Cancer Insurance

Claim notification form

Insuranceline

Need any help completing this form? Call us on 1300 880 750 8am-8pm AEST

1. Policy Owner:
2. Policy Number:
3. Life Insured to complete: PART A, PART B, PART D (DECLARATION).
4. Policy Owner to complete: PART C
5. Treating Specialist to complete: PART E (SPECIALIST'S MEDICAL REPORT)
   (Any fees for the completion of the Specialist's Medical Report is the responsibility of the Insured)

Part A – Personal details of the Life Insured

Surname: First name:

Date of Birth: dd: mm: yyyy:

Height: Weight:

Occupation:

Current Residential Address:

suburb: state: postcode:

Postal Address:

Email Address:

Phone Numbers: (H) (W) (Mob)

Part B – Medical details of the Life Insured

1. What diagnosis have you been given for your condition? Where available, please provide **copies of test results confirming your diagnosis**
2. When were you diagnosed?
3. What are/were your symptoms as a result of this condition?
4. On what date did your symptoms first commence?
5. On what date did you first attend a doctor as a result of these symptoms?
6. Have you previously had the same or similar condition or symptoms? No ☐ Yes ☐

   If "yes", please provide full details:

Part B – Medical details of the Life Insured continued

7. Please provide contact details for the following:

The doctor who provided your diagnosis:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

The first medical practitioner you saw for this condition:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

How long have you known this doctor? (If less than 12 months, please provide the name and address of your previous doctor).

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

The doctor from whom you are currently receiving medical treatment:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

The details of any other Specialists/Doctors you may have seen or are continuing to see for this condition:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

8. What treatment/s are you currently receiving and how frequently?

9. If you have Private Medical Insurance, please provide the following details:

Fund Name:

Membership Number:

10. Have you made, or do you intend to make, a claim with any insurer? No ☐ Yes ☐

11. Do you have any additional information you would like to advise concerning your claim?

Part C – Policy discharge to be completed by the Policy Owner

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

I / We hereby request payment of the benefit amount payable for the above policy to be paid by cheque or direct credit made payable to:

(Payee) of

Address

I / We accept payment in full satisfaction of all Cancer Insurance claims whatsoever under the above policy for the above life insured and do hereby discharge TAL Life Limited from all liability thereunder other than for payment of the amount stated.

Sign here: Date: dd / mm / yy

Please print name:

Declaration

I hereby declare that the information in this form is complete and correct. I understand and agree that if I make any false or fraudulent statements or fail to advise TAL Life Limited of any relevant information regarding my claim, TAL Life Limited may refuse to pay this claim.

Name:

Sign here: Date: dd / mm / yy

Medical authority

Notes on 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, the insurer, TAL Life Limited (TAL), 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.

Authority 1 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.

Authority 2 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.

Medical consent authority 1

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

Medical authority continued

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 TAL Life Limited (TAL), or to third parties they engage.

I agree to all the following:

- My health information can be released in the form TAL 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.
- TAL 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 TAL 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.

Name:

Sign here: Date: dd / mm / yy

Medical consent authority 2

Authority 2 – to 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 TAL Life Limited (TAL), or to third parties they engage, only if TAL 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:

- TAL 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 TAL 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.

Name:

Sign here: Date: dd / mm / yy

Information authority

Where we require information from other sources, such as your accountant or employer, we require your authority to obtain information about you from them. We will only use your authority to obtain information that we reasonably believe is relevant to your policy or claim.

I authorise any insurer (including workers compensation/CTP insurer), government agency or body (including Centrelink/Department of Veteran's Affairs), employer, accountant or other relevant holder of information, to release to TAL Life Limited, its related bodies, corporate, its agents or its representatives and my superannuation fund or its administrator, information which they require for the purpose of assessing or investigating my claim or application for cover, or verifying disclosures I made in connection with the cover.

A copy of this authority is to be regarded as if it were the original signed authority.

Name:

Sign here: Date: dd / mm / yy

Privacy

The ways in which Insuranceline & St Andrew's collect, use, disclose and secure your personal information is set out in their respective Privacy Policies available at www.insuranceline.com.au and www.standrews.com.au.

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Part E – Specialist's medical report to be completed by the Life Insured's treating specialist

(Any costs incurred in the completion of this report are to be paid by the Insured).

Life Insured Surname: First name:

Date of Birth: dd: mm: yyyy:

1. When was the Insured first referred to you and by whom?

2. For what condition were they referred to you?

3. What is your diagnosis of the Insured's current condition?

4. On what date was this diagnosis made?

5. When did the Insured first experience these symptoms?

6. What were these symptoms?

7. Has the Insured previously suffered from the same or a related condition? No ☐ Yes ☐

   If "YES", please provide details:

8. On the basis of which objective tests/investigations was this diagnosis based?

9. Has the Insured been hospitalised or consulted any other medical practitioner/s in relation to this condition? No ☐ Yes ☐

   If "YES", please provide details:

10. Is there any relevant family history? No ☐ Yes ☐

    If "YES", please provide details:

11. Has the Insured ever been a smoker? No ☐ Yes ☐

    If "YES", please provide dates and daily usage.

Please provide to TAL copies of all test results confirming the diagnosis (eg, histopathology, ECG results, etc)

The policy defines the Insured Conditions as set out below.

	Cancer means...
Explanation	The presence of one or more malignant tumours.
Evidence Required	This requires the malignant tumour to be characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. *Carcinoma in situ of the breast is covered if it results directly in the removal of the entire breast. The procedure must be performed specifically to arrest the spread of malignancy, and be considered the appropriate and necessary treatment.
Conditions Not Covered	The following tumours are excluded: • Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as premalignant*; • All skin cancers, unless there is evidence of metastases; • Melanoma of the skin at Stage 1A (tumour thickness of less than or equal to 1.00mm, Clark level II or III, without ulceration); • Prostatic cancers which are histologically described as TNM Classification T1 or are of another equivalent or lesser classification, unless resulting in the surgical removal of the prostate; • Papillary Micro-Carcinoma of the Thyroid or Bladder; and • Chronic Lymphocytic Leukaemia less than Rai Stage 1.

12. In your opinion, does the Insured's condition fully satisfy the definition of the event? No ☐ Yes ☐

Please comment:

SPECIALIST DETAILS:

Name:

Qualifications:

Address:

Phone Number: Fax Number:

Sign here: Date: dd / mm / yy

THANK YOU FOR YOUR ASSISTANCE

HOW TO RETURN YOUR DOCUMENTS

FREE Post Reply Paid GPO Box 5380, Sydney NSW 2001 FREE Fax 1800 245 662 1300 880 750 claims@insuranceline.com.au