Claim form for trauma insurance

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

MEMBERcare QBE

Please return to one of the following:
Address: GPO Box 1276 Sydney 2001
Email: Membercare.claims@qbe.com
Fax: 02 9295 5554

To be completed by the life insured

Please ensure that you read each question carefully and give full details. If you have any questions regarding the completion of this form please contact our claims department on 1800 226 122.

Insured's name	Surname			Given name(s)		
Credit Union name						
Policy No.				Date of birth *(dd/mm/yyyy)*		
Residential address						
			State		Postcode	
Postal address						
			State		Postcode	
Occupation						
Contact numbers	Home	( )		Mobile		

1. What was the nature of the trauma you suffered?

Cancer	☐	(Type:)	
Stroke	☐		
Heart attack	☐		
Coronary artery surgery	☐		
Major organ transplant	☐	(Type:)	
Kidney failure	☐		

2. When did symptoms commence? *(dd/mm/yyyy)*
3. When did you first consult a doctor in relation to these symptoms? *(dd/mm/yyyy)*
4. Have you previously had the same or similar condition? Yes ☐ No ☐ If 'yes', please provide details

5. What is the name and address of your usual doctor or medical centre?

Name					
Address					
		State		Postcode	
Phone No.	( )				

6. Please provide details of doctors consulted or hospitalisation

Doctor's name	Address	Date *(dd/mm/yyyy)*	Nature of consultation

7. Were any tests performed? Yes ☐ No ☐ If 'yes', please provide details.

8. Are you receiving, or do you expect to receive, any other benefits as a result of this condition? Yes ☐ No ☐ If 'yes', please provide details.

9. Are you aware of any other information that would assist us with the assessment of your claim?

Checklist

Completed trauma claim form ☐

Completed medical specialist's report ☐

Loan account statement as at date of trauma ☐

Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our **Privacy Policy** at **www.qbe.com.au/privacy**, or to obtain a copy by phoning us on **133 723** or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Declaration

I declare that the answers and statements made in this form are true and complete in every particular to the best of my knowledge.

I consent to QBE seeking and obtaining information from any other person or company in respect of this claim for benefits. I authorise and request any doctor who has been , or may be, consulted by me to divulge at any time to QBE, or any legal tribunal, any information that may have been acquired with regard to me.

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

Name of life insured:

Signature of insured 2. Date *(dd/mm/yyyy)*

Medical specialist's report

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

MEMBERcare QBE

To be completed by the medical specialist

Patient's name	Surname	Given name(s)
Date of birth *(dd/mm/yyyy)*		

1.	How long have you known the patient?	
2.	When was the patient first consulted in relation to their trauma? *(dd/mm/yyyy)*	
	By whom?	
3.	When did the patient first experience symptoms? *(dd/mm/yyyy)*	

4. What were the symptoms?

5. What tests/procedures were carried out? (Please include results including pathology results, cardiac enzymes, ECGs etc)

6. What was the diagnosis?

7. What date was the positive diagnosis made? *(dd/mm/yyyy)*

8. Was the condition caused by alcoholism, drug addiction, narcotics or the influence of intoxicating liquor, drugs or narcotics? Yes ☐ No ☐

9. Has the patient been hospitalised or consulted any other medical practitioner(s)? If 'yes', please provide details. Yes ☐ No ☐

10. Has the patient previously suffered the same or a related condition? If 'yes', please provide a brief history. Yes ☐ No ☐

11. Has the trauma occurred as a result of any other medical condition(s)? If 'yes', what condition(s)? Yes ☐ No ☐

11a. If 'yes', when did the patient become aware , or when could a reasonable person in their circumstances have been expected to have been aware, that they suffered from these contributing condition(s)?

12. Have any of the patient's family members suffered from the same or a related condition? If 'yes', please provide details Yes ☐ No ☐

13. Any other relevant information?

Cancer	Complete section **A**	**Coronary artery surgery**	Complete section **D**
Stroke	Complete section **B**	**Major organ transplant**	Complete section **E**
Heart attack	Complete section **C**	**Kidney failure**	Complete section **F**

Section A – cancer

1.	What was the date of the first unequivocal diagnosis of any internal malignant tumour made? *(dd/mm/yyyy)*	
2.	Does/did the patient require treatment for their internal malignant tumour by way of surgery, radiotherapy, hormone therapy or chemotherapy?	Yes ☐ No ☐ If 'yes', please specify
3.	If no treatment is/was required, is/was this due to the malignant tumour being too advanced or too serious for specific treatment to be warranted?	Yes ☐ No ☐
4.	Was the patient's malignant tumour treated by endoscopic procedure alone?	Yes ☐ No ☐
5.	Was the tumour classed as carcinoma in situ?	Yes ☐ No ☐
6.	Was the tumour classed as Karposi's sarcoma or any other tumours caused by HIV or AIDS?	Yes ☐ No ☐
7.	Is the patient suffering a prostate tumour that has not invaded the muscle layer?	Yes ☐ No ☐
8.	Is the patient suffering a tumour of the skin?	Yes ☐ No ☐
8a.	Is the patient suffering a malignant melanoma where evidence shows spread to the lymph nodes or distant tissue?	Yes ☐ No ☐

Section B – stroke

1.	Has the patient suffered from an infarction of brain tissue due to a cerebrovascular incident?	Yes ☐ No ☐
1a.	If 'yes', was this associated with evidence of a neurological deficit that creates permanent functional impairment?	Yes ☐ No ☐ If yes, provide details.
2.	Has the patient suffered an infarction of brain tissue as a result of violent, accidental, external and visible means?	Yes ☐ No ☐
3.	Has the patient suffered an infarction of brain tissue as a result of vascular disease affecting the eye or optic nerve?	Yes ☐ No ☐

Section C – heart attack

1.	Has the patient suffered from a diagnosed acute myocardial infarction?	Yes ☐ No ☐
1a.	If 'yes', has this resulted from inadequate cardiac blood supply that has been documented by the occurrence of chest pain, ECG evidence, and elevation in cardiac enzymes?	Yes ☐ No ☐

Section D – coronary artery surgery

1.	Has the patient undergone a coronary artery bypass grafting surgery performed via a thoracotomy?	Yes ☐ No ☐
2.	Briefly explain the reason for the coronary artery surgery.	

Section E – Major organ transplant

1.	Has the patient undergone, **as a recipient**, a medically necessary transplant procedure?	Yes ☐ No ☐
2.	Briefly explain the reason for the transplant?	
3.	Which of the following organs were transplanted (please tick)? Kidney ☐ Heart ☐ Liver ☐ Lung ☐ Bone Marrow ☐ Pancreas ☐ Other ☐	

Section F – kidney failure

1.	Is the patient suffering end-stage renal failure?	Yes ☐	No ☐
1a.	Is the patient suffering chronic irreversible failure of both kidneys to function?	Yes ☐	No ☐
2.	Has regular renal dialysis been initiated?	Yes ☐	No ☐ If 'yes', what type?
3.	Has a renal transplant been carried out?	Yes ☐	No ☐
4.	What is the cause of the renal failure? Please provide a brief history.		

Please print

Name			
Qualifications			
Address			
		Telephone No.	( )
Signature		Date *(dd/mm/yyyy)*	