Asteron Life

Trauma

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

_____

Member to complete

2. Compulsory details

1. Which defined condition are you claiming for?

2. When was diagnosis?

3. What is your diagnosis?

4. When did you first seek medical treatment?

5. Please provide details of your treatment providers including usual GP's (name, address and contact details).

6. What treatment(s) have you had and what treatment(s) is planned?

7. Are you insured with or have you previously made a claim against any other entity in respect of this condition? ..... Yes ☐ No ☐
If 'Yes', please give details and date of claim.

Date of claim

8. We may examine this information which may accelerate the assessment of your claim by avoiding any unnessary duplication of doctors' reports or medical information.

3. Medically underwritten members

This section is to be completed by members who have provided health evidence in the past, in support of their cover, such as for voluntary cover or cover in excess of automatic acceptance limits.

1. When did you first experience symptoms?

2. Have you ever had similar symptoms in the past? ..... Yes ☐ No ☐
If 'Yes', please provide full details including name, address and contact details of treatment providers.

3. Please advise contact details on previous doctors and when you last consulted them.

4. Have you ever submitted a claim for any other condition with any other entity including ACC, WINZ, other insurers? ..... Yes ☐ No ☐
If 'Yes', please provide full details.

Member to complete

4. 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, 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.

5. Member Signature

Name

Address

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.

Trauma

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

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 or 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

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.

- A claim is being made for your patient 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 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 she/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?

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

2. 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)
Email: claims@asteronlife.co.nz Web: asteronlife.co.nz

Issuer: Asteron Life Limited