



# REAL Trauma Cover claim form

This claim form is to be used for all REAL Trauma claims, including the Additional Female Cancer Rider benefit and Male Prostate Removal Rider benefit.

## Important information you must read before submitting this claim:

- *Claims must be submitted to AIA New Zealand within three months from the date of diagnosis.*
- *Please ensure that all attachments are originals. You may wish to make copies for your records.*
- *Upon completion, please give the entire form to the treating doctor for completion of sections 4, 5 and 6.*
- *Please complete the Authority to Act Form (page 4) if applicable.*

## Section 1: Personal details

### 1. Claimant Details

<b>Title</b>	<b>First name</b>	<b>Surname</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Date of birth</b>	<b>Gender (Please tick)</b>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>		
<b>Physical address</b>		<b>Postal address (if different from physical address)</b>	
Unit / apartment / building / floor		PO Box / private bag number	
Street		Street	
Suburb		Suburb	
Town / city		Town / city	
Postcode		Postcode	
Region / state		Country	
<b>Home phone</b>		<b>Business phone</b>	
<input type="text"/>		<input type="text"/>	
<b>Mobile phone</b>		<b>Email</b>	
<input type="text"/>		<input type="text"/>	
<b>Doctor's name (Personal doctor)</b>			
<input type="text"/>			
<b>Doctor's address</b>			
Street address		Phone	Fax
Suburb		Town / city	Postcode

### 2. Policy Owners Details (If the Policy Owner is not the Claimant)

<b>Title</b>	<b>First name</b>	<b>Surname</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Date of birth</b>	<b>Gender (Please tick)</b>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>		
<b>Physical address</b>		<b>Postal address (if different from physical address)</b>	
Unit / apartment / building / floor		PO Box / private bag number	
Street		Street	
Suburb		Suburb	
Town / city		Town / city	
Postcode		Postcode	
Region / state		Country	
<b>Home phone</b>		<b>Business phone</b>	
<input type="text"/>		<input type="text"/>	
<b>Mobile phone</b>		<b>Email</b>	
<input type="text"/>		<input type="text"/>	

## Section 2: Direct Credit Details

### 1. Direct credit details *(should the claim be accepted)*

Which bank account would you like your claim paid into?

☐ Same bank account as the one my premium is paid from ☐ A different bank account:

Name of account holder *(please attach deposit slip)*

Bank name / branch

Bank Branch number

Account number

Suffix

## Section 3: Disclosures and declarations

### 1. Statement of disclosure

1. This claim form collects personal information about you which will be used to: (a) investigate and determine the validity of your claim; (b) confirm the information in your application for this insurance product; (c) maintain relevant statistical records.
2. This information is collected and held by AIA New Zealand at 5-7 Byron Avenue, Takapuna, Auckland 0752, New Zealand.
3. You have a duty to provide AIA New Zealand with all the facts material to your claim and all information, which we may reasonably require in relation to your claim. If you fail to provide this information we may not pay your claim. If you provide false information this may result in your policy being voided from inception or cancelled.
4. Under the Privacy Act 1993 and Health Information Code 1994, you have the right of access to, and correction of, any information held or provided.

#### Declaration and authority to obtain and use information

1. I authorise any doctor, medical specialist, hospital, clinic, insurance company, ACC, employers or any other authority to disclose to AIA New Zealand any and all information concerning my medical history, financial, occupational and insurance information. A photocopy or facsimile of this authorisation shall be as valid as an original.
2. I have read and understood the information in this claim form including the section above relating to the Privacy Act 1993 and the Health Information Privacy Code 1994.
3. I declare that all information provided by me relating to this claim is true and correct, and no material information has been withheld.

### 2. Declaration to AIA New Zealand

I acknowledge that I may be required to attend additional medical assessments, should AIA New Zealand deem this necessary to complete the assessment of this claim.

I acknowledge that if I do not meet this responsibility, AIA New Zealand may be unable to assess and pay the claim.

I acknowledge that I may have to repay any overpayments made to me by AIA New Zealand.

Full name of Claimant

Signature of Claimant

Date

*(To be signed by the parent / legal guardian if claimant is a child under 16 years.)*

Full name of Policy Owner

Signature of Policy Owner

Date

Have you attached all clinical notes / reports related to this condition(s)?

☐ Y☐ N

## Section 4: Claim Details *(To be completed by your attending doctor or specialist)*

1. Details of the condition or symptoms that have resulted in this claim (include clinical details).


2. Date symptoms first arose Date

3. Date medical advice first sought Date

4. Date sickness/injury first diagnosed Date

5. Please provide full details of consultation and treatment

Date	Treatment	Treated By

6. Has the client ever in the past suffered from this injury or illness? ☐ **Y** ☐ **N** If yes, please provide details

Date	Diagnosis	Doctor/Hospital

7. Please give any other information and attach **all relevant medical reports** which may be helpful in assessment of this claim.


## Section 5. Family history

1. Is there anything in the client's medical, social or family history which would have increased the risk of this illness occurring? ☐ **Y** ☐ **N**

If yes, please give details


2. Relationship to claimant

3. Age when disorder diagnosed

4. Nature of illness/condition

5. Outcome of the illness/condition

## Section 6. Medical attendant

I declare that the answers to the above questions are true and correct.

Full name of medical attendant

Signature of medical attendant  Date

Phone number  Fax number

Professional qualifications

Have you attached all clinical notes / reports related to this condition(s)? ☐ **Y** ☐ **N**



## Authority to act form

Please complete the relevant section of this form if either of the following circumstances apply:

Please ensure that the witness section is completed in either case.

1. You are the Life Assured (Claimant) and wish to give consent for a third party (Spouse/Broker/Policy Owner) to act on your behalf for the duration of this claim.
2. You are the Policy Owner and wish to give consent to a third party (Spouse/Broker/Life Assured (Claimant)) to act on your behalf for the duration of this claim.

### Section 1: Statement from Life Assured *(Claimant)*

Title	First name	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	Gender <i>(Please tick)</i>	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	

I give consent that all information and / or communication pertaining to my claim may be released to my appointed representative and I appoint him / her to represent me in all matters pertaining to my claim.

Full name of Life Assured's representative

Life Assured's representative identification	Signature of Life Assured	Date
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

*(password / ID type / other)*

### Section 2: Statement from Policy Owner *(if the Policy Owner is not the Claimant)*

Title	First name	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	Gender <i>(Please tick)</i>	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	

I give consent that all information and / or communication pertaining to my claim may be released to my appointed representative and I appoint him / her to represent me in all matters pertaining to my claim.

Full name of Policy Owner's representative

Policy Owner's representative identification	Signature of Policy Owner	Date
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

*(password / ID type / other)*

### Section 3: Witnessed by

Witness name *(cannot be a direct family member)*

Signature of Witness	Date
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Witness occupation

Witness address

Street number / name		
Suburb	Town / city	Postcode

Phone	Best time to call
<input type="text"/>	<input type="text"/>