

**TERMINAL ILLNESS WAIVER REQUEST FORM**

Please return this waiver request form promptly to us with all questions fully answered

**1. Personal Details**

Surname.....	First name .....
Date of birth .....	Loan number .....
Address .....	Suburb/Town .....
Telephone.....(.....)	Email.....

**2. Medical Information Details (to be completed by or on behalf of the life assured)**

What is your current diagnosis/condition? .....

When was the diagnosis first made? By whom? .....

Please detail when you first noticed symptoms and what were they? .....

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Date you first sought medical assistance for your condition .....

Have you ever in the past suffered from the same, similar or related condition?  Yes  No

If 'Yes' please give details .....

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**2.1 Medical Information Details - Your General Practitioner (who holds all your medical notes)**

Surname.....	First name .....
Address .....	Suburb/Town .....
Telephone.....(.....)	Email.....

**2.2 Medical Information Details - Your Specialist (for more than one specialist please complete on a separate sheet of paper)**

Surname.....	First name .....
Address .....	Suburb/Town .....
Telephone.....(.....)	Email.....

**3. Declaration and Privacy Act 2020**

I acknowledge that this waiver request form collects personal information concerning me pursuant to the terms and conditions of the payment waiver for the purposes of evaluating my waiver request. The personal information provided in this waiver request form is collected and held by Oxford Finance Limited. I have the right to access and correct this information subject to the provisions of the Privacy Act 2020.

I authorise the use and disclosure of my personal information to Oxford Finance Limited and others for the purposes of assessing my request. I authorise any medical practitioner/s I have consulted to provide information and documents recording my medical condition and medical history.

I declare that all statements made in this form are true and correct and that no material information has been withheld.

I acknowledge that if I have not answered any questions correctly, completely or honestly, my waiver request may be declined.

I acknowledge that any benefits payable under this waiver request will be paid to the financier of my loan.

Signature X..... Date .....

**TERMINAL ILLNESS WAIVER REQUEST FORM cont.**

**4. Consent to Disclose Personal Information**

If you would like Oxford Finance to release details about you and your waiver request to any other person, please provide the following details:

Your relationship to the nominated person (e.g. your spouse, advisor, family member) .....

Their surname ..... Their first name .....

Address ..... Suburb/Town .....

**Authorisation**

Signature of Life Assured  ..... Date .....

Full name of Life Assured.....

**5. Medical Details (to be completed by the life assured's treating specialist, at the life assured's own expense)**

Life Assured surname..... Life Assured first name.....

Date of birth ..... NHI number .....

Address ..... Suburb/Town .....

Are you the life assured's usual medical attendant? Yes No If 'Yes' for how long .....

a) What is the life assured's diagnosis/problem? Please detail .....

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b) When was the diagnosis made and by whom? .....

c) What are the signs and symptoms leading to the diagnosis? .....

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d) Date the life assured first sought medical assistance for the claim/condition.....

e) Has the life assured ever suffered from the same, similar or related condition? Yes No

If 'Yes', please provide full details .....

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f) What is the current proposed treatment plan? .....

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g) Please give details of any other relevant treatment providers for the life assured .....

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**TERMINAL ILLNESS WAIVER REQUEST FORM cont.**

h) What is the prognosis of terminal illness? (including life expectancy irrespective of any treatment he/she may have received?)

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To assist with the assessment of this waiver request, please attach copies of all relevant specialist reports, clinical/hospital notes and any other supporting documents.

**6. Attending Physician's Details**

Surname.....	First name .....
Medical speciality .....	
Address .....	Suburb/Town .....
Telephone...( ) .....	Email .....
Signature X.....	Date .....