



Involuntary Unemployment Claim Form

IMPORTANT INFORMATION

Please ensure that all relevant sections of this claim form are fully completed. We are unable to consider assessment of your claim unless all information has been given. Failure to complete all information may result in a delay in the assessment of your claim.

1. Policy and Claimant Details

Name of Insured (Given Names) (Surname)

Policy Number

Sex Date of Birth Age

Postal Address (State) (Postcode)

Telephone Numbers Home: Business: Mobile:

Email:

Occupation

Electronic Funds Transfer

Following ACE approval of your claim, should you wish to have your claim settlement transferred directly into your bank account, please provide the following details:

Bank Name: Account Name: BSB Number: Account Number:

GST Information (For Australian Claims Only)

(a) Are you registered for GST purposes? Yes No
(b) What is your Australian Business Number (ABN)?
(c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? Yes No
(d) IF YES, what percentage of the GST did you claim or are you entitled to claim? %
(if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

2.

Unemployment Details

Note: A Separation Certificate must be attached to your Claim Form

(a) Name and address of last employer

(a) Name: _____ Phone No.: _____

Address: _____

(b) Length of employment with above employer

(b) _____ Years _____ Months

(c) Was this employment permanent, seasonal or for a specified period

(c) Permanent Seasonal Specified Period

(d) Date employment ceased

(d) _____ / _____ / _____

(e) First day as unemployed

(e) _____ / _____ / _____

(f) Reason for ceasing employment

(f) _____

(g) Did you voluntarily resign

(g) Yes No

(h) Date registered with Centrelink as unemployed

(h) _____ / _____ / _____

(i) Date re-employment commenced

(i) _____ / _____ / _____

3.

This Section to be completed by Centrelink

I hereby declare that _____ is unemployed and has been registered since _____ with Centrelink and is/is not in receipt of unemployment benefits.

What type of benefit is being paid (i.e. Newstart Allowance etc.)

Is Claimant actually seeking Re-employment?

Yes No

If No please advise reason

If not receiving benefits please advise why

Date

_____ / _____ / _____

Centrelink Authorised Representative

Centrelink Official Stamp

Office Contact Details:

Address:

Phone:

Fax:

Contact Name:

Privacy Consent - Claim Assessment

Protection of My Privacy Acknowledgement and Consents

ACE Insurance Limited (ACE) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principles.

A copy of our Privacy Policy is available on our website at www.aceinsurance.com.au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by ACE, or any third party that ACE provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:

- Any information provided in relation to your claim;
- Any information that is health information or sensitive information, including, without limitation, your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
- Any other personal information that you may provide to ACE or its third party contractors;
- Any information relating to any insurance policy on your life, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- Any other information relating to your income, assets, liabilities and solvency; and
- Any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ACE group, other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. ACE may also disclose your personal information to witnesses in respect to your claim.

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, ACE may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1800 815 675 or email customer.relations@ace-ina.com.

Medical Authority, Declaration and Power of Attorney

I DECLARE THAT,

I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to ACE using and disclosing my personal information pursuant to ACE's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to ACE's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to ACE such personal information (including health information) as ACE in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to ACE in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint ACE to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant

Date

Name of Claimant

Signature of Witness

Date

Name of Witness