

# Loss of Life Benefit Claim Form

**Important notice:** Please answer all questions fully to ensure the claim is assessed as quickly as possible. Answers left blank or not fully completed may delay the assessment of any entitlements to benefits. Coverforce are acting on behalf of the insurer, Hannover Life Re of Australasia Ltd (HLRA) and will be dealing with this insurance claim as an agent of the insurer and not the insured. False or fraudulent statements or failure to advise HLRA of any relevant information may lead to HLRA refusing to pay this claim. Please note that payments of \$20,000 or more must be paid by cheque to the "Estate of the Late".

## 1. Employer Details

Name of employer:

## 2. Member Details

Surname:

Given name(s):

Date of birth (DD/MM/YY):

## 3. Contact Person Submitting the Claim

Title:

Surname:

Given name(s):

Relationship to the deceased:

Phone:

Email:

Postal address:

Suburb:

State:

Postcode:

## 4. Information of Deceased

Date of death (DD/MM/YY):

Please specify the cause of death:

Please give details of the insured/deceased person's usual doctor.

Name:

Speciality:

Consultation date (DD/MM/YY):

Phone:

Suburb:

Please provide details of any other general practitioners that the insured/deceased person has consulted in the past 5 years.

**Please attach additional sheets if necessary.**

Name:

Speciality:

Consultation date (DD/MM/YY):

Phone:

Suburb:

Name:

Speciality:

Consultation date (DD/MM/YY):

Phone:

Suburb:

**Please attach a certified copy of the death certificate.**

## Privacy Statement

We are committed to protecting your privacy. We use the information you provide to advise about and assist with your insurance needs. We provide your information to insurance companies and agents that provide insurance quotes and offer insurance terms to you or the companies that deal with your insurance claim (such as loss assessors and claims administrators). Your information may be given to an overseas insurer (like Lloyd's of London) if we are seeking insurance terms from an overseas insurer, or to reinsurers who are located overseas. We will try to tell you where those companies are located at the time of advising you. We do not trade, rent or sell your information.

If you don't provide us with full information, we can't properly advise you, seek insurance terms for you, or assist with claims and you could breach your duty of disclosure.

For more information about how to access the personal information we hold about you and how to have the information corrected and how to complain if you think we have breached the privacy laws, you can access a copy of our Privacy Policy on our website [coverforce.com.au](http://coverforce.com.au) or alternatively contact our Privacy Officer on **02 9376 7888**.

## Returning Your Form

- |   |     |
|---|-----|
| 1. Have you signed the Privacy Statement & Declaration?                                       | Yes |
| 2. Has each question in this Form been answered?  | Yes |
| 3. Have you given complete, true and accurate answers to all relevant questions in this Form? | Yes |
| 4. Have you attached a certified copy of the death certificate to include with this Form?     | Yes |

**Please check you have correctly filled out all sections and saved the document before submitting the form.**

If you wish to return your form to Coverforce via post, email or fax, please use the details provided below.

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## Contact Coverforce

**Coverforce Pty Ltd**  
ABN 31 067 079 261 | ACN 067 079 261 | AFSL 238874

[paycover@coverforce.com.au](mailto:paycover@coverforce.com.au)  
[coverforce.com.au](http://coverforce.com.au)

Level 26, Tower One  
International Towers Sydney  
Barangaroo NSW 2000

Locked Bag 5273  
Sydney NSW 2001

**P** 02 9376 7888  
**F** 02 9223 1333

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## Medical Authority & Declaration

As duly authorised representative of the deceased I hereby authorise any hospital, physician, insurer, Health Insurance Commission, employer or other person who has attended the deceased to furnish to Coverforce Pty Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Worker's Compensation claims or claims with any other insurer to be released to Coverforce Pty Ltd. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

I also authorise Coverforce Pty Ltd or its representatives to provide to the deceased's employer or employer's representatives any information about the deceased regarding my claim.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, payment of my claim may be refused.

Signature:

Name:

Address:

Date (DD/MM/YY):