

Trauma Insurance Claim Form

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

Trauma Insurance Claim Form relating to:

Plan Name

Policy No.

Section 1. Personal details

Title Male Female Surname

Given names

Address

Suburb State Postcode

Phone No. (h) () Phone No. (w) ()

Mobile No. Date of birth / / +

Section 2. Claim details

1 What is the condition under which you are lodging this claim?

Heart Attack Cancer Coronary Artery Bypass Surgery
 Stroke Paraplegia Chronic Renal failure
 Quadriplegia Major Organ Transplant
 Other (please specify)

2 When did you first experience difficulty arising out of the above illness or injury? / /

3 When did you first seek medical advice/treatment for this condition? / /

4 Have you ever suffered from the same or a similar condition before? Yes No
If 'YES', please provide details:

Section 2. Claim details (continued)

5 Please state the name and address of your usual medical attendant:

Name	Address and phone number	Date last seen

6 Please state the names and addresses of medical practitioners attending to you for this condition:
(Please attach a separate list if insufficient space)

Name	Address and phone number	Qualifications	Date first consulted

7 Are you required to attend any surgery, hospital, clinic or other facility for continuing treatment? Yes No
If 'YES', please provide details: (Please attach a separate list if insufficient space)

Name	Address and phone number	Next appointment date

Section 3. Declaration and authority

I declare that the answers and statement made on this claim form are true and complete. I have not made any false or misleading statement 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, credit 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	<input type="text" value="x"/>
Name	<input type="text"/>
Date	<input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/>



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

Please return this form and any attachments to:

Insurance Claims
GPO Box 3319
Sydney NSW 2001

have you met life today?

For Client Services call

1300 134 669

Monday to Friday 8.00am to 6.00pm EST

MetLife®

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CIT3062 07/05

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