

TRAUMA INSURANCE CLAIM FORM

To be completed by the life insured.

Please ensure that you read each question carefully and give full details. If you have any questions regarding the completion of this form please contact our claims department on 1800 226 122.

Insured's Name	Surname	Given Name/s
Credit Union Name		
Policy number		
Date of Birth		
Residential Address	Postcode	
Postal Address	Postcode	
Occupation		
Telephone	Home	Mobile

1. What was the nature of the trauma you suffered?	<input type="checkbox"/> Cancer (Type _____) <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Attack <input type="checkbox"/> Coronary Artery Surgery <input type="checkbox"/> Major Organ Transplant (Type _____) <input type="checkbox"/> Kidney Failure
2. When did symptoms commence?	
3. When did you first consult a doctor in relation to these symptoms?	
4. Have you previously had the same or similar condition? If "YES" please provide details.	

5. What is the name and address of your usual doctor or Medical Centre?	Name Address Phone		
6. Please provide details of doctors consulted or hospitalisation			
Doctor's Name	Address	Date	Nature of consultation
7. Were any tests performed? If so, please provide details.			
8. Are you receiving, or do you expect to receive any other benefits as a result of this condition? If "YES", please provide details.			
9. Are you aware of any other information that would assist us with the assessment of your claim?			

Checklist

- Completed Trauma Claim Form**
- Completed Medical Specialist's Report**
- Loan Account Statement as at Date of Trauma**

Declaration

I declare that the answers and statements made in this form are true and complete in every particular to the best of my knowledge.

I consent to CUNA Mutual Group seeking and obtaining information from any other person or company in respect of this claim for benefits. I authorise and request any doctor who has been, or may be, consulted by me to divulge at any time to CUNA Mutual Group, or any legal tribunal, any information that may have been acquired with regard to me.

A photocopy of this declaration is as valid as the original.

Name of Life Insured.....

Signature of Life Insured Date.....

MEDICAL SPECIALIST'S REPORT

To be completed by the Medical Specialist.

Patients Name	DOB
1. How long have you known the patient?	
2. When was the patient first consulted in relation to their Trauma? By Whom?	
3. When did the patient first experience symptoms?	
4. What were the symptoms?	
5. What tests/procedures were carried out? (please include results including pathology results, cardiac enzymes, ECGs, etc)	
6. What was the diagnosis?	
7. What date was the positive diagnosis made?	
8. Was the condition caused by alcoholism, drug addiction, narcotics or the influence of intoxicating liquor, drugs or narcotics?	
9. Has the patient been hospitalised or consulted any other medical practitioner(s)? If yes, please provide details)	
10. Has the patient previously suffered the same or a related condition? If yes, please provide brief history.	
11. Has the Trauma occurred as a result of any other medical condition/s? What condition/s?	
11a. If YES, when did the patient become aware, or when could a reasonable person in their circumstances have been expected to have been aware, that they suffered from these contributing condition/s?	
12. Have any of the patient's family members suffered from the same or a related condition? If yes, please provide details	
13. Any other relevant information?	

Cancer	Complete Section A	Coronary Artery Surgery	Complete Section D
Stroke	Complete Section B	Major Organ Transplant	Complete Section E
Heart Attack	Complete Section C	Kidney Failure	Complete Section F

SECTION A - CANCER

1. What was the date of the first unequivocal diagnosis of any internal malignant tumour made?	
2. Does / Did the patient require treatment for their internal malignant tumour by way of surgery, radiotherapy, hormone therapy or chemotherapy? If YES, please specify.	
3. If no treatment is/was required, is/was this due to the malignant tumour being too advanced or too serious for specific treatment to be warranted?	
4. Was the patient's malignant tumour treated by endoscopic procedure alone?	
5. Was the tumour classed as carcinoma in situ?	
6. Was the tumour classed as Karposi's sarcoma or any other tumours caused by HIV or AIDS?	
7. Is the patient suffering a prostate tumour that has not invaded the muscle layer?	
8. Is the patient suffering a tumour of the skin?	
8a. Is the patient suffering a malignant melanoma where evidence shows spread to the lymph nodes or distant tissue?	

SECTION B – STROKE

1. Has the patient suffered from an infarction of brain tissue due to a cerebrovascular incident?	
1a. If YES, was this associated with evidence of a neurological deficit that creates permanent functional impairment? If yes, provide details.	
2. Has the patient suffered an infarction of brain tissue as a result of violent, accidental, external and visible means?	
3. Has the patient suffered an infarction of brain tissue as a result of vascular disease affecting the eye or optic nerve?	

SECTION C – HEART ATTACK

1. Has the patient suffered from a diagnosed acute myocardial infarction?	
1a. If YES, has this resulted from inadequate cardiac blood supply that has been documented by the occurrence of chest pain, ECG evidence, and elevation in cardiac enzymes?	

SECTION D – CORONARY ARTERY SURGERY

1. Has the patient undergone a coronary artery bypass grafting surgery performed via a thoractomy?	
2. Briefly explain the reason for the Coronary Artery Surgery.	

SECTION E – MAJOR ORGAN TRANSPLANT

1. Has the patient undergone, <u>as a recipient</u> , a medically necessary transplant procedure?	
2. Briefly explain the reason for the transplant.	
3. Which of the following organs were transplanted? (please circle)	KIDNEY / HEART / LIVER / LUNG / BONE MARROW / PANCREAS / OTHER _____

SECTION F – KIDNEY FAILURE

1. Is the patient suffering End-Stage Renal Failure?	
1a. Is the patient suffering chronic irreversible failure of both kidneys to function?	
2. Has regular renal dialysis been initiated? If YES, what type?	
3. Has a renal transplant been carried out?	
4. What is the cause of the renal failure? Please provide brief history.	

Please Print

Name Qualifications

Address Phone

Signature Date