SOUTHERN CROSS Assurance Limited

LOSS OF LIFE / ACCIDENTAL DEATH AND DISMEMBERMENTCLAIM FORM FOR A GROUP POLICY (COMPUSLORY

CLAIM FILING INSTRUCTIONS

NOTE TO ORGANIZATION AND MEMBER/INSURED/BENEFICIARY: Our objective is to provide fast and accurate claims service. Listed below are instructions on claim submissions that, when followed, will assist us in providing this service..

WHEN TO FILE A CLAIM

1. Written notice of the claim should be provided to us within 30 days after the loss begins or date of death.
2. Written proof of loss (completed claim form and supporting documents) should be provided to us within 90 days after the loss starts or date of death.

HOW TO FILE A CLAIM

Section I. The Employer along with the member/insured or beneficiary must complete this section by answering all
applicable questions.
Section II. Complete this section if the claim is related to a death, not due to an accident.
Section III. Complete this section if the claim is related to an accidental death or dismemberment.
Section IV. If the claim is related to a loss of use of a limb, loss of sight or loss of hearing, the attending physician must complete this section. It must also be signed by the member/insured.
Section V and VI. Complete these sections if claim is related to death or accidental death.

WHAT TO FILE WITH A CLAIM

All applicable questions on the claim form must be completed in full. Mail this form and any of the following to us at the address below:

a. Certified copy of death certificate, required if applicable
b. Autopsy report/coroner's report, if performed
c. Newspaper clippings, if applicable
d. Fire report, if applicable
e. Copy of membership form, if available
f. Copy of Beneficiary Designation form, if available

WHERE TO FILE A CLAIM or HOW TO CONTACT US

The Claims Manager
Southern Cross Assurance Limited
PO BOX 808
Port Moresby
Level 9, Monian Tower
Douglas Street
Port Moresby
National Capital District
Papua New Guinea

Telephone (Landline)	:	**(675) 308 3400**
Digicel Mobile	:	**(675) 7352 5579**
Digicel Mobile	:	**(675) 7327 3568**
BMobile	:	**(675) 7630 4204**
BMobile	:	**(675) 7630 4205**
Facsimile	:	**(675) 321 2950**
Web Address	:	**www.scal.com.pg**

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SECTION I. COMPLETE IN FULL (Policy Holder / Beneficiary Signature required at the end of Section VI

1. Policy Number: _____
2. Name of Policy Holder:_____
3. Name of Beneficiary(ies): i_____ ii._____

   iii._____ iv._____ v._____
4. Address:_____

   _____
5. If claim is for a dependent, please provide Name:_____
6. Dependent's Date of Birth:_____ Relationship to the insured member:_____

SECTION II. COMPLETE FOLLOWING QUESTIONS IF CLAIM IS RELATED TO A DEATH (THAT IS NOT DUE TO AN ACCIDENT)

1. Date of Death:_____ Approximate Time of Death :_____ [ ]AM [ ]PM
2. Where did the death take place?
3. How did the death take place? Be specific, explain exactly what happened. (Use additional paper if necessary).

4. Name of attending Physician:	5. Professional Designation:
6. Telephone No.	7. Signature of Physician:

Address of Physician:

8. Was an autopsy performed? [ ]Yes [ ]No- If Yes, by whom? Physician Name
9. Did deceased member/insured have any chronic disease, physical defects or deformities ?
   [ ]Yes [ ]No

   If Yes, please describe:
10. Did deceased member/insured receive any medical treatment in the last five years? [ ]Yes [ ]No
    If Yes, please describe:

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SECTION III. COMPLETE FOLLOWING QUESTIONS IF CLAIM IS RELATED TO AN ACCIDENTAL DEATH OR DISMEMBERMENT	
1. If accidental death, date and time of death. Date Time [ ]AM [ ]PM	
2. If accidental death, was autopsy performed? [ ]Yes [ ]No- If Yes, by whom? Physician Name:_____	
3. What injuries occurred?	
4. Where did the accident / death take place?	
5. How did the accident / death take place? Be specific, explain exactly what happened (Use additional paper if necessary).	
6. Name of attending Physician:	7. Professional Designation:
8. Telephone No.	9. Signature of Physician:
10. Address of Physician:	
11. If insured member is/was covered under a Sports Accident, Travel Accident or Specified Hazard Policy, did the accident / death occur while taking part in an activity sponsored and directly supervised by the Policy Holder? [ ]Yes [ ]No, If yes, describe type of activity involved?	
12. Did deceased member/insured have any chronic disease, physical defects or deformities ? [ ]Yes [ ]No If Yes, please describe:	
13. Did the deceased insured member receive any medical treatment in the last five years? ? [ ]Yes [ ]No If Yes, please provide dates and diagnosis. :	

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SECTION IV : ***TO BE COMPLETED NY ATTENDING PHYSICAN IF DISMEMBERMENT OR LOSS OCCURRED***

IV. A - LOSS OF LIMB – You must submit a medical report and / or medical records to support claim

Loss of Limb [ ] No [ ] Yes - If yes, please answer the following:-

1. Did insured lose limb as a result of an accident? Limb [ ] No [ ] Yes
2. If Yes, please mark applicable loss(es)

Right Wrist [ ]Above [ ] Below	Left Wrist [ ]Above [ ] Below
Right Arm [ ]Above Elbow [ ] Below Elbow	Left Arm [ ]Above Elbow [ ] Below Elbow
Right Foot [ ]Above [ ] Below	Left Foot [ ]Above [ ] Below
Right Leg [ ]Above Knee [ ] Below Knee	Left Leg [ ]Above Knee [ ] Below Knee

Right Thumb and Forefinger [ ]
Left Thumb and forefinger [ ]

3. Date of amputation / loss of use : _____

4. Name of attending Physician:	5. Professional Designation:
6. Telephone No.	7. Signature of Physician:
8. Address of Physician:	
9. Please note that the attending physician must provide a full medical report as well.	

SECTION IV B : ***LOSS OF SIGHT***

You must provide diagnosis and enclose medical records regarding existing eye condition

Loss of Sight [ ] No [ ] Yes - If yes, please answer the following

1. Did insured lose sight as a result of an accident? Limb [ ] No [ ] Yes

	Uncorrected	Corrected
2. Record of Vision		
a. Date if first observation_____	R.E_____ L.E_____	R.E_____ L.E_____
b. Date of last observation_____	R.E_____ L.E_____	R.E_____ L.E_____

3. From what date was vision recorded in question 2b?	4. If totally blind provide date this occurred Right Eye_____ Left Eye_____
5. If eye has been enucleated, provide date Right Eye_____ Left Eye_____	6. In your opinion, can vision be improved by treatment, operation or lenses? [ ] No [ ] Yes State your recommendations:

7. Is loss of sight irrecoverable? [ ] No [ ] Yes

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8. Was there any disease or condition prior to the date of the accident, which might have served as a contributory cause? [ ] No [ ] Yes – If Yes, please supply medical records	
9. If physician other than yourself treated the insured for this contributory condition, please provide the name and address of physician following the accident.	
10. Name of attending Physician:	11. Professional Designation:
12. Telephone No.	13. Signature of Physician:
14. Address of Physician:	

SECTION IV.C -	***LOSS OF HEARING – You must provide a copy of the following:*** Measurement of pure tone air-conduction & bone-conduction thresholds, speech reception threshold, discrimination score, tympanomtery, acoustic reflexes, acoustic reflex decay, and any medical records pertaining to this condition.
1. Name of attending Physician:	2. Professional Designation:
3. Telephone No.	4. Signature of Physician:
5. Address of Physician:	

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to provide Southern Cross Assurance Limited, or it legal representatives, any and all such information. I AGREE that a photographic copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

Date __-_____-_____ Signature of Insured _____Phone :_____
(parent or guardian, if minor)

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FRAUD NOTICES

- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty.

- A person who knowingly and with intent to injury, defraud, or deceive an insurance company files a claim containing, false, incomplete, or misleading information may be prosecuted under PNG law.

- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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SECTION V. - HANDLING OF BENEFICIARY INFORMATION

1. Benefit Amount

2. Are you making this claim as the **Beneficiary**? If so, what is your relationship with the deceased ?_____
_____

3. Beneficiary name(s) : i_____ ii._____
iii._____ iv._____ v._____

4. Beneficiary Dates of Birth: i_____ ii._____
iii._____ iv._____ v._____

5. Beneficiary address:_____
_____

6. Check One: Beneficiary Driver's Licence:_____ Other Source of ID._____

7. Beneficiary e-mail address : (optional)_____

I certify t hat the above information is correct to the best of my knowledge and belief, that the person named above was Insured by the Policy, and that his /her insurance was in effect on the date the accident or sickness occurred.

Beneficiary Signature :_____ Date : _____

Phone:_____

8. Are you making this claim as the **Administrator (Policy Holder), Guardian or Executor?** [ ]No [ ]Yes

If Yes, please provide appropriate proof:
_____

I certify t hat the above information is correct to the best of my knowledge and belief, that the person named above was Insured by the Policy, and that his / her insurance was in effect on the date the accident or death occurred.

Signature of Policy Holder :_____ Date : _____
(You may submit proof of membership or Certificate of Currency in Place of Policy Holder Signature)

Title:_____ Phone:_____