

Early Payment of Life Protection

Claim Form

Pages 1–3 to be completed by the insured person and pages 5–6 to be completed by the treating doctor.

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 your claim.

- Please have all the policy owners sign the declaration page.
- It is your responsibility to pay for any costs that might arise from the completion of the Treating Doctor's report.
- Page 4 has additional space if you run out of room answering these questions, or if you need to provide any information not covered by the questions.
- We encourage you to attach supporting medical records or any other information you have that will help us in assessing your claim.

We're happy to help if you have any queries about this form. Please call us on 0800 808 101, or talk to your adviser.

A. Your details

Policy number(s)

Please tick one Mr Mrs Miss Ms Other Please specify

Surname Given names

Home phone number (0) Date of birth / /

Business phone number (0) Email address

Mobile phone number (0)

Residential address

 Post Code

Postal address (if different)

 Post Code

B. Claim Details

1. Which condition are you claiming for? (Please give us as many details as you can)

2. When did you first notice symptoms? / /

Please describe these symptoms below.

3. Have you ever suffered from this condition or related condition(s) before? Yes No

If 'yes' please provide details.

Dates	Specific Details

Privacy Act 1993

This information is being collected and will be held securely by Asteron Life Limited ('Asteron Life'). It is intended for use by Asteron Life employees who require access to this information for administering your claim and policy. Under the Privacy Act 1993 you are entitled to request access to and request correction of any personal information about you held by Asteron Life. If you do not supply the information sought your claim may be declined.

In assessing and managing your claim we may need to disclose your personal information to other parties such as claims assessors, loss assessors, reinsurers, medical and financial professionals, judicial or dispute resolution bodies, joint venture partners and Suncorp Group companies.

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.

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 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

Date

Signature [Sign here](#)

Policy Owner(s) 1

Full name

Date

Signature [Sign here](#)

Policy Owner(s) 2

Full name

Date

Signature [Sign here](#)

Asteron Life

Level 13 Asteron Centre, 55 Featherston Street, PO Box 894, Wellington 6140, NZ
Ph: **0800 737 101** (Contact Centre hours: Mon-Fri 8am-6pm)
Fax: 0800 246 067 Email: claims@asteronlife.co.nz Web: asteronlife.co.nz

Early Payment of Life Protection

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

Regards,
Asteron Life Claims Team
Freephone Number: 0800 808 101

Insured's full name

Date of birth

1. Are you the insured's usual doctor? Yes No
If 'yes' please advise for how long and from what date you have records for your patient?

2. Are you the treating specialist? Yes No
What is your specialty? (please advise below)

3. What is the diagnosis and date of diagnosis?

Date of diagnosis

4. When did symptoms first appear?
Please describe these symptoms below.

5. When did you first see your patient for the current condition?

6. Does your patient have a history of the same or similar sickness or injury, or any sickness or injury likely to be connected with the current condition? Yes No
If 'yes' please provide the dates and details below.

7. What tests/investigations have been conducted

Dates	Description	Result

8. Has your patient been hospitalised? Yes No

Name of hospital

Procedure

Date from

Date to

9. Have you referred your patient to other doctors for further opinion, investigation or treatment?..... Yes No

If 'yes' please provide details below and send copies of any reports you have.

Dates	Practitioner	Contact details

10. Do you expect to see your patient again for the current condition?..... Yes No

If 'yes' please state approximately when.

11. What is the prognosis?

12. In your opinion, would the life expectancy be 12 months or less?

Please provide details of objective evidence on which your opinion is based.

13. Are you completing claim forms for any other insurer?..... Yes No

If 'yes' please provide details below.

Important Note

When returning this form, please **send copies of the following:**

- All consultation notes regarding the current condition including when symptoms were first noticed
- Your original referral to the specialist
- All specialist reports on file
- All test results including histology, scan and blood test results
- Any hospital notes on file eg hospital discharge summaries

I hereby declare that the above statements are true and correct.

Full name

Signature **Sign here**

Date

Phone number

Fax number

Doctors stamp