of all previous jobs you have performed and/or enclose a copy of your resume:

Employer	Description of job	Approximate dates
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY

m. Please list any work you think you may be able to perform in the future:

n. Have you received, or are you entitled to claim any benefits under any Insurance Policy such as income protection, lump sum total and permanent disablement or trauma, or any benefit such as Worker's Compensation, Invalid Pension, Sickness benefit, Veterans Affairs benefits or Unemployment benefits? No ☐ Yes ☐ ▶ Please supply details:

Period	Type of benefit	Name and company address	Case manager and telephone number	Claim number

o. Please state your current daily activities:

Please ensure that all questions have been answered before you proceed further.

5. Disclosure of information – doctor's authority

Releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **Hannover Life Re of Australasia Ltd**, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Doctor's Authority 1 – Release of information, excluding consultation notes

Explanatory notes: Through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Doctor's Authority 2 – Release of full record

Explanatory notes: Through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Doctor's Authority 1 – Release of information, excluding consultation notes

Release any of my health information except the consultation notes held by my General Practitioner/Practice.

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Hannover Life Re of Australasia Ltd, or to third parties they engage.

I agree to all of the following:

- My health information can be released in the form Hannover Life Re of Australasia Ltd asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- Hannover Life Re of Australasia Ltd can collect, use, store and disclose my 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.
- 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.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Life Insured's name

SIGN HERE ✗

Life Insured's signature

DD / MM / YYYY

Date

Doctor's Authority 2 – Release of full record

Release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances.

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Hannover Life Re of Australasia Ltd, or to third parties they engage, only if Hannover Life Re of Australasia Ltd. has asked them for a report on my health and either:

- The General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- Hannover Life Re of Australasia Ltd can collect, use, store and disclose my 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.
- 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.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim

Life Insured's name

SIGN HERE ✗

Life Insured's signature

DD / MM / YYYY

Date

Section C – 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.

Total & Permanent Disability

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

☐ ▶ **Go to Section G – Statutory Declaration on Page 10**

☐ A certified copy of proof of the Life Insured's identity (e.g. Birth Certificate, Driver's Licence or Passport)

☐ A certified copy of proof of the Policyowner's identity (e.g. Birth Certificate, Driver's Licence or Passport)

☐ A completed and signed Medicare Authority form authorising the release of your Medical and Pharmaceutical Benefits Scheme claim information

Section D – Policy Discharge

(Please note this section of the form will only be used if HLRA accepts liability for the claim)

☐ I/We hereby request payment of the benefit payable for the Insurance Policy (details on page 3 of this document), in full satisfaction for all claims whatsoever under the Policy for the Life Insured

Life Insured's name

and do hereby discharge HLRA from all liability thereunder other than for payment of the benefit.

Section E – Declaration & Consent

I have read and carefully considered the questions in this document and that all the responses are true and correct in relation to me.

I ACKNOWLEDGE that this Declaration is part of a claim for Total & Permanent Disability benefit and that the making of a false statement may invalidate my 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, and that I am the Insured Person of the Policy shown on this document.

I UNDERSTAND that in order to assess and process my application, HLRA may need information about me, including (but not limited to) medical, financial, legal and employment.

I CONSENT to HLRA obtaining information about me from any Medical Practitioner or health professional that I have consulted at any time and anyone that HLRA wishes to appoint to examine me, legal practitioners, legal tribunals and courts, investigation organisations, accountants or other consultants, HLRA's parent company, other insurance or reinsurance companies, the trustees of my superannuation fund, any organisation appointed by the trustees of my superannuation fund to receive or give information, my past and present employers, and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also CONSENT to HLRA disclosing information about me to any of the organisations mentioned above, insofar as such disclosures are necessary for HLRA to perform its functions.

SIGN HERE ▶ ✗ _____ DD / MM / YYYY

Life Insured's signature Date

Section F – 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.
- Once your claim has been assessed, 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. We suggest you contact your nominated Credit Union.

SIGN HERE ✗

Policyowner's signature

DD / MM / YYYY

Date

Section G – 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 Life Insured's name
issued by Hannover Life Re of Australasia Ltd ("HLRA").

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 HLRA 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 ✗

Policyowner/Life Insured's signature — Date: DD / MM / YYYY

Declared at — Date: DD / MM / YYYY

SIGN HERE ✗

Before me (authorised signatory's signature) — Date: DD / MM / YYYY

Full name

Occupation/Title

NOTE 1 – A person who wilfully 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: Employer's Statement in connection with a claim for a Disablement Benefit

To be completed by an authorised representative of the employer.

Name of employer

Full name of employee

Date of birth DD / MM / YYYY

Employee's address

Postcode

Date joined company DD / MM / YYYY

Date of birth DD / MM / YYYY

DD / MM / YYYY

a. Date the employee was last at work.

b. Why did the employee cease work?

c. Have there been any periods of absence? If so, list the periods and reasons.

d. Employee's job title.

e. Precise duties performed by the employee.

f. Number of hours normally worked each week.

g. The education, training or qualifications required to perform the job.

h. The education, training, qualifications and past experience of the employee.

i. Number of people supervised by the employee.

j. Did the employee spend any significant work on the following activities?

	Proportion of Time Spent (%)		Proportion of Time Spent (%)		Proportion of Time Spent (%)
Driving		Walking or standing		Lifting or carrying	
Climbing		Crawling or kneeling			

k. Did the employee's duties allow him/her to move freely during work hours or was he/she confined to a set space or position?

l. Is the employee's job still open?

m. Do you have any other jobs appropriate to the employee's level of skill and experience?

n. Have any alternative jobs been offered to the employee? If so, please give details.

o. Describe any previous jobs the employee has done while employed by you. Include time spent in each job.

p. Can the employee speak, read, and write English? Yes ☐ No ☐

q. Give details of the weekly income the employee was paid at the time of disablement.

r. Give details of the annual income the employee was paid prior to disablement.

s. Give details of any amounts you are currently paying to the employee (e.g. Worker's Compensation, salary).

t. Give details of any benefit already paid to the employee from the Superannuation Fund.

u. Is a claim being made for: Temporary Disablement? Yes ☐ No ☐ Permanent Disablement? Yes ☐ No ☐

v. Other comments (e.g. any other comments you may have which you believe may be relevant to the assessment of the claim).

I declare that I am authorised to answer the above questions on behalf of the employer; and that the responses to the questions on this Statement are true.

SIGN HERE ✗

Authorised representative of the employer's signature

DD / MM / YYYY

Date

PART C: Total & Permanent Disability Claim Form – Confidential Medical Report

This document is to be fully completed by the registered Medical Practitioner treating the Life Insured.

- Please note that the information required to be completed in this document is in relation to the Life Insured.
- Please note that it is the Life Insured's responsibility for the payment of all fees associated in the completion of this document.
- In order to ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this document are fully addressed and answered.
- If for any reason there is not enough room on this document 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 item on this document you are addressing. Please ensure that you sign and date the piece of paper.

The cost of this report is the Life Insured's responsibility.

1. Life Insured's details

Life Insured's family name _____ Given names _____

Date of birth DD / MM / YYYY Occupation _____

Home address _____ Postcode _____

2. Life Insured's medical details

Questions to be answered by the Life Insured's Medical Practitioner.

Please attach a separate statement if space is insufficient for any answer.

1. **a)** On what date did you first attend to the Life Insured in connection with his/her illness or injuries? DD / MM / YYYY

b) On what date did the illness or accident occur? DD / MM / YYYY

c) What was the date of your last attendance? DD / MM / YYYY

d) Has the Life Insured an appointment to consult you again? No ☐ Yes ☐ ▶ Approximate date DD / MM / YYYY

2. On what date did the Life Insured become completely unable to perform all the normal duties of his/her occupation? DD / MM / YYYY

3. Please provide details of other doctors seen by the Life Insured in connection with this disability:

Name of doctor	Address	Telephone	Date of first consultation
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

4. Please state the history of the illness or injury, including the exact nature and severity of the condition and give particulars of any treatment which has been necessary, including dates where relevant. Please also provide full details and results of any tests performed. Please give full details of the current condition.

5. Has hospital admission been necessary? No ☐ Yes ☐ ▶ Please give name of hospital(s) and relevant dates:

Name of hospital	Date of admission	Date of discharge
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY

6. Has surgical treatment been necessary? No ☐ Yes ☐ ▶ **a)** What operation(s) was/were performed?

Operation	Date of performed
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY

b) Post-operative course?

7. Has the Life Insured suffered from the same or similar or related condition?

Yes ☐ No ☐ ▶ Do you consider the disablement to be connected in any way with a previous illness or injury or unfavourable features of the Life Insured's history? No ☐ Yes ☐ ▶ Please provide details:

8. In respect of the Life Insured's present illness or injury, have you given any certificate to another insurance company, or in connection with Worker's Compensation, Social Security, sick leave benefits from the Life Insured's employer or for any other reason? No ☐ Yes ☐ ▶ To whom?

9. At the current time, can the Life Insured do his/her normal job? No ☐ ▶ Which work duties is the Life Insured unable to perform?

Yes ☐ ▶ From what date was he/she fit to return to work? DD / MM / YYYY

10. If you do NOT expect the Life Insured to EVER return to his/her normal work do you think he/she will EVER be able to do a job for which he/she is reasonably fitted by education, training or experience? No ☐ ▶ Please give detailed reasons:

Yes ☐ ▶ Please list examples of jobs which in your opinion would be appropriate:

3. Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended to the above named Life 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

Phone (home) (work) (mobile)

Email

SIGN HERE ▶ ✗

Medical Practitioner's signature

Date DD / MM / YYYY

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