Loss of Life Benefit
Claim Form

WageCare by COVERFORCE

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, AIA Australia Limited (ABN 79 004 837 861, AFSL 230043) (AIA) and will be dealing with this insurance claim on behalf of the insurer and not the claimant. False or fraudulent statements or failure to advise AIA of any relevant information may lead to AIA refusing to pay this claim.

The WageCare Group Income Protection Product is issued by AIA Australia Limited (ABN 79 004 837 861, AFSL 230043) (AIA).
It is distributed and administered by Coverforce Pty Limited (ABN 31 067 079 261).

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 claimant/deceased person's usual doctor.

Name: | Speciality:

Consultation date (DD/MM/YY): | Phone: | Suburb:

Please provide details of any other general practitioners that the claimant/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.

Please attach copies of one (1) of <u>either</u> The Will, Probate or Letters of Administration.

COVERFORCE Smart Insurance Solutions

5. Bank Details

Account name:

BSB:

Account number:

Privacy Statement

We are subject to the Australian Privacy Principles as per the *Privacy Act 1988 (Cth)* (the Act). We collect your personal information to enable us to provide, offer and administer our products and services or otherwise as permitted by law. Reasons for collection include, but are not limited to, responding to your enquiries, providing you with assistance you request us, maintaining and administering our products and services (for example processing requests for quotes, applications for insurance, offering insurance terms and any other purpose identified at the time of collecting your information). We may be required to disclose your information to third parties to assist with your insurance needs (this can include disclosure to an overseas insurer such as Lloyd's of London or reinsurer).

You can read more about how we collect, use and disclose your personal information through requesting a copy of our Privacy Policy from our privacy officer on **02 9376 7888** or accessing our website at **coverforce.com.au**.

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.

Submit Form >>

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

Contact Coverforce

Coverforce Pty Limited
ABN 31 067 079 261 | ACN 067 079 261 | AFSL 238874

wagecare@coverforce.com.au
coverforce.com.au/wagecare

Level 26, Tower One
International Towers Sydney
Barangaroo NSW 2000

Locked Bag 5273
Sydney NSW 2001

P 02 9376 7888
F 02 9223 1333

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 Limited 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 Limited. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I also authorise Coverforce Pty Limited 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):

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