Asteron Life

Kids Cover

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

A copy of your Birth Certificate, passport or drivers licence.

A copy of the member's child's Birth Certificate.

If you are not the child's biological parent, provide documentation confirming parental or guardianship status e.g Adoption Certificate or New Zealand Family Court order.

We encourage you to attach supporting medical records you have that will help us in assessing your claim. This should include reports, histology, rest results, specialist referrals, treatment plans, and any other information relating to the child's claimed condition.

Step 3 – Send the form and attachments

Email (recommended): ei.asteronlife@gbtpa.co.nz, or
Post: PO Box 894, Wellington 6140, Freepost 795

If you have any questions we're happy to help – just call us on 0800 737 101.

PART 1 – Members statement

To be completed by the member.

1. Child's details

Plan Name

Plan Number

Please tick one Miss ☐ Master ☐ Other ☐ *Please specify*

Surname

Given names

Residential address

Post Code

Date of birth

2. Who is completing this form

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

Surname

Given names

Relationship to child

Home phone number

Work phone number

Mobile phone number

Email address

Residential address
(if different from child)

Post Code

Postal address
(if different from residential)

Post Code

3. Authorised contact person (if different from above)

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

Surname

Given names

Relationship to child

Home phone number

Work phone number

Mobile phone number

Email address

Residential address
(if different from child)

Post Code

Postal address
(if different from residential)

Post Code

4. Claim details

1. What condition are you claiming for? (Please refer to your Policy Document for a full list of conditions covered)

2. a. If a **sickness**, when were the first symptoms noticed?
   b. Please describe these symptoms.

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

4. Has your child ever suffered from this condition or related condition(s) before? .....Yes ☐ No ☐
   If 'yes' please provide all dates and details.

Dates	*Specific Details*

5. Has your child consulted any doctors/specialists with regard to these previous conditions?.....Yes ☐ No ☐
   If 'yes' please provide details.

Name	*Address and phone number*

5. Medical details

6. a. Please provide the date of the first consultation for your child's current condition and the result.

b. Please name the doctor(s)/specialist(s) your child consulted and provide contact details.

7. Please give dates of all investigations and treatments including medication, provided by your child's attending doctors for this condition.

Dates	*Treatment*	*Doctor*

Feedback, comments and suggestions

If there is anything more we can do to assist you during this time, please let us know in this section.

6. 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 with the consent of the individual to whom it relates I confirm that I have the authority to act on behalf of the persons 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 Limited of any relevant information regarding my claim, Asteron Life Limited may refuse to pay and cancel my claim. I understand that I can be prosecuted if I make any fraudulent statements.

I hereby declare that I am the parent/legal guardian of,

a minor, and am duly authorised to act on their behalf.

Medical and Information Authority

I hereby authorise any dentist, hospital, doctor or other person who has attended my child, 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, 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.

7. Member Signature

Name

Contact phone

Contact email

Signature

Sign here

Date

Trauma

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 for their child 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 as possible and returning it to the claimant.

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

1. Employer Statement

Plan name

Plan number

Name of employee

Date of birth

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/her first day?

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

2. Payment Instructions and signature

Asteron Life prefers to make payments directly to a bank account

Payee (please attach a deposit slip)

Bank account number

BANK BRANCH ACCOUNT NUMBER SUFFIX

3. 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 of the above-named 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 the claim.

4. Employer Signature

Name of authorised employer representative

Position

Contact phone

Contact email

Signature

Sign here

Date

Trauma

PART 3 – Treating Doctor Form

To be completed by the treating doctor.

Thank you for taking the time to complete this form.

- A claim is being made for your patient as a result of a sickness or injury.
- So that we can accurately assess the claim, we would appreciate you filling out this form in as much as possible and returning it to the claimant.

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

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

Regards,

Asteron Life Claims Team | Freephone Number: 0800 737 101

Plan name

Plan number

Your patient is the subject of a claim for a lump sum benefit that becomes payable if sh/he meets a defined condition. To assess this, we require the underlying test results which may include histology reports, ECG reports, blood tests and supporting specialist reports.

1. Details

Family name

Given name(s)

Are you the usual GP? ..... Yes ☐ No ☐

Are you the treating doctor? ..... Yes ☐ No ☐

Are you a specialist? ..... Yes ☐ No ☐

If 'Yes', what is your speciality?

2. Patient's details

1. Please advise current diagnosis?

2. Please advise of current symptoms and objective signs?

3. What tests have been performed during the current period? Please provide a copy of all test results/specialist reports related to this condition and advise what effect, if any this had on the patient's diagnosis and treatment.

4. Please advise on past and planned treatment(s)

5. Please advise on prognosis

3. Medical history

From what date do you have records for this patient?

6. Has your patient suffered from the same or similar condition before? ..... Yes ☐ No ☐
If 'Yes', please provide details

7. Have you treated this patient for any other condition? ..... Yes ☐ No ☐
If 'Yes', please provide details

4. 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.

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

Issuer: Asteron Life Limited