

Terminal Illness benefit

Privacy Statement

FlexiSure collects personal information so that we can process and administer this claim on behalf of the insurer St Andrew's Life Insurance Pty Ltd (St Andrew's). Without your information we will not be able to process and administer this claim. The completed claim information will then be sent to St Andrew's to assess the claim. If they require any further information, they will contact you directly or through us. If you have any queries in relation to your claim, please contact FlexiSure in the first instance.

If you provide us with personal information about someone else, you should ensure that you are authorised to do so and agree to inform that person of the contents of this notice.

We exchange your personal information with organisations in the normal operation of our business, for example, with our related companies and agents, coinsurers, reinsurers and with service providers (such as professional advisors, IT support and mailing houses). In relation to your claim, your information may also be exchanged with other parties including ex-employers, government agencies, financiers, insurers, underwriters, claims investigators, other insurance companies, lawyers, recovery agents, hospitals, doctors, medical specialists or other health professionals. We do not send your personal information offshore.

By providing this information you consent to us collecting, using and disclosing information about you in the manner described above. You also specifically consent to 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.

The following Privacy Policies contain information about how you can have access to your personal information and seek the correction of your personal information, and how you can complain about a breach of the privacy laws that bind us and how your complaint will be handled.

The St Andrew's Privacy Policy (also applicable to St Andrew's Australia Services Pty Ltd) is available at www.standrews.com.au. If you have any query in relation to your privacy please contact St Andrew's on 1300 363 159, standrews@standrews.com.au or PO Box 7395, Cloisters Square WA 6850.

The FlexiSure Privacy Policy is available at www.flexisure.com.au. If you have any query in relation to your privacy please contact FlexiSure:

Phone: 1300 279 279 (Mon - Fri, 9am - 5pm AEST)

Email: customerservice@flexisure.com.au

Mail: Customer Service; FlexiSure PO Box 1192, Chatswood NSW 2057

Completion instructions

Step 1: As the Policy Owner, you should first check your most recent policy schedule to make sure that the life insurance cover is in place and current for the Terminally Ill Life Insured. Then complete **Section 1: Parts A to D**. Note that once the claim is approved, the claim payment will be made to you.

Step 2: The Life Insured who is suffering the Terminal Illness must complete **Section 2: Parts E to I**. If you are both the Policy Owner and Life Insured, then you must complete **all Parts A to I**. Our assessment is based on the details provided here and the details provided by the Life Insured's Medical Specialist.

Step 3: Once Sections 1 and 2 have been **fully completed**, please forward this form to the Medical Specialist who is predominantly attending to the terminally ill Life Insured, to complete **Section 3: Parts J and K**. Once your Medical Practitioner has completed **Section 3: Parts J and K** please send the whole completed form back to FlexiSure.

Section 1: Policy Owner's details

Only to be completed if the Policy Owner is not the Life Insured. If the Policy Owner and the Life Insured are the same please go to Section 2.

Part A: Policy Owner's details

Policy Owner:		Policy number:	
Address:			
Suburb:		State:	Postcode:
Phone (H):	Phone (W):	Phone (M):	
Email:			

Please indicate your preferred method of communication with an asterisk (*)

Part B: Policy Owner's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	
Policy Owner's signature:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>

Part C: Policy Owner's Payment Authority

Once the claim has been accepted the benefit will be credited to the account below.

Name of bank:	Name of account holder:
BSB number: <input type="text"/> - <input type="text"/>	Account number: <input type="text"/>

Part D: Policy Owner's declaration

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, that if I fail to provide all or part of the information St Andrew's requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner's signature:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
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Section 2: Policy Owner/Life Insured's details

To be completed in full when the Policy Owner and Life Insured are the same individual.

Part E: Policy Owner/Life Insured's details

Title:	First name:	Surname:
Date of birth:	<input type="text"/> / <input type="text"/> / <input type="text"/>	Weight: <input type="text"/> kg Height: <input type="text"/> cm
Occupation:		
Address:		
Suburb:	State:	Postcode:
Phone (H):	Phone (W):	Phone (M):
Email:		

Please indicate your preferred method of communication with an asterisk (*)

Part F: Policy Owner/Life Insured's Terminal Illness claim

1.	What condition are you claiming for? (Please give as many details as you can.)
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
2.	What treatment have you received for your condition?
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
3.	Detail and describe all of your first symptoms:
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
4.	Date the symptoms first began: <input type="text"/> / <input type="text"/> / <input type="text"/>
5.	Please provide details of the doctor you are predominantly consulting with about your terminal illness:
	Doctor's name: <input type="text"/>
	Address: <input type="text"/>
	Suburb: <input type="text"/> State: <input type="text"/> Postcode: <input type="text"/>
	Phone: <input type="text"/>
	Date of first consultation: <input type="text"/> Date of last consultation: <input type="text"/>

Part F: Policy Owner/Life Insured's Terminal Illness claim (continued)

6.	Have you ever had similar symptoms prior to this period? If 'yes', please give details and dates of the doctor or hospital that treated you:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Phone:		
	From: <input type="text"/> / <input type="text"/> / <input type="text"/>	To: <input type="text"/> / <input type="text"/> / <input type="text"/>	
	Detail and describe all of your prior symptoms:		
7.	Please give details of your usual doctor:		
	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
8.	Please give details of all other doctors you have consulted for your current condition:		
(i)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Dates of consultation:	<input type="text"/> / <input type="text"/> / <input type="text"/>	
(ii)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Dates of consultation:	<input type="text"/> / <input type="text"/> / <input type="text"/>	
(iii)	Doctor's name:		
	Address:		
	Suburb:	State:	Postcode:
	Dates of consultation:	<input type="text"/> / <input type="text"/> / <input type="text"/>	

Part G: Policy Owner/Life Insured's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below.

First name:	Surname:
Relationship to you:	
Policy Owner/Life Insured's signature:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>

Part H: Policy Owner/Life Insured's consent to obtain a medical report

I hereby consent to St Andrew's and FlexiSure being provided with medical information, including copies of any medical reports, clinical reports or otherwise, from any Medical Practitioner who at any time has attended me concerning anything which affects my physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

First name:

Surname:

Date of birth:

 / /

Policy Owner/Life Insured's signature:

Date:

 / /

Part I: Policy Owner/Life Insured's declaration

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, that if I fail to provide all or part of the information St Andrew's requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement above.

Policy Owner/Life Insured's signature:

Date:

 / /

Please have the treating Medical Practitioner complete parts J & K on the following pages.

Section 3: Medical details

This section (Parts J and K) is to be fully completed by the registered treating Medical Specialist.

Part J: Confidential Medical Report – Terminal Illness benefit

Please note that the information required to be completed in this document is in relation to the insured person (patient).

Please note that it is the insured person'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.

1. Patient's details

First name:

Surname:

Address:

Suburb:

State:

Postcode:

2. Medical details

a. Are you the patient's usual Medical Specialist? Yes No If no, please provide details of usual doctor below:

Doctor's name:

Address:

Suburb:

State:

Postcode:

Phone:

b. What is the diagnosis?

Please fully describe the patient's terminal illness:

Given the diagnosis and terminal illness, and after taking into account all reasonably available treatment, what is the patient's life expectancy?

Part J: Confidential Medical Report – Terminal Illness benefit (continued)

c. Detail and describe all of the first symptoms as reported to you:

On what date did the symptoms commence: / /

d. Date of the first consultation in connection with the current condition: / /

e. Provide the dates and results of any X-rays, ECG, blood pressure or other tests performed. Alternatively please supply a complete copy of your patients clinical notes, test results, reports.

Date:	Test:	Results:
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="text"/> / <input type="text"/> / <input type="text"/>		

f. What treatment is currently being given, including surgery and medication, if any:

g. Please provide the names and addresses of other consulting specialist(s) or medical services the patient has been referred to.

Name:	Speciality or medical service:

h. If the patient has been hospitalised, provide the following details.

Admission date:	Discharge date:	Name of hospital:
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

i. Have you ever treated the patient before for any condition? Yes No If 'yes', please supply details.
Alternatively please supply a complete copy of your patients clinical notes.

Date consulted:	Nature of the condition:
<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/> / <input type="text"/> / <input type="text"/>	
<input type="text"/> / <input type="text"/> / <input type="text"/>	

Part J: Confidential Medical Report – Terminal Illness benefit (continued)

j. Please provide details if the patient has a previous history of the current condition, or any impairment likely to be connected with the current condition. Include dates and which doctors attended for each previous episode. Alternatively please supply a complete copy of your patients clinical notes.

Part K: Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended the above named patient and that all the information supplied by me in this Report is true. I agree that St Andrew's may provide copies of this Report to any Medical Practitioner from whom St Andrew's 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 the Insurer is obligated under the Privacy Act 1988 to give access to this Report.

First name:	Surname:	
Qualifications:		
Address:		
Suburb:	State:	Postcode:
Phone:	Fax:	
Medical Practitioner's signature:	Date:	<input type="text"/> / <input type="text"/> / <input type="text"/>

Please return the completed form to FlexiSure. You can either:

1. Scan and email to claims@flexisure.com.au (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); or
2. Mail to The Claims Manager, FlexiSure, PO Box 1192, Chatswood NSW 2057 (please mark the envelope as CONFIDENTIAL); or
3. Fax to 1300 361 097 (please address the cover page to The Claims Manager).