Claims Guide
Group Insurance

Our desire is to help members when they need it most

We know it can often be difficult for members to make a claim during a time of ill health

We also recognise that whilst it's important to accept a claim quickly, even more critical to delivering the best outcome for a member is to provide assistance with integrity & compassion throughout the claim journey

It's because of these reasons we focus on how best to support and meet the needs of the member

Claims Philosophy

Our philosophy is to assess each claim with integrity and compassion whilst ensuring we remain fair and reasonable. We achieve this by:

- Allocating each claim to a dedicated case manager who will look after the member from start to finish.
- Being completely transparent and communicating openly with all parties
- Reaching conclusions that are based on facts & sound reasoning
- Ensuring genuine claims are paid as soon as possible
- Providing a range of support services that the member can access after they make a claim to help them get better and return to work safely
- Working with the member, their doctor and employer to assist a member's recovery
- Establishing agreed times for the delivery of service and reports
- Monitoring our claims assessments with an internal quality verification process
- Maintaining confidentiality of all information

What makes us different

We focus on how best to support and meet the needs of the member

Dedicated Case Manager

We allocate each claim to a dedicated case manager who will be responsible for the claim from start to finish. All case managers only have a medium size portfolio to ensure the member receives excellent support.

To ensure the best chance of positive outcomes being achieved, we select the case manager based on the member's condition. This is often the case with mental illness claims which need an additional level of care. This ensures the case manager has the experience and expertise to support the member.

Direct Contact with Members

Our preference, is for the case manager to have direct contact with the member. We have found this a positive approach that improves the member's experience. All calls direct with the member are recorded to safeguard information.

Early Intervention

We are very supportive of any framework which promotes the early notification of a claim to us during the waiting period ("Day 1") so that we can assess the need for rehabilitation and co-ordinate a return to work strategy.

The assessment of a claim often requires advanced specialist skills based on current medical treatments. For this reason we have engaged several external companies to complement our internal claim team's expertise.

We often utilise the specialty staff of an external provider to provide highly personalised support to members for the completion of claim forms and to gather information. This reduces the amount of time taken between claim notification and the payment of benefits, improves the ongoing management and provides the member with support for recovery.

Rehabilitation and Support Services

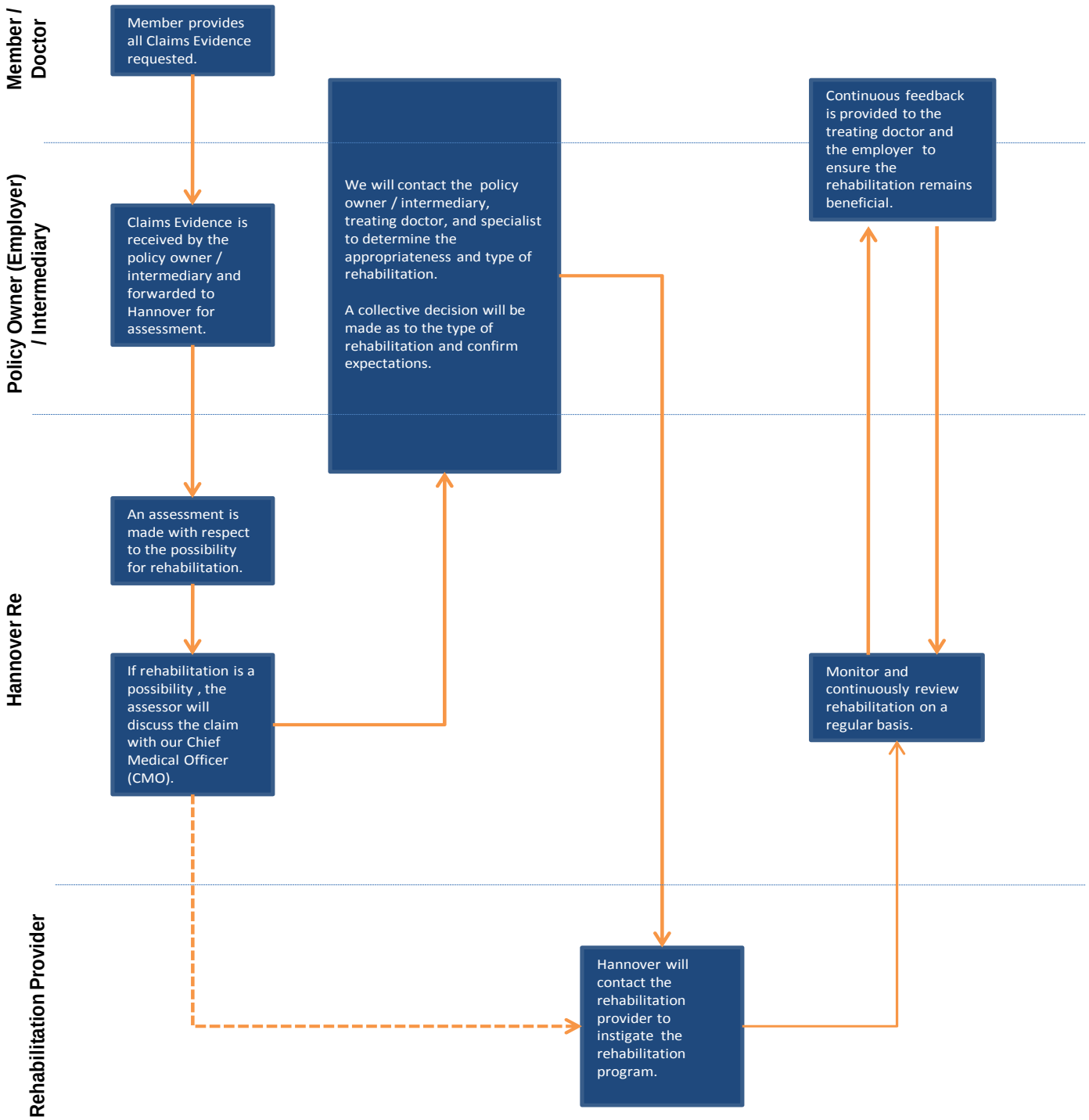
After lodging a claim the member can access a range of support services to help them get better and return to work safely.

We work with specialist rehabilitation service providers and in consultation with the member, their doctor and the employer to develop positive fully-accredited rehabilitation programs tailored with consideration to all relevant information including medical capacity, education, training and experience.

We may also instruct an external provider to assist with liaising with the member and the appropriate medical specialist to agree on a unified medical management program.

Our case manager will monitor the member's progress to ensure the rehabilitation plan remains effective. There is no maximum limit on the amount of rehabilitation to assist the member, subject to our prior approval.

Rehabilitation Process



Claims Systems and Technology

Claims and Underwriting Enquiry System

Hannover has a market leading Claims & Underwriting Enquiry System (CUES) which allows clients, consultants and administrators direct online access enabling them to monitor each individual underwriting and claim case from the date received at our office until completion. This results in quicker response times to member enquiries.

Features of our system include the ability to:

- Track the daily progress of member's claims and underwriting applications
- Search and view comprehensive case information
- Generate and configure reports
- Receive electronic reminders via an automated follow up process
- Access New Movements and nominate date ranges to review past movements
- Create personal Watch Lists to receive automatic emails each time a new movement has occurred
- Download underwriting and claim forms

CUES can be accessed at https://cltenq.hlra.com.au/

For assistance or to request login details, please contact us on 02 9251 6911 or cues@hlra.com.au

The Claims Management System (CMS)

Our claims system works behind the scenes, the benefits it provides are:

- Faster claims processing and turnaround times
- Improved reporting
- Live uploading of claims status and information into CUES, rather than overnight

Reporting

Our online Claims and Underwriting Enquiry System (CUES) allows clients, consultants and administrators to download tailored reports directly from our system to meet their individual reporting requirements.

We can also provide tailored reports in line with most requirements and at any frequency.

Some examples of these reports include:

- Service Standards
- Claims Summary
- Claims Status
- Finalised Claims
- Underwriting Summary
- Underwriting Status
- Finalised Underwriting

Service Standards

We are committed to developing strong partnerships with our clients and to providing the highest levels of quality service

We pride ourselves on our ability to deliver or exceed our agreed service standards and deliver what we promise, it's the way we do business and it's our culture

This is something that we would encourage prospective clients to talk to our existing clients about

Procedural Fairness

We are committed to assessing all claims fairly. We will send a procedural fairness letter to the policy owner 30 days prior to reaching our decision. The letter will contain details of the evidence Hannover has obtained and should be forwarded immediately to the member for their comment.

The claim will be re-assessed by the original claims assessor if further information is received. If no additional information is received within 30 days, we will proceed with making a decision and a written report explaining the reason for our decision will be forward to the policy owner.

Review Forum & Committee

We provide a Claims Review Forum and a Claims Review Committee to ensure that a claim dispute is re-assessed thoroughly and independently and that the decision is fair and reasonable.

Where the policy owner disagrees with our decision, we will require a written objection stating the basis of their disagreement and any supporting evidence. The claim will then be reviewed by the original claims assessor and may be referred to our Claims Review Forum. The Claims Review Forum consists of our National Claims Manager and other senior claims assessors.

If the policy owner is still not satisfied with our decision after our reassessment of the claim they are able to request that the claim be reviewed by the Claims Review Committee. The Claims Review Committee consists of senior management employees from a variety of business units within Hannover.

Claim Requirements

The claimant is responsible for all expenses incurred in the provision of all Standard Requirements in support of their claim. We will pay for the cost of any additional requirements we request.

Standard Requirements for All Claims

- Certified and valid identification which includes the member's age (i.e. driver's licence or passport), and
- Confirmation of membership, including their application, the date of the last premium payment and the agreed benefit, and
- A copy of the member's health evidence if the previous insurer or administrator accepted the member for cover,
- Any test results or additional medical evidence, and
- The additional requirements for each claim type as stated below:

Death Claim:

- A certified copy of the member's death certificate.

Terminal Illness Benefit (TIB) Claim:

- Member's TIB Claim Form, Specialist Report Claim Form (including test results if available) and confirmation from the member's treating medical practitioner that they are suffering from a Terminal Illness.

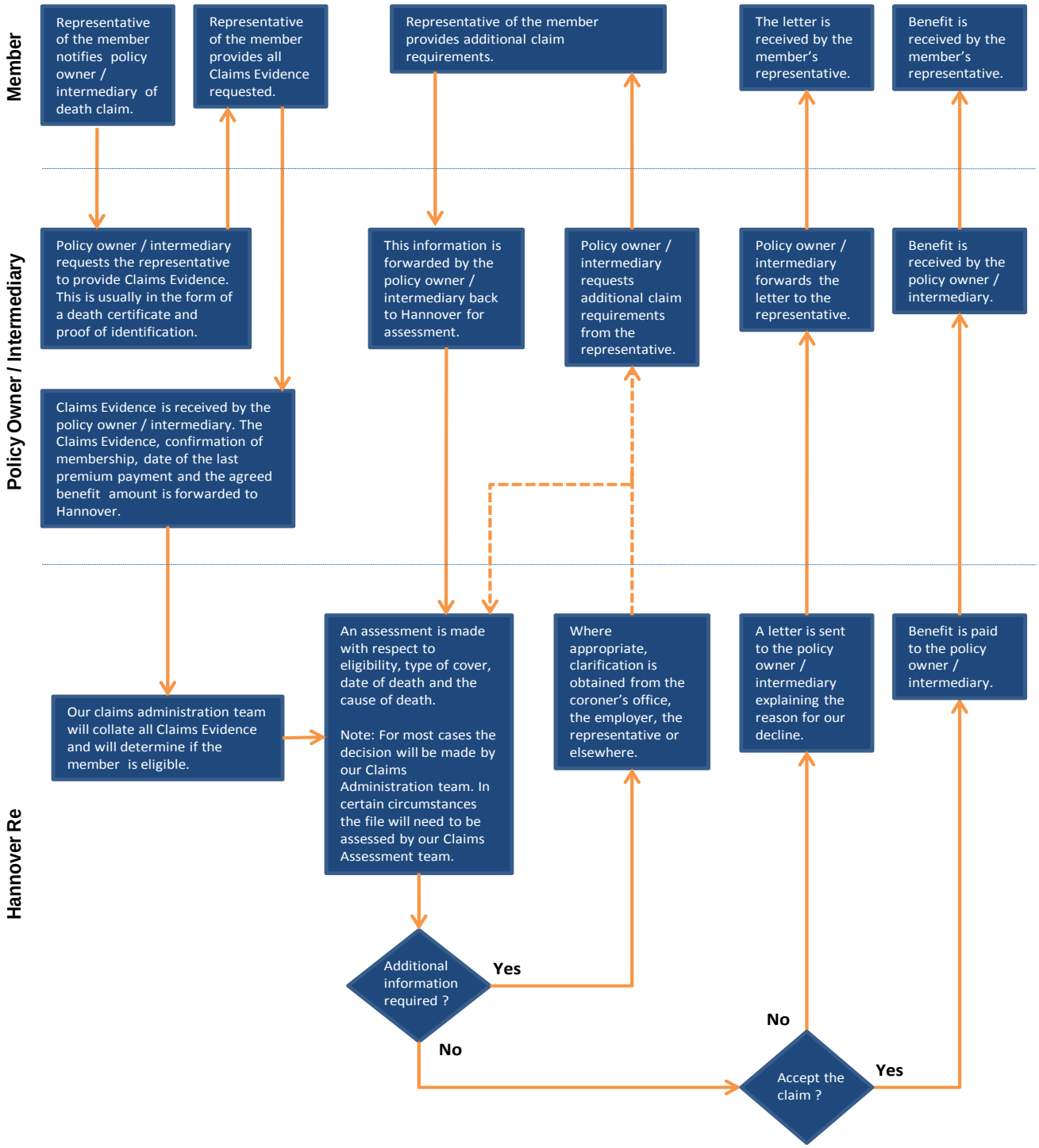
Total & Permanent Disablement (TPD) Claim:

- Employer's Statement, Member's Statement and Confidential Medical Report(s) including any medical test results.
- If the notification date of the claim to Hannover is more than 18 months after the incident date, we will require a copy of the member's taxation returns/assessments.

Claim Process – Death

The process maps outline our standard guidelines for the assessment of Death and TPD claims. Some actions may occur concurrently rather than sequentially and we reserve the right to modify these guidelines at any time in light of evolving market conditions, new methodologies or with regard to the particular circumstances surrounding a claim. We are also able to customise our guidelines to meet each client's specific needs.

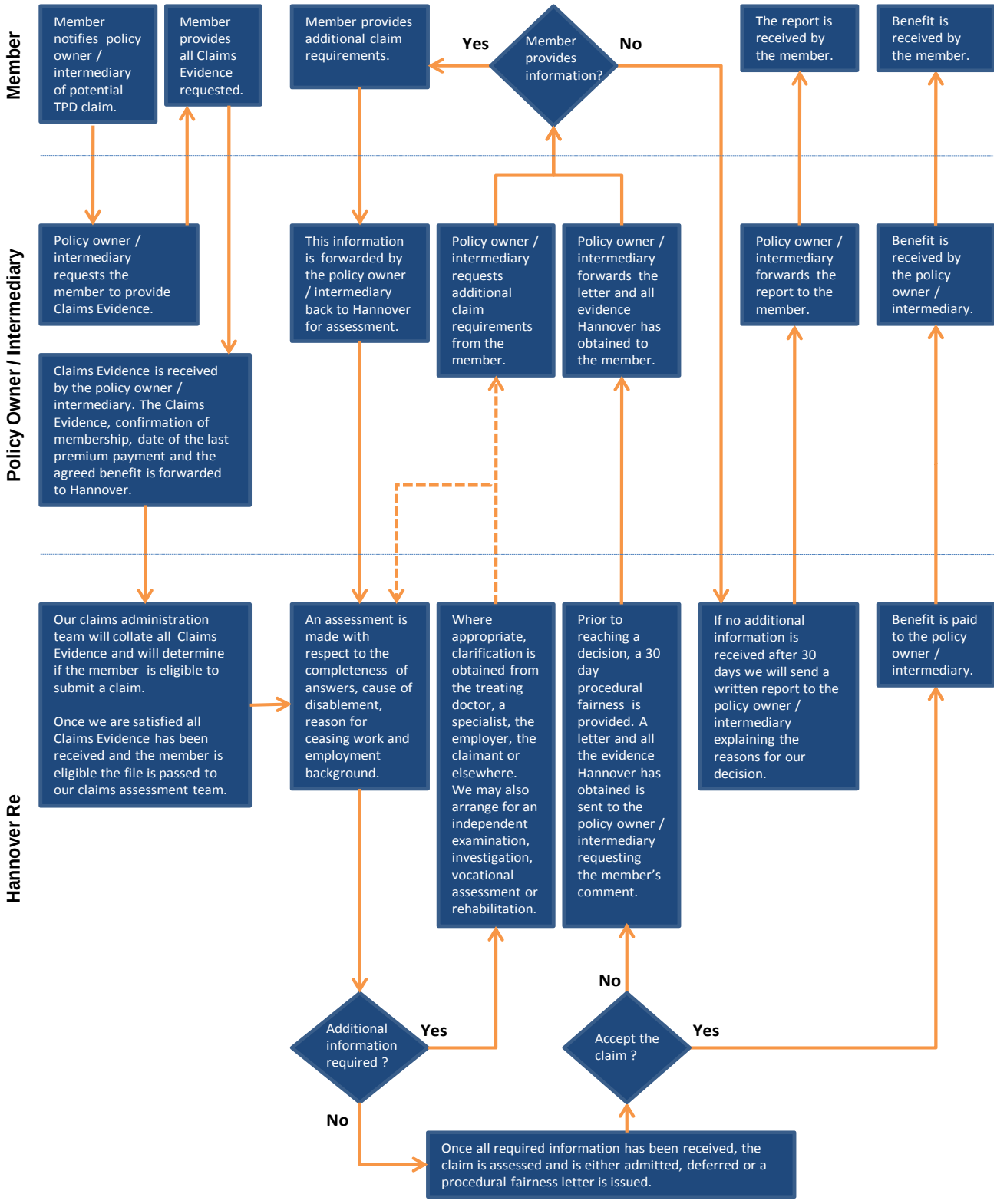
Standard Death Guidelines



Follow up of outstanding claim requirements will occur on a regular basis but at a maximum interval of monthly

Claim Process – Total & Permanent Disablement

Standard TPD Guidelines



Follow up of outstanding claim requirements will occur on a regular basis but at a maximum interval of monthly

Contact Us

GROUP INSURANCE TEAM

All members of the Hannover team can be contacted by telephone on 02 9251 6911

Claims

We allocate each claim to a Claims Administrator and they will be responsible for the claim until it is finalised.

For all general enquiries in relation to the co-ordination of claim requirements, claims assessment and payments, please contact your dedicated administrator by sending an email to:

groupclaims@hlra.com.au

Please submit all claim forms, requirements and correspondence to:

groupclaims@hlra.com.au

Administration

We allocate each policy to a Group Risk Administrator who is the contact point for all administration matters.

For all general policy enquiries relating to the administration, installation or renewal of the policy please contact your dedicated administrator by sending an email to:

groupunderwriting@hlra.com.au

Underwriting

For all general enquiries in relation to the co-ordination of underwriting, please contact your dedicated Group Risk Administrator by sending an email to:

groupunderwriting@hlra.com.au

Please submit all underwriting applications, forms, requirements and correspondence to:

groupunderwriting@hlra.com.au

Marketing

For business development, quotations, product design and policy documentation enquiries, please email:

grouprisk marketing@hlra.com.au