Claim Form Medical

partnersLIFE

Private Medical Cover

Policy number

1.0 Life assured's details

Title | Surname | First name(s)

Male | Female | Date of birth / /

Street address | Suburb

Town/city | Postcode

Postal address (if different from above)

Email address | Business phone ( )

Home phone ( ) | Mobile ( )

2.0 Policy owner(s) details

First owner

Title | First name(s)

Surname or company name

Postal address

Town/city | Postcode

Email address

Contact phone number ( )

Male | Female | Date of birth / /

Second owner

Title | First name(s)

Surname or company name

Postal address

Town/city | Postcode

Email address

Contact phone number ( )

Male | Female | Date of birth / /

a) Are you notifying a change of address? Y | N

b) If yes do you want Partners Life to update your records? Y | N

c) Are you applying for prior approval? Y | N

If **yes** please give the date of expected admission. / /

3.0 Claim details

a) Please give details of the disease/disorder/condition which has resulted in this claim.

b) Please give details of your symptoms.

c) Please give the date the symptoms started. / /

d) Please give the date that you sought medical advice. / /

e) Please state the name of procedure/surgery/investigation.

f) Please give the name of the hospital/clinic where the treatment/procedure is to be undertaken.

g) Please give the name of the specialist/surgeon who has performed or will perform the treatment or procedure.

h) Please give the name and address of the registered medical practitioner who referred you for treatment, procedure or to the hospital.

Name Address

i) Details of your usual GP. If different from above.

Name Address

j) Please give the date of admission/procedure/surgery/investigation. / /

Date of discharge. / /

k) Has this claim resulted from an accident or injury? Y | N

If **yes** please give the date of the accident or injury. / /

l) Have you, or are you claiming any amounts from ACC or any other insurer in relation to this procedure/surgery/investigation? Y | N

If **yes** please give details of the organisation/insurer and what the amounts are of the claim(s). Please attach copies of the relevant documentation.

Details of organisation/insurer	Amount $

m) What is the estimated cost of the procedure/surgery/investigation or admission? Please attach a copy of the estimate if available.

Details of organisation/insurer	Amount $

4.0 If your claim is accepted, please note payment will be made by direct credit into the nominated account

It's important that you complete this section properly

Please pay direct into the nominated bank account below

Account holder

Bank/Building society name

Bank Branch Account number Suffix

(Please attach an encoded deposit slip to ensure your number is loaded correctly)

5.0 Adviser involvement

Would you like your financial adviser to be involved with the progress of your claim? Y | N

6.0 Final checklist of documents you need to send to us

- ☐ Medical questionnaire section on the back page completed by your medical provider.
- ☐ Original/copy of the referral letter from your medical provider.
- ☐ Copies of other medical information in support of your claim. (Such as a report from a specialist)
- ☐ Copy of the estimate.
- ☐ Copy of the ACC letter of acceptance/decline for any accident/injury related claim.
- ☐ Copies of any receipts/invoices.

7.0 Declaration and consent

Please read and sign this declaration

This application collects personal information about you and any life assured for whom you are claiming under your policy. The intended recipient of this information is Partners Life Limited ("the Company").

Failure to provide this information may result in your claim being declined or unable to be assessed. You and any life assured have the right to request access to and correction of your respective personal information at any time by contacting Partners Life on 0800 14 54 33.

Declaration

I am the policy owner and hereby claim the benefit amount payable on the basis of the statements and information provided by the life assured in this claim form which I believe to be accurate and complete in every respect.

As part of a medical insurance claim with the company, I, the life assured, consent and give authority to the company to seek from, and for all and any of the following, their officers and employees, to disclose to the company, its advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me:

- Registered medical practitioners and specialists
- Dentists
- Counsellors, psychologists and therapists
- Government departments, agencies, organisations and enterprises
- Hospitals (whether public or private)
- Accident Compensation Corporation
- Insurers (whether public or private)
- Credit rating and collection agencies
- Employers (whether current or not)

I agree that a photocopy, facsimile or scan of this authority will be valid as an original.

Privacy Act requirements

- This claim form and any supplementary material which may be required in connection with this claim is a collection of personal information.
- This information will be used to: assess and administer this claim; service and administer the policy; maintain relevant statistical records; and provide you with information about other products and services offered by Partners Life Limited.
- You are required to provide the medical information which has been requested so as to comply with your common law duty to disclose all matters material to the insurance.
- The information will be held by Partners Life Limited at the address on this form.
- Under the Privacy Act 1993 you have the rights of access to, and correction of, any information provided.

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide Partners Life Limited such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

Name/company name of first policy owner

Signature/authorised signature of first policy owner

Date / /

Name/company name of second policy owner

Signature/authorised signature of second policy owner

Date / /

Name of life assured

Signature of life assured

Date / /

Parent or guardian if life assured is under the age of 16.

Name of parent or guardian

Signature of parent or guardian

Date / /

Partners Life Limited
Private Bag 300995, Albany
Auckland 0752
New Zealand
0800 14 54 33
partnerslife.co.nz

Private medical doctor's questionnaire (To be completed by a registered medical practitioner or dentist at the client's expense)

Policy number

Life assured

Title | Surname | First name(s)

To the medical attendant:

The above life assured is claiming a private medical benefit from Partners Life Limited and we require the following information from you, as the registered medical practitioner for the life assured, in order to assess this claim as quickly as possible. Thank you for your assistance.

Doctor/dentist

Title | Surname | First name(s)

Address

Business phone ( ) | Facsimile ( )

Email address

a) How long has the patient been under your care?

Months | Years

b) Do you hold all medical records for the last five years? Y | N

If **no** please give details of the previous doctor(s) if known.

Name	Address
Name	Address

c) What is the medical condition or suspected condition requiring treatment or investigation?

Please also provide the ICD 10 reference code.

d) When did the signs and/or symptoms of this condition become apparent to the life assured for the very first time? / /

e) When did the life assured first consult with a medical professional including you or your practice in regards to this condition? / /

f) Is the claim accident or injury related? Y | N

If **yes** please give the date the accident or injury or symptoms of this condition occurred. / /

g) How often has the life assured consulted a medical practitioner regarding this condition?

Please give dates.

Name of medical practitioner	Date
	/ /

h) Has the life assured consulted you, or any other treatment provider for any other symptoms or conditions that may be associated with the condition they are claiming for? Y | N

If **yes** please give details.

i) Please give date of referral to specialist.
Please attach a copy of the referral letter and the specialist report received in response.

/ /

j) Please give details of any other treatment options that have been, or may be considered.

Declaration

- I declare that the above information, and other information supplied by me in relation to this form, is true and correct and that no information relevant to the life assured has been omitted from this form.
- I declare that I am registered as a medical practitioner with the Medical Council of New Zealand and am not the patient, the policy owner or either of their respective partners or relatives.
- I consent and authorise Partners Life Limited to disclose to its associated companies, advisers, reinsurers or any other party authorised by the life assured, any information provided by me in connection with this form for any of the purposes authorised by the life assured.

Signature of doctor/dentist

Date / /

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