Asteron Life

# Early Payment of Life Protection

## Claim Form

**Pages 1–3 to be completed by the insured person. Have your treating Specialist Doctor complete pages 5 and 6.**

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.
- We encourage you to attach supporting medical records or any other information you have that will help us in assessing your claim.

Email (recommended): claims@asteronlife.co.nz, or Post: Freepost 198921, PO Box 894, Wellington 6140.

If you have any questions we're happy to help. Call us on 0800 737 101, or talk to your adviser.

# PART 1: Insured person details

(To be completed by the insured person)

## A. Your details

Claim Number

Policy number(s)

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

Please specify

Surname

Given names

Home phone number

Date of birth

Business phone number

Email address

Mobile phone number

Residential address

Post Code

Postal address *(If different)*

Post Code

## B. Claim details

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

2. When did you first notice symptoms? Date
*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? Yes ☐ No ☐
(eg medical, health, etc) *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

For the purpose of the Privacy Act, we confirm that we collect and use your personal information and may disclose your personal information to third parties for the purpose of administering your policy or in order to comply with legal requirements. Your details are stored securely within Asteron Life and may also be securely stored electronically on servers located in New Zealand or overseas, by third parties on our behalf. You can contact us at any time to request access to and correction of your personal information. The collection of this information is required under the terms of your policy.

For further information about how we deal with your personal information, please refer to Asteron Life's Privacy Policy. It is available online at www.asteronlife.co.nz by phoning 0800 737 101, or by writing to Asteron Life Limited, PO Box 894, Wellington 6140.

### Consent and Declaration

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.

| | Full name | Signature | Date | |
|---|---|---|---|---|
| **Insured Person** | | | | Sign here |
| **Policy Owner 1** | | | | Sign here |
| **Policy Owner 2** | | | | Sign here |
| **Policy Owner 3** | | | | Sign here |

# PART 2: Treating specialist form

(This section to be completed by the treating specialist 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
Email: claims@asteronlife.co.nz
Ph: 0800 737 101

Insured's full name

Date of birth

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

2. What is your specialty area?
   *(please advise below).*

3. What is the diagnosis and date of diagnosis? Date

4. When did symptoms first appear?
   *Please describe these symptoms below.* Date

5. When did you first see your patient for the current condition?

6. 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 below.*

7. What tests/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 details below and send copies of any reports you have.*

| Dates | Practitioner | Contact details |
|---|---|---|
| | | |
| | | |
| | | |

10. Do you expect to see your patient again for the current condition? Yes ☐ No ☐
*If 'yes' please state approximately when.*

11. In your professional medical opinion, how long do you expect your patient to live based on their current medical condition.

Less than 6 months ☐ 6-12 months ☐ 13-24 months ☐ 24+ months ☐

12. Have all standard medical treatments aimed at curing or improving the condition been fully exhausted?
*If not, please provide information on any remaining treatment options*

13. 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.**

Phone number

Email

| | Full name | Signature | Date |
|---|---|---|---|
| **Treating Doctor** | | | |

Sign here

**Asteron Life** PO Box 894, Wellington 6140, Freepost 795
Ph: **0800 737 101** (Contact Centre hours: Mon–Fri 8.30am–5pm)
Email: **claims@asteronlife.co.nz** Web: **asteronlife.co.nz**

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