MetLife®

Terminal Illness Claim Form

To be completed by the claimant.

Please note: All questions must be completed.

Mark boxes with ☒ where appropriate, otherwise use block letters. Leave a box between words.

Claim Form relating to:

Plan Name

Policy/Member No.

Section 1. Personal details

Title

Surname

Given names

Address

Suburb

State

Postcode

Occupation/Profession

Date of birth / /

Phone No. (h) ( )

Phone No. (w) ( )

Email

Date joined employer / /

Date last worked (if applicable) / /

Section 2. Details of medical condition

1 What is the nature of the medical condition?

2 When did you first experience symptoms for the above condition? / /

3 When did you first consult a doctor for this condition? / /

4 When were you first diagnosed with the above condition? / /

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Section 2. Details of medical condition (continued)

5 Based on medical advice given to you, what is your life expectancy? Months ☐

6 When were you first advised that your life expectancy was less than twelve (12) months? __ __ / __ __ / __ __ __ __

7 Have you performed your usual work or performed any other work since your condition commenced? Yes ☐ No ☐

If 'YES,' please provide details:

Employer ______________________

Duties ______________________

Period from __ __ / __ __ / __ __ __ __ to __ __ / __ __ / __ __ __ __

Basis of employment for this period: Full-time ☐ Part-time ☐
(Please provide a copy of pay slips/details of earnings relating to this period)

Section 3. Details of medical attendants

8 Provide the name and address of the doctor(s) who diagnosed you with this condition. +

Name & Specialty	Address and phone number	Date first seen	Date last seen

9 Please state the names and addresses of any other medical practitioners who you have seen for this condition:

Name & Specialty	Address and phone number	Date first seen	Date last seen

(Please use other comments section if insufficient space)

Please attach copies of any medical reports, medical certificates or test results you may have in your possession.

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Other comments (please use this space if required)

Comments:

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Section 4. Declaration and authority

I declare that the answers and statements made on this claim form are true and complete. I have not made any false or misleading statements and I have included all information relevant to the assessment of my claim.

If any of the answers are not in my handwriting I certify that I have checked them and they are correct.

I hereby authorise MetLife Insurance Limited (MetLife), or any person duly authorised by MetLife to disclose my personal information (which may include sensitive or health information) to the following nominated parties. I further consent to the nominated parties collecting information about me and releasing to MetLife any information they may hold about me (including their report) which relates to MetLife's administration of the policy/plan, including this claim.

- Any physician, hospital or any other healthcare provider who has attended or examined me in order for them to supply MetLife with full particulars of my medical history including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.
- Any claims assessor, investigator, medical professional, healthcare provider, insurance reference service, financial institution, legal or accounting firm, auditor, employer, consultant or reinsurer in order for the nominated party to produce a report concerning my claim.
- Any benefit provider such as other insurers or Government Departments (including Workers' Compensation, Centrelink or similar benefit providers) that provide benefits in the event of my sickness and/or injury. I authorise for the nominated party to supply MetLife with full particulars of any and all claims I have made for benefits in the event of my sickness and/or injury including copies of evidence they hold.
- My Accountant, Financial Adviser/Planner, Fund Trustee/Fund Administrator including but not limited to providing my Accountant, Financial Adviser/Planner Fund Trustee/Fund Administrator with copies of all correspondence (which may include personal and sensitive information) between MetLife and myself in respect of the claim in order for the nominated party to supply MetLife with the requested particulars.

I also authorise my Financial Adviser/Fund Trustee/Fund Administrator to make inquiries regarding the progress of the claim for the purpose of providing me with ongoing service. I understand that this information is required to enable MetLife to assess and manage my claim in accordance with the Terms and Conditions of my policy/group life cover.

I understand and agree that if I do not give the information requested by MetLife or its representative that MetLife may not be able to assess, investigate or pay my claim.

A photocopy of this authority is as valid as the original.

Signature ✗

Name

Date / /

MetLife®

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