

Critical Conditions Progressive Care Claim Form



Guide to completing this claim form

At AIA our aim is to process your claim in a timely manner. To help us, please ensure that you complete all the relevant sections and attach all the required information.

- > Complete sections 1, 2, 3 and 5 (complete section 4 if you purchased your cover through ASB)
- > If you have any medical information please feel free to submit this with your claim form. Otherwise we will request this on your behalf on return of this claim form.
- > Certified copy of your birth certificate **or** passport **or** driver licence*

* The following can certify the document: Lawyer, Solicitor, Chartered Accountant, Registered Medical Doctor, Justice of the Peace, Police Officer, Notary Public or anyone else by law authorised to administer an oath.

1 Life Assured details

Claim number	<input type="text"/>	Policy number	<input type="text"/>
Date of birth	<input type="text" value="DD / MM / YYYY"/>		
Full name	<input type="text"/>		
Addresses	Street <input type="text"/>	Suburb	<input type="text"/>
	City <input type="text"/>	Postcode	<input type="text"/>
Contact details	Home phone <input type="text"/>	Work phone <input type="text"/>	Mobile <input type="text"/>
Email address	<input type="text"/>		

2 Medical information questions (for completion by or on behalf of the Life Assured)

a. What is your current diagnosis/condition?

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

c. When did your symptoms first become apparent and what were they?

d. On what date did you first seek medical assistance for your claim/condition?

e. Have you ever previously suffered from the same, similar or related condition? Yes No

If Yes, please give full details including what the condition was, who you saw, and when it was?

f. Your GP details
(If your GP does not hold all your medical notes, please provide contact details of who does).

Name	<input type="text"/>		
Medical practice	<input type="text"/>		
Address	Street	<input type="text"/>	
	Suburb	<input type="text"/>	
	City	<input type="text"/>	Postcode <input type="text"/>
	Phone	<input type="text"/>	Fax <input type="text"/>
Email address	<input type="text"/>		

g. Your specialist details
(continue on separate sheet if more than one specialist)

Name	<input type="text"/>		
Practice name	<input type="text"/>		
Specialty	<input type="text"/>		
Address	Street	<input type="text"/>	
	Suburb	<input type="text"/>	
	City	<input type="text"/>	Postcode <input type="text"/>
	Phone	<input type="text"/>	Fax <input type="text"/>
Email address	<input type="text"/>		

h. Your hospital details

Name of hospital	<input type="text"/>		
Address	Street	<input type="text"/>	
	Suburb	<input type="text"/>	
	City	<input type="text"/>	Postcode <input type="text"/>
	Phone	<input type="text"/>	Fax <input type="text"/>
Email address	<input type="text"/>		

i. Please advise if any other settlement is/or will be claimed in relation to this claim. Whether it be from a public or private insurer eg: ACC.

Name of Insurer	<input type="text"/>		
Policy number	<input type="text"/>		
Contact person's name	<input type="text"/>		
Address	Street	<input type="text"/>	
	Suburb	<input type="text"/>	
City	<input type="text"/>	Postcode	<input type="text"/>
Phone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		
Type of claim	<input type="text"/>		

3 Consent to disclose personal information

If you would like **AIA** to give details about you and your claim to any other person eg: your spouse, adviser, trusted family member, you must complete this section below:

Name of Person(s) that information is to be released to:	<input type="text"/>			
Their address	Street	<input type="text"/>	Suburb	<input type="text"/>
	City	<input type="text"/>	Postcode	<input type="text"/>

Authorisation

I authorise **AIA** to release any of my personal information, and to discuss any details of my claim, including medical or financial details, with the above named Person(s).

Full name of Life Assured	<input type="text"/>		
Signature of Life Assured	<input type="text"/>	Date	<input type="text" value="DD / MM / YYYY"/>

4 Consent

As part of an insurance claim with AIA, I, the **Life Assured** consent and give authority to AIA and any of its related entities and agents to request any of my medical or other personal information affecting my insurance or the assessment of my claim from any third party which AIA reasonably considers may hold that information. I also authorise those third parties to disclose that information to AIA, its advisers and reinsurers, and to any legal tribunal before which any question concerning my insurance may arise. Those third parties may include:

- > Registered medical practitioners and Specialists (which may include an entire copy of my/our medical file)
- > Medical laboratories and testing facilities
- > Accident Compensation Corporation, governmental departments or bodies
- > Advisers
- > Insurers or reinsurers (whether public or private)
- > Accountants
- > Counsellors, psychologists and therapists, and
- > Any other person or organisation which holds information which is relevant to my insurance or the assessment of my claim.

I understand that the supply of the information gathered from the above sources is voluntary and that AIA may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my Insurance. I understand that AIA may share my claim details with related insurers to enable co-ordination of claim resolution. I understand that my personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.

I understand that my personal information will be stored at AIA's Auckland office, 74 Taharoto Road, Takapuna, Auckland and by AIA's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I understand that AIA will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).

I consent and give authority to ASB Bank Limited and AIA to request from AIA International Limited (trading as AIA New Zealand 'AIA'), or disclose to AIA, any information pertaining to me and relevant to the assessment of my insurance claim.

I understand that AIA may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of my personal information may be requested by me.

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following :

I consent to the disclosure of my claims information to ASB for the purposes of notifying ASB of issues or disputes arising in respect of my claim

Yes

No

5 Declaration – important, please read carefully

I declare that all medical information pertaining to me and relevant to my insurance claim has been provided and disclosed to AIA.

I understand that failure to provide full disclosure of all medical information that AIA would deem as relevant in the assessment of my claim would be considered to be material misrepresentation and/or material non-disclosure and as such AIA is entitled to use legal remedy, should this occur.

I further understand that the medical information provided is the basis on which AIA will assess and manage my claim and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed.

I declare that all the answers to questions in this form are true and complete. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I further agree that a photocopy of this authority will be valid as an original.

Full name of Life Assured

Signature of Life Assured

Date

DD	MM	YYYY
/	/	

