Life Insurance
Initial claim form
for Trauma under Children's Cover

Avant
By doctors for doctors

Office use only

Avant plan number(s): _____

☐ Children's Cover – Trauma Cover (CCTC)

Who is to complete this form?

This form is to be completed for any Trauma claims under Children's Cover.

This form is to be completed by the **Plan Owner**, being the owner of the relevant Avant Life Insurance policy.

How to complete this form?

Please print this form, fill in the responses and email a copy of the completed form back to us at avantlifeclaims@avant.org.au

Please answer all questions unless indicated otherwise.

Should you require additional space to answer any of the questions or provide additional information in relation to your claim, we have provided additional space on page 7 of this form. Please make reference to which question you are responding to (if applicable).

Questions?

Avant is here to support you in any way we can, please contact us on 1800 128 268 or email us at avantlifeclaims@avant.org.au.
Should you wish to discuss your claim or need help completing this claim form, please contact NobleOak's claims team directly on 1300 756 817.

1. Your personal details			
Full name			
Date of birth		Mobile	
Telephone		Business	
Email address			
Residential address			
Postal address ☐ Same as residential address			

2. Insured child's details	
Full name	
Date of birth (DD/MM/YYYY)	

3. Insured child's treating doctor

Insured child's treating doctor

Full name			
Specialty		Contact number	
Address			
State		Postcode	

When did the insured child first see this doctor for this condition? (DD/MM/YYYY)

Was the treating doctor of the injury or illness the insured child's regular doctor? ☐ Yes ☐ No

If **NO**, please provide your regular doctor's details.

Full name			
Specialty		Contact number	
Address			
State		Postcode	

How long did the insured child attend the regular doctor? Years/months

Which doctor would best know the complete history of the insured child's medical condition(s)? ☐ Treating doctor ☐ Regular doctor ☐ Other

If **Other**, please provide details of the doctor and/or surgery.

Full name			
Specialty		Contact number	
Address			
State		Postcode	

4. Other doctors/healthcare professionals consulted in relation to this illness

Other doctors/healthcare professionals consulted

Full name					
Specialty		Contact number			
Address					
State		Postcode			
Dates of medical treatment		From (DD/MM/YYYY)		To (DD/MM/YYYY)	

Other doctors/healthcare professionals consulted

Full name					
Specialty		Contact number			
Address					
State		Postcode			
Dates of medical treatment		From (DD/MM/YYYY)		To (DD/MM/YYYY)	

Other doctors/healthcare professionals consulted

Full name					
Specialty		Contact number			
Address					
State		Postcode			
Dates of medical treatment		From (DD/MM/YYYY)		To (DD/MM/YYYY)	

Was the insured child referred to any other doctors, medical providers, rehabilitation providers or other health professionals for treatment or consultation? ☐ Yes ☐ No

If **YES,** please provide details.

Complete **Section 5** in case of an **injury** only.

5. Nature of injury					
When did the injury occur?		Date (DD/MM/YYYY)		Time (am/pm)	
Location of injury (address)					
Did police or first aid services attend the accident scene?				☐ Yes	☐ No
If **YES**, please provide details of police station or first aid service to which the accident was reported.					
Please provide details of how the injury occurred.					
What was the nature of injury sustained? Please provide full details of the nature of your injuries e.g. if to a limb, specify whether left or right.					
Has the insured child had the same, similar or related injury in the past?				☐ Yes	☐ No
If **YES**, please provide details.					

Complete **Section 6** in case of an **illness** only.

6. Nature of illness			
Date symptoms first appeared?		Date of diagnosis?	
Was this condition diagnosed by the insured child's current treating doctor?			☐ Yes ☐ No
If **NO**, please provide name of doctor.			
Please provide full details of the insured child's illness.			
Please describe the insured child's current symptoms and their severity.			
What restrictions occurred as a result of this illness?			
Have the insured child had the same, similar or related illness in the past?			☐ Yes ☐ No
If **YES**, please provide details.			

7. Medical treatment details

Did the insured child require the services of an ambulance?	☐ Yes	☐ No
Did the insured child attend hospital as an outpatient?	☐ Yes	☐ No

If **YES,** please provide details.

Have the insured child been admitted to hospital for this injury or illness? ☐ Yes ☐ No

If **YES,** please provide the following details:

Hospital name		Date admitted		Date discharged	
Hospital name		Date admitted		Date discharged	
Hospital name		Date admitted		Date discharged	

Please provide details of the treatment prescribed (including the names and dosages of any medication).

Treatment/medication			
Dosage and frequency		Prescribed by	
Treatment/medication			
Dosage and frequency		Prescribed by	

How has the insured child responded to treatment?

Has the insured child followed the treatment plan prescribed? ☐ Yes ☐ No

If **NO,** please comment.

8. Additional information

Please provide any additional information or comments you feel are relevant to this claim.

9. Benefit payment

Direct credit details
Please provide the bank account details where you would like any claim funds payable to be deposited into.

Name of financial institution		Account name	
BSB number		Account number	

10. Checklist

☐ I have fully completed this form as required.

☐ I have provided my treating doctor with my Medical Attendant's Statement form to complete in support of this claim.

I have attached a certified copy of my: ☐ Driver's licence ☐ Passport ☐ Birth Certificate

☐ I have provided all the other required information as requested.

Declaration and authorities

In signing below, I am making the following Declaration and am providing the Authorities to obtain information.

Declaration

- I declare that the information in this claim form is true, correct and complete.
- I have not made any false or misleading statements and I have included all information relevant to the assessment of this claim.
- I understand and agree that if I make any false or fraudulent statements in this claim, NobleOak may be entitled to reject this claim and/or the Children's Cover for the insured child and/or to avoid the cover or the Plan altogether.
- I declare that I have read and understood the Privacy Statement which follows this Declaration and the Authority below and I consent to the collection, use and disclosure of the insured child's personal and sensitive information in the manner described in the Privacy Statement; and I understand that for the purposes of this claim, the term 'your personal information' as used in the Privacy Statement also extends to include the personal information of the insured child because it is required to assess and process the claim.
- I consent to NobleOak and its representatives to use the insured child's personal and sensitive information (whether received by NobleOak from me or a third party) to investigate, assess and manage the insured child's claim and to disclose that information to medical, or health professionals and institutions and:
  a. reinsurers and other insurers (including Workers' Compensation insurers);
  b. investigators;
  c. the ambulance;
  d. NobleOak's service providers;
  e. statutory bodies including law enforcement agencies;
  f. insurance or credit reference agencies;
  g. financial institutions; and
  h. such other third parties as is necessary for that purpose.

Authority to obtain information

I hereby authorise any individual organisation or entity with any of the aforementioned entities (a to h) that holds the insured child's personal and sensitive information to release that information to NobleOak on request, for the purpose of investigating, assessing and managing my claim.

I hereby authorise any medical practitioner, medical provider, health professional, hospital, dentist or other person who has attended the insured child to release to NobleOak or its representatives (including Avant Life Insurance, a registered business name of Doctors Financial Services Pty Ltd ABN 56 610 510 328, as administrator of the life risk product issued by NobleOak) all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records.
I acknowledge that a photocopy or PDF copy of this authorisation can be accepted to be as effective as the original.

Name of **Plan Owner**			
Signature of **Plan Owner**		Date (DD/MM/YYYY)	

IMPORTANT: If you as the Plan Owner are not the parent or legal guardian of the insured child, then please arrange for the Parent/Guardian to read the completed claim form and to also sign below to make the Declaration and provide the Authorities appearing above. Please also ensure they read the Privacy Statement (referred to in the Declaration) over the page.

Name of **Parent** or **guardian**			
Signature of **Parent** or **guardian**		Date (DD/MM/YYYY)	

Privacy statement

Within this section, 'we' and 'us' refer to NobleOak, Avant and Avant Life Insurance.

We collect, use and retain personal information in accordance with the Australian Privacy Principles and the Privacy Act 1988 (Cth) (Privacy Act). Our detailed privacy policies are available on our respective websites at:

- avant.org.au/privacy-policy
- nobleoak.com.au/terms-of-use-privacy-policy
- or by calling us on 1800 128 268.

We collect your personal information (which may include sensitive information such as health information) when you are applying for or changing an insurance plan with us, or when we are processing a claim, in order to help us properly administer your insurance application, plan or claim.

The primary purpose for our collection and use of your personal information is to enable us to provide insurance services to you. Sometimes, we may use your personal information for our marketing campaigns, in relation to new products, services or information that may be of interest to you.

We may also disclose your personal information to third parties, including service providers engaged by us to carry out certain business activities on our behalf, other companies within our group of companies, other insurers, our reinsurers, medical and health practitioners, government agencies and regulators (where we are required to by law), law enforcement bodies and agents and/or representatives of persons covered under our plans. Some of these third parties may be located outside Australia. Lists of countries in which recipients of your information are likely to be located are available in the privacy policies on our respective websites.

In all instances where personal information may be disclosed to third parties who may be located overseas, in addition to any local data privacy laws to which those entities are subject, we have measures in place to ensure that those parties hold and use such information in accordance with the consent provided by you and in accordance with our obligations under the Privacy Act. In dealing with us, you agree to us using and disclosing your personal information as set out in this section and in our respective privacy policies. This consent remains valid unless you alter or revoke it by giving written notice to our respective privacy officers. However, should you choose to withdraw your consent, it is important for you to understand that this may mean we may not be able to provide you with this insurance or respond to any claim.

Please return this form to **Avant Insurance Limited PO BOX 746 Queen Victoria Building NSW 1230**, or email **avantlifeclaims@avant.org.au** or contact us on **1800 128 268**.