Trauma/Major Health Problems

Claim Form

Pages 1–3 to be completed by the insured person and pages 5–6 to be completed by the treating doctor.

We'll assess your claim as quickly as possible. The information you provide will help us do this and make sure our assessment is accurate. Please complete all sections of the form as requested – an incomplete form could delay the assessment of your claim.

- Please have all the policy owners sign the declaration page.
- It is your responsibility to pay for any costs that might arise from the completion of the Treating Doctor's report.
- Page 4 has additional space if you run out of room answering these questions, or if you need to provide any information not covered by the questions.
- We encourage you to attach supporting medical records or any other information you have that will help us in assessing your claim.

We're happy to help if you have any queries about this form. Please call us on 0800 808 101, or talk to your adviser.

A. Your details

Policy number(s)

Please tick one Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ *Please specify*

Surname

Given names

Home phone number (0)

Date of birth / /

Business phone number (0)

Email address

Mobile phone number (0)

Residential address

Post Code

Postal address *(if different)*

Post Code

B. Claim Details

1. Which Trauma Condition are you claiming for? (Please give us as many details as you can)

2. When did you first notice symptoms? / /
   Please describe these symptoms below.

3. Have you ever suffered from this condition or related condition(s) before? ..... Yes ☐ No ☐
   If 'yes' please provide details.

Dates	Specific Details

4. a. Please advise the date you were first treated for this condition. / /

   b. Please advise the name, address and phone number of the doctor you consulted.

   c. If this is not your usual doctor please give the name, address and phone number of your usual doctor.

5. Please give details of all treatment you have received for your condition (eg x-rays, blood tests, ECG's, biopsies, etc)

Dates	Treatment	Doctor

6. Have you seen any other doctors about your condition? ..... Yes ☐ No ☐
   If 'yes' please give names and addresses.

Doctor	Address

7. Have you lodged, or are you intending to lodge, any claims with any other insurers for your condition? (eg medical, health, etc)..... Yes ☐ No ☐
   If 'yes' please provide details.

C. Payment Details

If your claim is accepted, your payment will be made by direct credit. Please provide your bank account details below:

Account name

Account number

BANK BRANCH ACCOUNT NUMBER SUFFIX

Name of Bank and Branch

Signature of Account Holder(s) Sign here

Sign here

Please print name(s)

Privacy Act 1993

This information is being collected and will be held securely by Asteron Life Limited ('Asteron Life') and my adviser. It is intended for use by Asteron Life employees who require access to this information for administering your claim and policy. Under the Privacy Act 1993 you are entitled to request access to and request correction of any personal information about you held by Asteron Life. If you do not supply the information sought your claim m

ay be declined. In assessing and managing your claim we may need to disclose your personal information to other parties such as cla ims assessors, loss assessors, reinsurers, medical and financial professionals, judicial or dispute resolution bodies, joint venture partn ers and Suncorp G

roup companies. **Consent**

I have read and understood and have made the other people named on this form aware of the privacy disclosure statement above. I acknowledge that where information is provided it is with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the person as named on this form.

I hereby declare that the information in this Claim Form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise Asteron Life of any relevant information regarding my claim, Asteron Life may refuse to pay my claim. I understand that I can be prosecuted if I make any fraudulent statements.

Medical and Information Authority

I hereby authorise any dentist, hospital, doctor or other person who has attended me, to release to Asteron Life Limited ("Asteron Life") or its representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

I hereby authorise any insurer, adviser/broker, accountant, institution, employer, business entity, medical institution, professional board or company, legal professional or entity, to release to Asteron Life or its representatives, all information which Asteron Life requests for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Person Insured

Full name _____ Signature _____ Sign here

Date / /

Policy Owner(s) 1

Full name _____ Signature _____ Sign here

Date / /

Policy Owner(s) 2

Full name _____ Signature _____ Sign here

Date / /

Asteron Life
Level 13 Asteron Centre, 55 Featherston Street, PO Box 894, Wellington 6140, NZ
Ph: **0800 737 101** (Contact Centre hours: Mon–Fri 8am–6pm)
Fax: 0800 246 067 Email: claims@asteronlife.co.nz Web: asteronlife.co.nz

Issuer: Asteron Life Limited

Additional Information

Trauma/Major Health Problems

Treating Doctor Form

To be completed by the treating doctor.

Thank you for taking the time to complete this form.

- Your patient is making a claim as a result of sickness or injury.
- So that we can accurately assess the claim, we would appreciate you filling out this form in as much detail as possible and returning it to the patient.
- **The patient will pay any fee you may charge for this service.**

Regards,
Asteron Life Claims Team
Freephone Number: 0800 808 101

Insured's full name

Date of birth / /

1. Are you the insured's usual doctor? ..... Yes ☐ No ☐
   If 'yes' please advise for how long and from what date you have records for your patient?

2. Are you the treating specialist? ..... Yes ☐ No ☐
   What is your specialty? *(please advise below)*

3. If sickness, when did symptoms first appear? / /
   Please describe these symptoms below.

4. If injury, when did the incident occur? / /
   Please provide details as known by you.

5. Does your patient have a history of the same or similar sickness or injury, or any sickness or injury likely to be connected with the current condition? ..... Yes ☐ No ☐
   If 'yes' please provide the dates and details.

6. What is the diagnosis and date of diagnosis?

   Date of diagnosis / /

7. What investigations have been conducted?

Dates	Description	Result

8. Has your patient been hospitalised? ..... Yes ☐ No ☐

Name of hospital

Procedure

Date from / / Date to / /

9. Have you referred your patient to other doctors for further opinion, investigation or treatment? ..... Yes ☐ No ☐
If 'yes' please provide the dates and details below.

Dates	Practitioner	Contact details

10. What is the prognosis?

11. Are you completing claim forms for any other insurer? ..... Yes ☐ No ☐
If 'yes' please provide details below.

Important Note

When returning this form, please **send copies of the following:**

- All consultation notes regarding the current condition including when symptoms were first noticed
- Your original referral to the specialist
- All specialist reports on file
- All test results including histology, scan and blood test results
- Any hospital notes on file eg hospital discharge summaries

I hereby declare that the above statements are true and correct.

Full name

Signature Sign here

Date / /

Phone number (0)

Fax number (0)

Doctors stamp