



# Loan Termination Insurance -Claim Form-

**INSTRUCTIONS ON HOW TO COMPLETE YOUR CLAIM FORM**  
You must answer **ALL** questions. Where indicated please tick box  as applicable.

**Policy No.** \_\_\_\_\_ **Period of Insurance: From** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **to** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## SECTION 1: GENERAL INFORMATION (COMPULSORY)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ P/Code: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Telephone: Private: \_\_\_\_\_ Business: \_\_\_\_\_ Mobile: \_\_\_\_\_

Vehicle Details (make and model): \_\_\_\_\_ Registration No: \_\_\_\_\_

Tax Declaration (please tick one). Are you registered for GST:  YES  NO

Dealership Vehicle purchased from: \_\_\_\_\_

Finance Company: \_\_\_\_\_

Finance Contract No.: \_\_\_\_\_

Outstanding Balance: \_\_\_\_\_

### Reason for Claim: PLEASE TICK ONE

- |   |                            |
|---|----------------------------|
| <input type="checkbox"/> Involuntary Unemployment                 | Complete Sections 2, 4 & 5 |
| <input type="checkbox"/> Trauma, Disability & Driving Restriction | Complete Sections 3 & 5    |
| <input type="checkbox"/> Job Transfer, Bankruptcy & Divorce       | Complete Sections 4 & 5    |

## SECTION 2: INVOLUNTARY UNEMPLOYMENT CLAIM

Name and Address of last employer: Name: \_\_\_\_\_

Address: \_\_\_\_\_ P/Code: \_\_\_\_\_

Was this employment Permanent, Seasonal, Contract of Service or of a specific period? \_\_\_\_\_

Date employment Commenced: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date employment Ceased: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Period employed: \_\_\_\_\_

Hours worked per week: \_\_\_\_\_

Reason for termination: \_\_\_\_\_

Did you voluntarily resign? \_\_\_\_\_

Date you registered with Centrelink as Unemployed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date re-employment commenced: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Centrelink Office where you registered as Unemployed: \_\_\_\_\_

Period for which you are claiming: From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION 3A ONLY: DRIVING RESTRICTION CLAIM** (PLEASE COMPLETE 1-8 ONLY)  
**SECTION 3A & B: TRAUMA & DISABILITY**  
(TO BE COMPLETED BY TREATING DOCTOR)

**SECTION 3A**

1. Name of Claimant: \_\_\_\_\_

2. Occupation: \_\_\_\_\_

3. Are you the Claimant's usual medical attendant? \_\_\_\_\_

4. State FULLY the exact nature and extent of injuries sustained and/or illness/disabilities suffered by the Claimant (Detail organs affected etc):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. On what date did you first attend the Claimant in connection with his/her present disablement? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

6. Was there any external and visible sign of injury?  YES  NO

If YES, give details: \_\_\_\_\_

7. In your opinion would the symptoms have been evident to the Claimant for any length of time? \_\_\_\_\_

**8. DRIVING RESTRICTIONS ONLY—PLEASE ENSURE THE APPROPRIATE AUTHORITIES HAVE BEEN ADVISED**

State the period for which the Driving Restriction will apply: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**SECTION 3B**

9. State period that the claimant: \_\_\_\_\_

a) will be totally unable to attend his/her usual occupation or business: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

b) has been totally unable to attend his/her usual occupation or business: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

9. When did he/she or at what date do you expect that the Claimant will be able to resume: \_\_\_\_\_

a) some part of his/her work? From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

b) the whole part? From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

10. Has the treatment or medicine prescribed by you been adhered to by the Claimant: \_\_\_\_\_

11. Are you aware of the claimant previously suffering from this condition:  YES  NO

If YES please provide FULL details: \_\_\_\_\_

12. Has the Claimant previously suffered from any illness which would have contributed to or would have accelerated the occurrence of the Claimant's

current medical condition:  YES  NO

If YES please provide FULL details: \_\_\_\_\_

**GENERAL REMARKS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Qualifications: \_\_\_\_\_

## SECTION 4: REQUIRED DOCUMENTATION

When claiming under the following policy terms please provide the following documents;

### Personal Bankruptcy:

- A copy of the order of a court confirming your bankruptcy

### Divorce:

- A copy of the order of a court confirming termination of marriage

### Unemployment

- A copy of your separation certificate
- A copy of your registration with Centrelink

### Job Transfer

- A copy of your job transfer letter confirming both your relocation details and the expected duration

### Driving Restriction

- A copy of your letter outlining the driving restrictions from the appropriate authority

## SECTION 5: DECLARATION AND SIGNATURE OF INSURED

I hereby declare that I am the person referred to in the above statements and that the statements are true and correct in every respect and made without reservation or misrepresentation and thereby claim to be paid compensation in terms of my policy.

**If this claim is for an Accident or an Illness, I authorise all Medical Attendants to supply to AVEA Insurance Limited as agent for the Underwriters or its representative my complete medical history including fully detailed medical reports, clinical notes and finding on my examination, and advise whether any period of incapacity arose from the condition for which treatment was sought**

I also authorise AVEA Insurance Limited to obtain or provide information or documents in relation to insurance related matters or claims history from or to another insurance company or an insurance reference bureau or similar organisation.

Signature of Insured: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### RETURNING INSTRUCTIONS:

Please complete and return this form to the Postal Address below, together with all documentation requested to:

AVEA Insurance Limited  
PO Box 226 Nunawading VIC 311

### CLAIM ENQUIRIES:

AVEA Insurance Limited claims officers are available to assist you with any queries relating to your claim. Please contact our Australia wide phone service on FreeCall 1800 99 99 77 for assistance. If you have an unresolved complaint or dispute, you should first speak with our Operations Manager.

If you are not able to resolve your concerns with the Operations Manager, you should ask that your query be referred to AVEA's Internal Disputes Department.



AVEA Insurance Limited  
Customer Service 1800 999 977  
Email: [claims@avea.com.au](mailto:claims@avea.com.au)