Asteron Life

Income Protection

Initial Claim Form

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 the claim.

Step 1 – Complete the form

Fill in then print the form, sign it at the bottom, scan and email it, or send by post.

Step 2 – Include the following attachments

Any medical reports or test results you hold copies of

Step 3 – Send the form and attachments

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

The member is responsible for meeting any cost associated with the completion of the treating doctor's report.
If you have any questions we're happy to help – just call us on 0800 737 101, or talk to your adviser.

Please note: this claim form is not an admission of liability by Asteron Life Limited.

Member to complete

PART 1 – Members statement

To be completed by the member.

1. Member's details

Plan name _____ Plan number _____

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ *Please specify:* _____

Surname _____ Date of birth* _____

Given name(s) _____

Home phone _____ Mobile phone _____

Email address _____

Residential address _____ Post Code

Postal address
If different from above _____ Post Code

Please advise if you are working overseas, and if so where and since when?

_____

Member to complete

2. Claim details

1. What condition are you claiming for?

2. a. If a **sickness**, when did you first notice symptoms?

   b. Please describe these symptoms

3. If an **injury**, when, where and how did it happen?

4. Have you ever suffered from this condition or related condition(s) before? ..... Yes ☐ No ☐
   If 'yes', when? Please provide all dates and details.

Specific Details	Date

5. a. When did you stop or reduce your work hours?

   If you have reduced your hours, please provide full details below in question 6.

   b. Was this on medical advice? ..... Yes ☐ No ☐
   If 'yes' please provide details

   c. Please advise your current symptoms and how these affect your ability to work:

6. Have you worked at all since you first consulted your doctor? ..... Yes ☐ No ☐
   If 'yes' please provide details

Dates	Full time / Part time	Total hours	Activity	Gross earnings
				$
				$
				$

Member to complete

3. Medical details

1. Please name the doctor(s)/specialist(s) you have consulted and provide name(s) and address(es):

2. On what date did you first consult a doctor in relation to your claimed condition?

3. Please give dates of all treatments, including medication, provided by your doctors for this condition:

Dates	Treatment	Doctor

4. Have you received any other treatment relating to this condition? (eg; physiotherapy, hydrotherapy, chiropractic, acupuncture, massage and/or psychological) ..... Yes ☐ No ☐
If 'yes' please provide details

Type	From Whom	Dates

5. Have you discussed a return to work plan with your doctor? ..... Yes ☐ No ☐
If 'yes' please provide details

If 'no', please provide reasons

6. Please provide details of your current daily activities (eg; hobbies, exercise, housekeeping, driving etc)

7. a. Have you lodged a claim with ACC or are you contemplating lodging a claim with ACC? ..... Yes ☐ No ☐
If 'yes' please provide details

Claim number Date lodged

Case manager

b. Claim accepted? ..... Yes ☐ No ☐
If 'yes' please provide details

Date accepted Weekly entitlement (pre-tax) $ / week

Member to complete

c. Claim pending? ..... Yes ☐ No ☐
If 'yes', please provide reasons

d. Claim declined? ..... Yes ☐ No ☐
If 'yes', please provide reasons

8. Have you lodged a claim with any other insurer are you contemplating lodging a claim? ..... Yes ☐ No ☐
If 'yes' please provide details

Claim number | Date lodged

Case manager

4. Occupation / Income details

1. Please state your occupation(s) immediately prior to your sickness/injury:

2. Occupational duties: What work activities did you actually perform in your occupation(s)?
Please also indicate the percentage (%) performed in each of the duties carried out

Duties	Percentage (%)

3. a. Did you work from home? ..... Yes ☐ No ☐
If 'yes', how many hours per week?
/ week

b. What duties did you perform at home?

4. Please describe your occupation in the following categories:
Heavy Manual ☐ Light Manual ☐ Clerical ☐ Manager/Supervisory ☐ Other ☐

5. If you did manual work, what part of your week was spent doing manual work?
0–10% ☐ 10–20% ☐ 20–30% ☐ 30–40% ☐ 40–50% ☐ 50% or more ☐

6. How many hours per week did you normally work prior to your injury/sickness?
/ week

7. Please indicate part-time or full-time:P/T ☐ F/T ☐

8. Do you have any trade/tertiary/professional qualifications? ..... Yes ☐ No ☐
If 'yes' please describe

9. Do you receive income from any other source (ie rental, investment, shares, commission)?

Gross Monthly Income	Source

10. Has alternate employment been offered by your employer? ..... Yes ☐ No ☐
If 'yes' please provide details

11. Has rehabilitation been attempted? ..... Yes ☐ No ☐
If 'yes' please provide details

If 'no' please provide reasons

Please complete the Members Form by filling in the Privacy and Declaration and Member Signature sections on the next page

5. Privacy and Declaration

Privacy Statement

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 with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the personas named on this form.
- I hereby declare that the information in this Claim Form is correct and complete. I understand and agree that if I have provided any information which is incomplete and incorrect, Asteron Life Limited may be unable to fairly assess the claim, and the claim, and any related claim, may not be payable in whole or in part, and we may also cancel your cover under the policy. 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 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, ACC, accountant, institution, employer, business entity, medical institution, professional board or company, legal professional or entity, to release to Asteron Life Limited or its representatives, all information which Asteron Life Limited 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.
- I hereby authorise Asteron Life Limited to supply information relating to the claim to data matching services subscribed to by Asteron Life Limited.

6. Member Signature

Name

Contact phone

Contact email

Signature

Sign here

Date

*If the declaration is completed by a person other than the Life Insured, please specify the relationship with the Life Insured and the terms of authority (eg; Power Of Attorney or Next of Kin) held to act on his/her behalf.

Income Protection

Employer to complete

PART 2 – Members employer form

To be completed by the members current or most recent employer.

Thank you for taking the time to complete this form.

- Your employee 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 employee.

This form can be completed electronically **(recommended)**: Fill in then print the form, sign it at the bottom, and scan and email it.

Regards,
Asteron Life Claims Team | Freephone Number: 0800 737 101 | ei.asteronlife@gbtpa.co.nz

Employer Details

Name of employee _____ Date of birth _____

Company name _____

Street address _____

Postal address _____

Telephone _____ Email address _____

Name and position of person completing this form _____

Do you give Asteron Life permission to contact the member directly to discuss the claim?.....Yes ☐ No ☐

Please attach:

- Job Description
- Printout showing all sick leave
- All Medical Certificates for the claimed condition

1. Please advise whether member was at work on performing all the duties of his/her usual occupation without any restriction on the date of commencement of the policy or, if the member joined afterwards, on his or her first day?

   _____

   _____

2. Please advise the date the member ceased work or first reduced their usual working hours by more than 25% _____

3. Please advise if the member is or was working overseas, and if so where and since when?

   _____

4. Please advise the member's monthly salary immediately prior to the date of Question 2. $ _____ / month

   If your Schedule includes other sources of income (e.g. expense allowances, superannuation contributions, overtime) as part of the Monthly Income you can detail these below or we can contact you for this.

Type of income component	$ Monthly Amount

5. Is the member entitled to, or has the member received any remuneration from you since ceasing work?.....Yes ☐ No ☐
   If 'yes', please detail the (monthly) gross amount before tax and what this remuneration relates to (ie; is it for work done, sick/annual leave, special leave, etc)?

   _____

   _____

6. Does the position remain open for the member to return to when their health allows? ..... Yes ☐ No ☐
If "no", please provide full details.

7. Are you supportive of a graduated return to work plan as part of the member's rehabilitation?..... Yes ☐ No ☐
E.g. flexible hours or alternative duties. If "no", please provide full details.

8. Have you had any discussions with the member about a return to work plan?.....Yes ☐ No ☐
If so, please detail.

9. Is there any other information that may assist us with understanding this claim?

Please complete the Members Employer Form by filling in the Payment Instructions and Privacy and Declaration sections on the next page

Employer to complete

Payment Instructions

Asteron Life prefers to make payments directly to a bank account

Payee name

Bank account number

BANK BRANCH ACCOUNT NUMBER SUFFIX

Privacy and Declaration

Privacy Statement

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.

Declaration

I agree that:

- I am a representative of the employer named above and am duly authorised to complete this form on behalf of my employer.
- All the information I have given in this Claim Form is complete and correct and
  that all answers have been written or dictated by me. I have not withheld any information that may be relevant to Asteron Life's assessment of the claim.
- I acknowledge and agree that if I have provided any information which is incomplete or incorrect, Asteron Life may be unable to fairly assess the claim, and the claim in question, and any related claim, may not be payable in whole or in part, and we may also cancel the employee's cover under the policy.
- I give consent for Asteron Life to release information they have regarding this claim to anyone who may be involved in the management of this claim.

Employer Signature

Name of authorised employer representative

Position

Contact phone

Contact email

Signature

Sign here

Date

Income Protection

PART 3 – Treating Doctor Form

To be completed by the treating doctor.

Attending doctor to complete

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.

This form can be completed electronically **(recommended)**: Fill in then print the form, sign it at the bottom, and scan and email it.

The patient will pay any fee you may charge for this service.

Regards,

Asteron Life Claims Team | Freephone Number: 0800 737 101 | ei.asteronlife@gbtpa.co.nz

1. Patient's details

Patient's name

Date of birth*

Please advise your patient's occupation

Are you the patients usual medical practitioner? ..... Yes ☐ No ☐

If yes, how long has the patient been attending you or your practice?

If no, when did the patient first attend your practice?

2. Medical details

1. Is the present condition the result of:

   ☐ **a sickness** When did the symptoms first appear?

   ☐ **an injury** When did the injury occur?

2. When did your patient first consult you for the current condition?

3. What is your current diagnosis and when was this diagnosis made?

4. What are your patient's current symptoms?

5. Please advise the date the patient was first advised to cease work as a result of the current condition?

6. Please indicate whether the cessation of work was either Total, Partial. ☐ Total ☐ Partial

   If partial please indicate how many hours the insured is able to work hours / week

7. Was the cessation of work due to disability? ..... Yes ☐ No ☐

8. What is your patient's general medical history?

9. Was your patient admitted to hospital for this condition? ..... Yes ☐ No ☐
If 'yes', please provide details

a. Name and address of Hospital

b. Period of Hospitalisation *From:* *To:*

10. Treatment received or details of operation performed

11. Has your patient ever suffered the same or similar condition? ..... Yes ☐ No ☐
If 'yes', please provide details including dates

12. Have you referred your patient for further opinions, treatment or tests? .....Yes ☐ No ☐
If 'yes', please provide details including copies of any correspondence or test results

13. Is your patient still disabled?.....Yes ☐ No ☐

If 'yes', when do you consider your patient will be fit to return to work?

Part time Full time

If 'no', when did your patient return to work?

Part time Full time

If your patient returned to work part-time, please advise the number of hours they are capable of working per week hours / week

14. Please specify which pre-disability duties the patient can and cannot perform.

Pre-disability duties	Able to perform Y/N	Nature of restriction

15. Are there any other sicknesses, conditions or factors affecting the present condition? .....Yes ☐ No ☐
If 'yes', please provide details

16. Are you providing certificates/reports to another insurer/ACC/third party for this condition? .....Yes ☐ No ☐
If 'yes', for whom

17. What rehabilitation and/or vocational supports do you consider would assist your patient's recovery and their return to work?

Please complete the Treating Doctor Form by filling in and signing the following page

3. Doctor's Signature

I agree that all the information I have given in this report is true and correct.

Name and Qualifications

Address

Contact phone

Contact email

Signature

Sign here

Date

Important Note

When returning this form, please send **copies of all relevant specialist reports and documents in your possession** for Asteron Life Limited.