

Claim number: (Office use only)

Term Life Insurance - Notice of Claim

Supporting Documents: So that we can assess the claim, please provide the following documents with this completed Notice of Claim form. Failure to provide the documents may delay our assessment.

- A certified copy of the insured/deceased's birth certificate
- A certified copy of the insured/deceased's death certificate
- The original policy document that was issued to the insured/deceased on DD / MM / YY

You must also provide copies of the following reports or documents if applicable to this claim:

- The insured/deceased's will
- Any autopsy report, police report or coroners report
- Probate or letters of administration which has been granted

Glossary

administrator	A person to whom the court has issued letters of administration.
executor	The person named in a will as being responsible for administering the deceased person's estate. (An estate is the property that a person leaves when they die).
letters of administration	An authority granted by a court where a person has died without having left a valid will, which authorises the administrator to administer the deceased person's estate in accordance with the laws that specify how in those circumstances the estate is to be distributed. Letters of administration may also be granted where a will has been made but no executor is named in the will, or where the will names an executor but that person is not willing or able to act.
probate	A certificate granted by the court that the will of the deceased person has been proved as valid, and authorising the person named as the executor in the will to administer the deceased person's estate in accordance with the terms of the will.
will	A document in which a person states what it to happen to their property after they die.

Privacy notice and consent

We collect personal information about you, about relatives of the insured and about other individuals who had some relevant connection with the insured so that we can process the claim. Without this information we may not be able to process the claim. We may disclose that personal information to third parties to assist us (and where applicable them) in processing the claim. Those third parties may include medical practitioners, hospitals, other health service providers, present and past employers of the insured, other insurance companies holding information relevant to the claim, other GE companies (both in Australia and overseas), and claims handlers. We limit the use and disclosure of any personal information we give those parties to the specific purpose for which we give it.

By completing this Notice of Claim form you consent to us collecting and disclosing personal information about you in the ways set out above. You can have access to the personal information we hold about you (subject to the Privacy Act 1988) by telephoning 1800 800 230 or writing to GE Money at GPO Box 1571, Sydney, NSW 1025. Where we hold personal information about any other individual, they can have access to the information about them, in the same way.

Section A: Insured's/Deceased's details

Name of insured: _____

Policy issued on: DD / MM / YY Policy number: _____

Address of insured prior to their death: _____

Postcode: _____

Insured's date of birth: DD / MM / YY Claim number: _____

Section B: Your details

First name: _____ Last name: _____

Address: _____

Postcode: _____

Telephone number: _____ Facsimile number: _____

Email address: _____

Your relationship to the Insured (please tick one of the following):

Wife/husband Defacto Son/daughter

Family friend (please explain further): _____

Solicitor acting for: _____

Executor of estate Administrator of estate power of attorney

Other (please explain further): _____

Brother/sister/other relative (please explain further): _____

Section C: Family contact details

We require the contact details of at least one member of the insured's family. If you (the person completing this form) are not a family member, please complete this section by providing the details of at least one or preferably two family members.

1. Relationship to the insured _____
(wife, husband, defacto, son, daughter, etc.):

First name: _____ Last name: _____

Address: _____

Postcode: _____

Telephone number: _____ Facsimile number: _____

Section C: Family Contact Details (continued)

2. Relationship to the insured: _____
(wife, husband, defacto, son, daughter, etc.):
- First name: _____ Last name: _____
- Address: _____
_____ Postcode: _____
- Telephone number: _____ Facsimile number: _____

Section D: Details about the insured's estate

D1. Will

- (a) Did the insured leave a will? Yes No
If "Yes", please provide copy and go to section D2.
If "No", go to section D3.

D2. Probate

- (a) Please give the following details of the person named in the will as the executor of the estate:
- Name: _____
- Address: _____
_____ Postcode: _____
- Telephone number: _____
- Relationship to the insured: _____
(wife, husband, defacto, son, daughter, etc.):
- _____

- (b) Has probate been granted? Yes No
If "Yes", please provide a copy and go to section D4.
- (c) Has an application for probate been made? Yes No
If "Yes", go to section D4.
- (d) Will an application for probate be made? Yes No
Go to section D4.

D3. Letters of administration

- (a) Please give the following details of the administrator or intending administrator of the estate:
- Name: _____
- Address: _____
_____ Postcode: _____
- Telephone number: _____
- Relationship to the insured: _____
(wife, husband, defacto, son, daughter, etc.):
- _____

Section D: Details about the insured's estate (continued)

- (b) Have letters of administration been granted? Yes No
If "Yes", please provide a copy and go to section D4.
- (c) Has an application for letters of administration been made? Yes No
Go to section D4.

D4. Third party interests

- (a) So far as you are aware, was the insured an undischarged bankrupt when they died? Yes No
If "Yes", please give bankruptcy reference number and name and contact details of the trustee in bankruptcy (if known):

- (b) So far as you are aware, before the insured died did they give any interest in the policy to any third party? Yes No
If "Yes", please give name and contact details of the third party and state the nature of their interest (if known):

D5. Public trustee

- (a) Is the Public Trustee (or equivalent) involved in administering the estate? Yes No
- (b) If "Yes", please identify which State or Territory Public Trustee (or equivalent) and give their reference number (if known):

Section E: Insured's particulars

Date of death: DD / MM / YY

- Has the cause of death been ascertained? Yes No

If "No", please explain: _____

If "Yes", what was the insured's cause of death? _____

Were there any other conditions that contributed to the death? _____

Section E: Insured's particulars (continued)

After the insured's death:

- (a) Was an autopsy performed? Yes No
If "Yes", was a report issued? Yes No
(b) Was there a police investigation? Yes No
If "Yes", was a report issued? Yes No
(c) Was there a coronial inquest? Yes No
If "Yes", was a report issued? Yes No

Please provide the contact details for the person who is preparing an autopsy report, a police report or a coroners report:

1. Name: _____
Address: _____

Postcode: _____
Telephone number: _____ Facsimile number: _____
2. Name: _____
Address: _____

Postcode: _____
Telephone number: _____ Facsimile number: _____

Section F: Insured's doctor contact details

Please provide the following details of the doctors, (both general practitioners and specialists) who treated the insured in the period from 5 years before the policy was issued until the insured's death. (The date when the policy was issued appears on page 1). Please also provide details of hospitals where the insured was treated in the same period. We may use this information to obtain a medical report from the doctors or hospitals you have listed. If there is not enough room for this information, please attach a separate sheet.

1. Name of doctor/hospital: _____
Address: _____

Postcode: _____
Telephone number: _____ Facsimile number: _____
Period of treatment from: DD / MM / YY to: DD / MM / YY
2. Name of doctor/hospital: _____
Address: _____

Postcode: _____
Telephone number: _____ Facsimile number: _____
Period of treatment from: DD / MM / YY to: DD / MM / YY

Section F: Insured's doctor contact details (continued)

3. Name of doctor/hospital: _____

Address: _____

_____ Postcode: _____

Telephone number: _____ Facsimile number: _____

Period of treatment from: DD / MM / YY to: DD / MM / YY

4. Name of doctor/hospital: _____

Address: _____

_____ Postcode: _____

Telephone number: _____ Facsimile number: _____

Period of treatment from: DD / MM / YY to: DD / MM / YY

5. Name of doctor/hospital: _____

Address: _____

_____ Postcode: _____

Telephone number: _____ Facsimile number: _____

Period of treatment from: DD / MM / YY to: DD / MM / YY

6. Name of doctor/hospital: _____

Address: _____

_____ Postcode: _____

Telephone number: _____ Facsimile number: _____

Period of treatment from: DD / MM / YY to: DD / MM / YY

Section G: Medical authority form

Please note: This section may **only** be completed by the executor/administrator of the estate, or the next of kin (wife, husband, defacto, son, daughter, etc). If you are not a person in one of these categories, please arrange for this authority to be completed by someone who is. Failure to complete this section may delay our assessment of the claim.

Release of medical history information

I, _____ hereby authorise
(print your name in full)

all medical practitioners, specialists and hospitals stated in Section F to furnish Hallmark Life Insurance Company Limited

with all information it may request regarding the late _____
(print name of insured in full)

and their medical history, for the period DD / MM / YY to DD / MM / YY

The insured's date of birth was: DD / MM / YY

The insured's residential address was: _____

Postcode: _____

My relationship to the insured is: _____
(Executor of estate, administrator of estate, wife, husband, defacto, son, daughter, etc.):

My postal address is (if different from above): _____

Postcode: _____

Signed: _____ Date: DD / MM / YY

A photocopy of this authority shall be considered as effective and valid as the original.

Section H: Your declaration

I declare that to the best of my knowledge and belief, the information provided in this Notice of Claim form is correct.

Signed: _____ Dated: DD / MM / YY

