Accidental Death Benefit Claim Form

This claim form consists of 2 parts and all sections must be completed in full.

Section A Beneficiary Statement This section is to be completed by the **Beneficiary** or such authorised person.

Section B Employer Statement This section must be completed by employee's **Employer**.

Important information

1. A claim cannot be assessed until we receive at a minimum, **all sections of the completed claim form**.
2. Incomplete questions or supporting documentation may delay the assessment process and the claim form could be sent back to be completed.
3. To have a valid claim, you must provide certified copies of the **Death Certificate**, **proof of your relationship to the deceased** and **proof of beneficiary**.
4. Please ensure you provide to us **proof of identification** for both the beneficiary and the deceased e.g. copy of driver's licence, proof of age card, passport etc.
5. Depending on your policy you may also need to provide **funeral receipts** - Please refer to your policy document.
6. All information provided must be legible.
7. **You must contact UWU via email to confirm contact and banking details to ensure the safe and timely transfer of this benefit to the beneficiary. Please email uwuaccounts@unitedworkers.org.au**

Please return the completed Claim Form to n2n Claims Solutions

Email: info@n2nclaims.com.au

Post: Locked Bag 3111, Rhodes NSW 2138

If you have any questions, please don't hesitate to contact our claims department on **1800 999 626**

Section A – Beneficiary Statement

Employee's Details

Given name		**Surname**	
Name of Employer			
Who are you claiming through?	**United Workers Union**		
Membership No. (if applicable)			
At the time of death, was the employee employed	☐ **Yes** ☐ **No**		
Employee is the	☐ **Deceased** ☐ **Spouse** ☐ **Other, please specify**		

Deceased's Details

Given name		**Surname**			
Address					
Suburb		**State**		**Postcode**	
Gender		**Date of Birth**		**Date of Death**	
Marital Status (please include dates)	☐ **Never Married**	☐ **Divorced**		☐ **Separated**	
	☐ **Married**	☐ **De Facto, please advise period lived together (years & months)**			
Cause of Death	☐ **Natural Causes** ☐ **Accident** ☐ **Suicide**				
If death was due to natural causes, please specify the medical condition					

If death was due to an accident, specify how, when & where it occurred					
If death was unnatural, please provide the Police Report Number					
Reporting Police Station		Police Officers Name			
In your opinion, do you believe the cause of this death was work related?	☐ Yes ☐ No				

Beneficiary's Details

Given name		Surname			
Address					
Suburb		State		Postcode	
Home phone		Mobile			
Fax		Gender		Date of Birth	
Email					
Relationship to deceased	☐ Spouse ☐ Child ☐ Other, please specify				
Have you claimed this benefit or similar type of benefit with another policy	☐ Yes ☐ No				
If "Yes", please provide details of your claim, including any additional documentation for example an acceptance letter, copies of any benefits and receipts.					
Insurer/Company name					

Authorised Representative/s (This section is optional)

Complete this section if you **wish to authorise a family member or friend** to assist you with the claims process. It is required to allow us to disclose any personal information about your claim which includes medical, financial, employment and insurance information.

Name of authorised representative			
Representative's relationship to you		Representative's date of birth	
Representative's Phone Number			
Representative's Email Address			

Declaration and Authorisation

Privacy Statement

In this statement "we", "us" and "our" means the Underwriter and n2n Claims Solutions Pty Ltd as its authorised representatives.

We are bound by the obligations of the Privacy Act 1988 (Cth) and the Australian Privacy Principles. This sets out basic standards relating to the collection, use, storage and disclosure of personal information.

Our Privacy Policy, available at www.n2nclaims.com.au or by calling us on 1800 999 626 and it sets out how:

- **we protect your personal information;**
- **you may access your personal information;**
- **you may correct your personal information held by us;**
- **you may complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint.**

We, and our agents, need to collect, use and disclose your personal information in order to assess and manage any claim or obtain feedback on our group services. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to assess or manage a claim.

We may disclose your personal information to third parties who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers (including reinsurers) and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). Some of these parties may be located outside of Australia which includes but is not limited to the United Kingdom.

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- **you have the authority from them to do so and it is as if they provided it to us;**
- **you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the other parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.**

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by us by contacting n2n Claims Solutions on 1800 999 626 or via email at info@n2nclaims.com.au.

By signing this form, you consent to us and the parties mentioned below collecting, using, and disclosing personal and sensitive information about you for the purposes described above of assessing and managing your claim or obtaining feedback on our group services.

1. **Parties may include: Any representative of n2n Claims Solutions, my Superannuation Fund(s), my Insurance Policy Broker, my Union/ association, my authorised representatives, Employer(s) workers compensation insurer, insurance companies, government department (which includes Centrelink or similar benefit providers), claims assessor, legal firm, accountant, financial advisor, and any physician, hospital, healthcare provider who has attended or examined me, in order for n2n Claims Solutions to be supplied with my full employment, financial and medical history including but not limited to tax returns, any medical or hospital records, reports, clinical notes and referral letters.**

2. **I hereby declare that all information that I've supplied is true and correct in every aspect. I have not made any false or misleading statements.**

3. **I do understand that this claim and any future claims may be refused if any information I've provided is not true, misleading or relevant information has been withheld.**

4. **A photocopy, emailed or faxed version of this Declaration and Authority is considered as effective and valid as the original.**

Name (please print)			
Signature		**Date**	

Section B – Employer's Statement **(Must be completed by the employer paymaster/manager only)**

Employee's Details

Employee's name		**Employee number**	
Employee's Job Title			
Employment type	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Self-Employed ☐ Contractor ☐ Project Specific Work		
If employee was employed on a specific work project	**Project Name**		
Current work status	☐ Employed ☐ Resigned ☐ Terminated		
Date commenced employment		**Date Ceased**	
Is the employee covered under an Employer Enterprise Agreement Income Protection policy?		☐ Yes ☐ No	
If "Yes", please advise insurance company's name			
In respect of this claim has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?		☐ Yes ☐ No	
If "Yes", please advise when and to which company			
Do you believe the employee's condition is work related?	☐ Yes ☐ No		
Is the employee currently on workers compensation?	☐ Yes ☐ No		

Employer's Declaration and Authority

I am authorised to complete this form on behalf of the employer and all information I've supplied is true and correct. I also acknowledge that n2n Claims Solutions may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.

Company name					
Paymaster/Manager name		**Job title**			
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax No.**			
Email					
Signature		**Date**			