



Loan Termination Insurance -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)

Full Name of Insured: Surname: _____ Given Names: _____

Date of Birth: _____ / _____ / _____

Private Address: _____

Postal Address: _____

Name of Employer: _____

Occupation: _____

Telephone: Private: _____ Business: _____ Email: _____

Vehicle Details (make and model): _____ Registration No: _____

Dealership Vehicle purchased from: _____

Finance Company: _____ Finance Contract No. _____

Amount of Monthly Payment: _____ Outstanding Balance: _____ Date Payment Due: _____

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? YES NO

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: YES NO

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: _____

Address: _____ P/Code: _____

Signature: _____ Date: _____ / _____ / _____

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 the information I have submitted in relation to this claim is true and correct in every particular;
- In the event that this claim references any Accident, Injury or Illness, I authorise all Medical Professionals to supply Avea Insurance with my complete medical history including fully detailed medical reports, clinical notes, examination findings, and full details of any period of incapacity that may have arisen from the condition for which treatment was sought;
- I agree to provide any information that is requested by Avea that it deems is relevant to assessing this claim; and
- I acknowledge that Avea Insurance may provide, and obtain from, other insurers and/or the Insurance Reference Bureaux personal information relating to this claim as well as claims I have previously lodged, in accordance with Avea's Privacy policy. I understand that I may request a copy of Avea's Privacy policy at any time or obtain it from Avea's website.

Signature of Insured: _____ Date: _____ / _____ / _____

Print Name: _____

(A photocopy of this authority has the same effect as the original)

RETURNING INSTRUCTIONS:

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

Avea Insurance Limited

PO Box 116 BERWICK VIC 3806

claims@avea.com.au

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 Free Call 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