Allianz

Consumer Credit Insurance
Death benefit claim form

Instructions

1. Please read and complete this claim form carefully.
2. Answer all questions in full and attach any pages of additional information to ensure we can process your claim promptly.
3. Please send your completed claim form and attachments to:

Email: claims_0292667797@allianz.com.au

OR
Fax: (02) 9266 7797
Attention: CCI Claims

OR
Allianz Australia Insurance Limited
CCI Claims
GPO Box 4049
Sydney NSW 2001

Please include the following with this form:

- A certified copy of the original death certificate
- A certified copy of the insured person's birth certificate, or driver's licence, or front page of the insured person's passport (showing name, place and date of birth)
- A certified copy of the Will or Letters of Administration, if available
- The signed Medicare and Pharmaceutical Benefits Scheme (PBS) Authority (included with this form)

Please note:

- As each claim is unique, we may require further information to consider your claim.
- For any enquiries regarding the claim, please contact Allianz on 1300 362 108.
- The supply or acceptance of this form is not an admission of liability on the part of Allianz.

Insured Person's details

Full name ______________________ Date of birth ____/____/____

Postal address ______________________

______________________ State __________ Postcode __________

Date of death ____/____/____ Cause of death ______________________

Place of death ______________________

Your details

Full name ______________________ Date of birth ____/____/____

Postal address ______________________

______________________ State __________ Postcode __________

Home telephone no. ( ) ______________________ Mobile no. ______________________

Email address ______________________

Preferred method of contact Email ☐ Telephone ☐ Letter ☐

Your relationship to the insured person ______________________

Authorised representative

Name of any other person who can act on behalf of the Estate (this may include discussing the insured's medical history) ______________________

____

Relationship to Estate ______________________

Date of birth ____/____/____ Telephone no. ( ) ______________________

Email address ______________________

Who do you wish claim updates to be provided to? You ☐ Estate representative ☐ Both ☐

Allianz Australia Life Insurance Limited AFS Licence No. 296559 ABN 27 076 033 782 (Allianz) of 2 Market Street, Sydney NSW 2000 Australia

Policy and Loan details

1. Allianz Policy number

   Lender's name

   Loan account number ______ Loan start date ___/___/___ Loan end date ___/___/___

   Loan balance at date of death $ ______ Arrears at date of death $ ______

2. Allianz Policy number

   Lender's name

   Loan account number ______ Loan start date ___/___/___ Loan end date ___/___/___

   Loan balance at date of death $ ______ Arrears at date of death $ ______

If you have more than 2 policies please attach a separate page with the policy information.

Medical details

Please provide specific details of the illness or injury that has caused the death of the insured person ______

If death was due to an illness, please provide details of when symptoms of the illness first commenced. Date ___/___/___

If death was due to injury, please provide details of when and how the injury occurred. Date ___/___/___ Time ______

Has the death been referred to the Coroner? Yes ☐ No ☐

If an inquest has been/is being held please advise the date and place of the inquest ______

If you have a copy of the Coroner's Report please provide a copy with the claim form.

Was the insured person unable to perform his/her usual employment prior to death as a result of the injury or illness? Yes ☐ No ☐

If yes, on what date did disablement commence? ___/___/___

Was the injury or illness in any way connected with the insured's consumption or use of intoxicating liquor, narcotics or drugs? Yes ☐ No ☐

Has the insured, in the past, received medical advice or had treatment for the injury or illness which was the cause of death or a similar condition? Yes ☐ No ☐

If yes, please provide details below.

Date ___/___/___ Details (include any doctors seen) ______

Date ___/___/___ Details (include any doctors seen) ______

Insured person’s treating medical practitioners

Name of usual treating doctor/medical centre at the date of death ____________________

When did the insured start attending that doctor/medical centre? Date ____/____/____

Telephone no. ( ) ____________________

Address ____________________ State __________ Postcode __________

Name of any specialist seen in relation to the injury or illness which caused the death ____________________

Telephone no. ( ) ____________________

Address ____________________ State __________ Postcode __________

Name of specialist or hospital ____________________

Telephone no. ( ) ____________________

Address ____________________ State __________ Postcode __________

Insured's previous medical practitioners

Please provide the details of all other doctors, medical centres attended, specialists or health professionals consulted by the insured person 5 years before the policy commenced until present. We will only ask for information we reasonably need to assess the claim and the policy.

1. Name ____________________ Telephone no. ( ) ____________________

   Address ____________________ State __________ Postcode __________

   From ____/____/____ To ____/____/____

2. Name ____________________ Telephone no. ( ) ____________________

   Address ____________________ State __________ Postcode __________

   From ____/____/____ To ____/____/____

3. Name ____________________ Telephone no. ( ) ____________________

   Address ____________________ State __________ Postcode __________

   From ____/____/____ To ____/____/____

4. Name ____________________ Telephone no. ( ) ____________________

   Address ____________________ State __________ Postcode __________

   From ____/____/____ To ____/____/____

If there are additional medical practitioners, please attach a separate page with the information.

Privacy

The personal and sensitive information collected in this form and other information you or third parties provide in connection with this claim will be used to process this claim, compile and analyse data, and resolve claim disputes. If you do not provide this information to us we may not be able to process this claim.

We may have to disclose the insured's personal and other information to third parties who assist us in assessing and processing this claim, including other insurers, health service providers, investigators, our specialist advisors, our service providers or as required by law.

You have the right to seek access to your personal information and to correct it at any time. For information about how you may access and request correction of personal information we hold about you, or complain about a breach of the Australian Privacy Principles, please see our privacy policy available at www.allianz.com.au or contact us on 1300 360 529 EST 9am–5pm, Monday–Friday.

Declaration and authority

I acknowledge and declare that: the information given in this form is truthful, accurate and complete; no information likely to affect this claim has been withheld; I understand that this claim may be refused if information is untrue, inaccurate or omitted; all personal information provided by me about another person is provided with their consent; and I am authorised to provide the authority below on behalf of the insured person.

I also authorise and direct all doctors and other medical staff, all hospitals, clinics and other health care service providers, the Health Insurance Commission, Police, the Coroner's Office and all insurance companies to supply Allianz (or its agents) with any medical or insurance information which they hold, are aware of or are able to obtain with regard to the insured person. I also authorise and direct the lender named on the policy schedule and/or this claim form (or their agents or related companies) to provide details to Allianz (or its agents) of the insured person's loan and other information required for this claim. I agree that a photocopy of this Authority when attached to a letter from Allianz shall be considered to be valid as if it were the original Authority.

Insured Name and Date of Birth ______________________________

Name of person signing ______________________________

Relationship to insured person ______________________________

Your signature ______________________________

Date ______ / ______ / ______