Asteron Life

Total and Permanent Disablement

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

Step 3 – Send the form and attachments
Email (recommended): ei.asteronlife@gbtpa.co.nz, or
Post: PO Box 894, Wellington 6140, Freepost 795

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.

PART 1 – Members statement

To be completed by the member.

Member to complete

1. Member's details

Plan name _____ Plan number _____

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

Surname _____ Date of birth* _____

*please provide evidence of your date of birth e.g. copy of your birth certificate, passport or drivers licence

Given name(s) _____

Home address _____ Post Code

Home phone _____ Business phone _____

Mobile (if applicable) _____ Fax (if applicable) _____

Employer Name _____

Employer Address _____

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

_____

Member to complete

2. Sickness or injury details

1. If **sickness**

   a. Date symptoms first noticed

   b. Date condition diagnosed

   c. Please give details of the sickness (including your symptoms and their severity)

   d. Have you previously had the same or a similar condition? ..... Yes ☐ No ☐

   If 'Yes', please provide details

2. If **injury**

   a. Date of injury

   b. Can you briefly describe the circumstances of the accident (including where occurred)?

   c. Please provide details of witnesses, if appropriate:

   Name

   Address

   Phone no

   d. Nature of injury

   e. Have you previously had the same or a similar injury? ..... Yes ☐ No ☐

   If 'yes', please provide details

3. a. How does this injury/sickness affect your ability to perform your occupational duties?

   b. How does this injury/sickness affect your daily activities (such as, leisure activities, personal grooming, house keeping etc)?

   e. Have you undergone a rehabilitation or return to work program? ..... Yes ☐ No ☐

   If 'yes', please provide details

4. Medical Attendant's Details

Name of usual Doctor

Address Post Code

Member to complete

3. Occupation details

1. Please state your occupation prior to your sickness/injury:

Was there a termination of employment with your employer? ..... Yes ☐ No ☐

Was the termination of employment the result of this sickness/injury? ..... Yes ☐ No ☐

Date of termination of employment with your last employer

2. How many hours do you work? / day / week

3. Please provide all duties of your occupation including percentage of time spent in each.

Duties	Percentage (%)

4. How long have you been in this occupation?

5. Please indicate below the percentage of your day spent performing the physical activities of your occupation.

Activities	Percentage (%)
Lifting 20kg or over	
Lifting 7kg and under	
Carrying 20kg and over	
Carrying 7kg and under	

Activities	Percentage (%)
Standing	
Climbing (Ladders etc)	
Bending	
Kneeling	
Sitting	

6. Have you ceased all work? ..... Yes ☐ No ☐

If 'Yes', please provide the date you ceased all work

7. Have you been able to do any work in any occupation since you were disabled? ..... Yes ☐ No ☐

If 'Yes', please provide details, including work performed and hours per week spent performing at work.

8. Have you sought alternative employment? ..... Yes ☐ No ☐

If so, please give details, including any voluntary employment

9. Were you employed in a supervisory capacity? ..... Yes ☐ No ☐

If 'Yes' a. how many kilometres per week? km

b. how many people did you supervise?

10. Did you travel as part of your work? ..... Yes ☐ No ☐

If 'Yes' a. how many kilometres per week? km

b. what type of vehicle?

Member to complete

11. What level of education do you have (secondary, tertiary, etc)?

12. What year did you finish school

13. Please specify your qualifications. Please include any courses attended, skills or trade apprenticeship qualifications.

Qualification	Year completed

15. Have you in the past worked in any other occupation? ..... Yes ☐ No ☐
If 'yes' please provide details

Occupation	Period	Employers / Business name	Duties
	to		
	to		
	to		
	to		

16. Please describe your domestic duties

4. Hobbies and interests (ie; memberships, fishing, golf, reading etc)

5. Medical attendant's details

Member to complete

Can you please provide details of **all** medical treatment (including physiotherapy, acupuncture, chiropractic or any other practising alternative therapies) and consultations in the last 3 years:

Date first consulted

Name

Qualifications (or specialty)

Address

Reason for the consultation

Date first consulted

Name

Qualifications (or specialty)

Address

Reason for the consultation

Date first consulted

Name

Qualifications (or specialty)

Address

Reason for the consultation

Date first consulted

Name

Qualifications (or specialty)

Address

Reason for the consultation

6. Additional Information

Member to complete

7. 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 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, 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 the 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.

8. 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.

Total and Permanent Disablement

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

Employer Statement

Plan name _____ Plan number _____

Name of employee _____ Date of birth _____

Home address _____ Post Code

Occupation _____ Date Joined Company _____

Basis of Employment: Full time ☐ Part time ☐ Casual ☐ Other ☐ *Please give details* _____

Salary for the last 12 months $ _____ p.a. Salary for previous 12 months $ _____ p.a.

Please provide a copy of the following in support of this claim:

- Job Description
- Curriculum Vitae
- Copies of any medical information you hold
- Copy of last Performance Appraisal

1. Please advise nature of disability and provide full details

2. 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?

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

4. Date claimant physically ceased all occupational duties due to this disability.

5. What condition gave rise to this absence from work?

6. Would you describe the employee's usual job as: (Tick more than one box if appropriate)

☐ Sedentary ☐ Light Manual ☐ Moderately Manual ☐ Heavy Manual ☐ Clerical ☐ Skilled ☐ Semi Skilled ☐ Unskilled

☐ Other *Please give details* _____

Employer to complete

7. What qualifications, training and experience does the claimant have?

8. How does the claimant's condition prevent them from working?

9. What attempts at rehabilitation have been made (including any return to work in an alternative occupation)? Please provide dates and details.

10. Is the claimant applying for benefits with any other entity including other insurers, ACC, WINZ?.....Yes ☐ No ☐
If 'Yes', please provide details.

11. Please provide us with any other information, which may be relevant to the consideration of this claimant.

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.

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

Employer Signature

Name of authorised employer representative

Position

Contact phone

Contact email

Signature

Sign here

Date

Total and Permanent Disablement

Attending doctor to complete

PART 3 – Treating Doctor Form

To be completed by the treating 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.

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

Plan name _____ Plan number _____

Your patient is claiming for a lump sum benefit that is assessed based on their ability to function in the workforce, not only now but permanently. To facilitate our assessment, please ensure all questions are answered.

1. Member's details

Name of individual _____ Date of birth _____

Are you the treating:

GP ..... Yes ☐ No ☐

or specialist? ..... Yes ☐ No ☐

What is your area of specialty? _____

Who referred this patient to you? _____

1. Please advise the date and nature of initial consultation. _____

2. When did the Life Insured first consult you for the present condition? _____

3. When did the present condition commence? _____

4. Please provide a full report on the Life Insured's condition including cause, symptoms and diagnosis

5. Is the Insured's current condition related to his or her work in any way? ..... Yes ☐ No ☐
   If 'Yes', please provide details.

6. What is the current status of the condition?

7. Please indicate the past and present treatment, including medication for this condition.

8. What treatment is planned for the future?

9. Is there a history of this condition or any condition likely to have contributed to or be connected with the Life Insured's present condition? ..... Yes ☐ No ☐
If 'Yes', please provide details.

10. Please provide a full history of all consultations and treatments for the Life Insured

Dates	Reasons for consultations including nature	Treatment prescribed	Results

11. Is there a family history of this condition? ..... Yes ☐ No ☐
If 'Yes', please advise family member, the condition and age at onset.

12. Are you completing claim forms on behalf of the Life Insured for any other insurance companies in relation to this condition? Yes ☐ No ☐
If 'Yes', please provide the name of the company

13. Medical History

a. From what date do you have records for this patient?

b. Has your patient suffered from the same or similar condition before? ..... Yes ☐ No ☐

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

14. Please provide full details of the Life Insured's capabilities and limitations in relation to his/her occupation

a. Capabilities (what the Life Insured can do)

b. Limitations (what the Life Insured cannot do)

15. Is the Life Insured likely to be able to work in their own or any other occupation now or in the future? ..... Yes ☐ No ☐
If 'Yes', please provide details

2. 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.

3. Additional Information