

# Cancer Insurance Plan Claim Form

Policy Owner (Claimant):   
Policy Number:

Please ensure you read each question carefully and provide full details. This form is to be completed in a **BLACK** or **BLUE** ink. Your answers need to be clear and legible.

- ∞ Life Insured to complete: PART A, PART B, PART D (DECLARATION) and MEDICARE AUTHORITY Form as attached
- ∞ Policy Owner (Claimant) to complete: PART C
- ∞ Treating Specialist to complete: PART E (SPECIALIST'S MEDICAL REPORT)  
*(Any fees for the completion of the Specialist's Medical Report is the responsibility of the Claimant)*

## PART A: PERSONAL DETAILS OF THE LIFE INSURED

Surname:  Given Names:   
Date of Birth:  Weight:   
Height:

Occupation:

Current Residential Address:   
*(not a post office box)*

Postal Address   
*(if different from above)*

Email Address:

Telephone Numbers:   
Home:   
Work:   
Mobile:

## PART B: MEDICAL DETAILS OF THE LIFE INSURED

1. What diagnosis have you been given for your condition?

2. When were you diagnosed?

3. What are/were your symptoms as a result of this condition?

4. On what date did your symptoms first commence?

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5. On what date did you first attend a doctor as a result of these symptoms?

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6. Have you previously had the same similar condition or symptoms? **YES / NO** (Please circle)  
If "yes", please provide full details:


7. Please provide contact details for the following:

The doctor who provided your diagnosis:

Name:	
Address:	
Phone Number:	Date Last Seen:

The first medical practitioner you saw for this condition:

Name:	
Address:	
Phone Number:	Date Last Seen:

How long have you known this doctor?

*(If less than 12 months, please provide the name and address of your previous doctor).*

Name:	
Address:	
Phone Number:	Date Last Seen:

The doctor from whom you are currently receiving medical treatment:

Name:	
Address:	
Phone Number:	Date Last Seen:

The details of any other Specialists/Doctors you may have seen or are continuing to see for this condition:

Name:	
Address:	
Phone Number:	Date Last Seen:
Name:	
Address:	
Phone Number:	Date Last Seen:

8. What treatment/s are you currently receiving and how frequently?


9. If you have Private Medical Insurance, please provide the following details:

Fund Name:
Membership Number:

10. Have you made, or do you intend to make, a claim with any insurer?  
(Please circle) **YES / NO**

11. Do you have any additional information you would like to advise concerning your claim?


**It is essential you provide to TOWER copies of all test results confirming your diagnosis. Should the test results not be provided with this claim form it may result in delays to the assessment of your claim.**

**PART C: POLICY DISCHARGE to be completed by the Policy Owner**  
(Please note this section of the form will only be used if TOWER accepts liability for the claim)

I / We hereby request payment of the benefit amount payable for the above policy to be paid by cheque or direct credit made payable to: \_\_\_\_\_ (Payee) of \_\_\_\_\_ (Address)

I / We accept payment in full satisfaction for all Cancer Insurance Plan claims whatsoever under the above policy for the above life insured and do hereby discharge TOWER Australia Limited from all liability thereunder other than for payment of the amount stated.

Signature of Policy Owner:  Date:

Please print name:

**PART D: DECLARATION to be completed by the Life Insured**

I, ..... (PRINT NAME) 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 TOWER Australia Limited (TOWER) seeking and obtaining information from any other person or company in respect of this claim. I authorise and request any doctor who has been, or may be, consulted by me to divulge at any time to TOWER, or any legal tribunal any information that may have been acquired with regard to myself.

Personal and sensitive information is collected from you to enable TOWER to provide the product or service you request. Without this information, TOWER cannot provide this product or service. Your personal information may be disclosed to TOWER and any relevant bodies corporate including the following third parties, where necessary; health professional; your (or your employer's, if relevant) Adviser or Financial Planner; other companies within TOWER Group; organisations to whom we outsource our mailing; administration and information technologies; the Insurance Reference Service; investigators; the Trustee (if relevant); the administrator of the product or fund; reinsurers; government regulatory bodies; lawyers; accountants. By signing this form you consent to TOWER and these organisations collecting your personal and sensitive information. In accordance with Privacy legislation, you can also obtain access to your information. A photocopy of this declaration is as valid as the original.

Signature of Life Insured:  Date:

Please print name:



TOWER Australia Limited ABN 70 050 109 450  
Registered Office: 80 Alfred Street  
Milsons Point NSW 2061 Australia  
Address for correspondence: PO Box 142 Milsons Point NSW 1565  
Customer Enquiry Centre: 1800 226 364 Facsimile (02) 9448 9100

**PART E:**

**SPECIALIST'S MEDICAL REPORT to be completed by the Life Insured's treating specialist** (Any costs incurred in the completion of this report are to be paid by the Claimant).

Life Insured Surname:  Given Names:   
Date of Birth:

1. When was the Claimant first referred to you and by whom?

2. For what condition were they referred to you?

3. What is your diagnosis of the Claimant's current condition?

4. On what date was this diagnosis made?

5. When did the Claimant first experience these symptoms?

6. What were these symptoms?

7. Has the Claimant previously suffered from the same or a related condition? **YES / NO** (*please circle*)  
If "YES", please provide details:

8. On the basis of which objective tests/investigations was this diagnosis based?

9. Has the Claimant been hospitalised or consulted any other medical practitioner/s in relation to this condition? **YES / NO** (*please circle*)  
If "YES", please provide details:

10. Is there any relevant family history? **YES / NO** (*please circle*)  
If "YES", please provide details:

11. Has the Claimant ever been a smoker? **YES / NO** (*please circle*)  
If "YES", please provide dates and daily usage.

It is essential you provide to TOWER copies of all test results confirming the diagnosis (eg, histopathology, ECG results, etc)

The policy defines the condition as follows:

	<b>Cancer means...</b>
Explanation	The presence of one or more malignant tumours.
Evidence Required	This requires the malignant tumour to be characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. *Carcinoma in situ of the breast is covered if it results directly in the removal of the entire breast. The procedure must be performed specifically to arrest the spread of malignancy, and be considered the appropriate and necessary treatment.
Unacceptable Symptoms	The following tumours are excluded: <ul style="list-style-type: none"><li>∞ Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as premalignant*;</li><li>∞ All skin cancers, unless there is evidence of metastases;</li><li>∞ Melanoma of the skin at Stage 1A (tumour thickness of less than or equal to 1.00mm, Clark level II or III, without ulceration);</li><li>∞ Prostatic cancers which are histologically described as TNM Classification T1 or are of another equivalent or lesser classification, unless resulting in the surgical removal of the prostate;</li><li>∞ Papillary Micro-Carcinoma of the Thyroid or Bladder; and</li><li>∞ Chronic Lymphocytic Leukaemia less than Rai Stage 1.</li></ul>

12. In your opinion, does the Claimant's condition fully satisfy the definition of the event? **YES / NO**  
(please circle)

Please comment:

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**SPECIALIST DETAILS:**

Name:  Qualifications:

Address:

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Phone Number:  Fax Number:

Signature:  Date:

**THANK YOU FOR YOUR ASSISTANCE**



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