

# Trauma/Major Health Problems

### Claim Form

Use this form if you are the insured person and wish to make a claim as a result of trauma or a major health issue.

Please ensure all sections of the form are complete and correct. This will ensure we can assess your claim as quickly and as accurately as possible.

#### How to fill in this form

- Please complete all sections of the form with as much detail as possible.
- You can also download this form from www.asteronlife.co.nz/ documents/trauma-major-health-problems-claim-form.pdf and fill it in electronically.

- Ensure all policy owners sign and date the declaration page.
- If you need more space to answer any questions or provide additional information, you can do so on page 4. We encourage you to attach any supporting medical records or other information that will help us to assess your claim.
- Return to us via email to claims@asteronlife.co.nz or post to Asteron Life, PO Box 894, Wellington 6140, Freepost 795.

If you have any questions about the form, we're here to help. Give us a call on 0800 737 101, or talk to your adviser.

#### Personal Information Disclosure

This form collects personal information which is necessary to assess and manage your claim. If you do not provide all the requested information we may not be able to accept or assess your claim correctly. Personal information you provide about yourself or other individuals will be used and stored by Asteron Life Limited.

Under the Privacy Act individuals have certain rights of access to, and to request correction of, any personal information we hold about them. More detail about Asteron Life's privacy practices is contained in the Asteron Life Privacy Statement available at www.asteronlife.co.nz/privacy or on request.

#### A. Your Details

Policy number(s)								
Please tick one	Mr 🗌	Mrs $\square$	Miss	Ms $\square$	Other	Please specify		
Surname						Given names		
Home phone numbe	er					Date of birth		
Work phone number						Email address		
Mobile phone number	er							
Residential address						Postal address (if different)		
						,		
			Post C	ode			Po	st Code

## B. Claim Details

. \ [	Which Trauma/condition	n are you claiming for?	(Please give us as many de	tails as you can)	
	When did you first notice Please describe these s				
[ 3.	Have you ever suffered If 'yes' please provide d	from this condition or r	related condition(s) before?.		Yes No
	Dates Dates	Specific Details			
	a. Please advise the da		ed for this condition. e number of the doctor you	consulted.	
[	c. If this is not your ust	ual doctor please give th	he name, address and phone	e number of your usual doc	tor.
] ] 	Please give details of al	I treatment vou have re	eceived for your condition (e.	g. x-ravs. blood tests. ECC	G's. biopsies. etc)
	Dates	Treatment		<u> </u>	Doctor
	Have you seen any othe		ondition?		Yes No
	Doctor		Address		
(		)	e, any claims with any other		
] ]					

### 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												
7 (000 dirit mamber	BANK	BRA	NCH		ACC	COU	NT N	IUME	BER	S	UFFI	X

## 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. XI 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.

Person Insured					
Full name		Signature		] {	Sign here
Date		J	If electronically completing form, type your name here		
Policy Owner(s	) 1				
Full name		Signature		]4	Sign here
Date			If electronically completing form, type your name here		
Policy Owner(s	) 2				
Full name		Signature			Sign here
Date		-	If electronically completing form, type your name here		

## Additional Information