Accidental Injury Claim Form

Guide to completing this claim form

To help us process your claim in a timely manner, please ensure that you have completed all the relevant sections of this form and attached all the required information.

Step 1 Complete all the relevant sections of this form.

Step 2 Attach the following documents:
- A copy of your Hospital Admission and Discharge Summary
- Evidence of the injury such as X-ray Report or GP notes
- Any other medical information which will assist in the assessment of your claim
- (ONLY if you want your claim payment made to a different bank account to the one your premiums are deducted from), an encoded bank deposit slip or a signed verification of the bank account number from your bank showing the account number.

Step 3 Once this form has been completed, please email to us at enquireNZ@aia.com or post to us at FreePost AIA, Private Bag 92499, Victoria Street West, Auckland 1142.

1 Life Assured's details

Complete this section for all claims.

Policy number		Claim number	
Full name			
Street		Suburb	
City		Postcode	
Home phone		Mobile	
Work phone		Date of birth (DD MM YYYY)	/ /
Email address			

2 Injury details

Please complete the following details as accurately as possible.

1. Date of injury (DD MM YYYY) / /
2. What is your current diagnosis/condition?
3. Please advise how the injury happened and what injuries were suffered
4. Your current GP details

Name			
Medical practice			
Address	Street		
	Suburb		
	City	Postcode	
Telephone		Fax	

3 Optional Hospital Cash Benefit

Complete this section only if you are claiming under this benefit

Name of hospital			
Date of admission (DD MM YYYY)	/ /	Date of discharge (DD MM YYYY)	/ /

4 Claim payment

Please confirm the bank account details you would like your claim payment paid to.
If this bank account is different to the one your premiums are deducted from, please also enclose an encoded bank deposit slip or a bank-signed verification of the bank account number.

Name of Bank

Bank account name

Bank account number

Bank | Branch number | Account number | Suffix

Name of Policy Owner

Signature of Policy Owner

X

Date DD/MM/YYYY

Name of Policy Owner

Signature of Policy Owner

X

Date DD/MM/YYYY

5 Consent to disclose personal information

(to be completed by the Life Assured)

If you would like to authorise AIA to give details about you and your claim to any other person e.g. your spouse or another family member, you MUST complete the section below.

Full name of person(s) information is to be released to

Their address

Street

Suburb | Town/City | Postcode

Authorisation

I authorise AIA New Zealand Limited to release and/or discuss any of my personal and health information, including medical or financial details with the above-named person(s).

Full name of Life Assured

Signature of Life Assured

X

Date DD/MM/YYYY

I consent to AIA sharing information regarding my claim with ASB Bank Limited

6 Declaration and Consent (to be completed by the Life Assured)

This claim form collects personal information about you, the Life Assured, for the purpose of assessing your insurance claim under the policy.

The intended recipient of this information is AIA New Zealand Limited ("AIA") and/or any of its related entities, their officers, their advisers, their agents and reinsurers and the information collected will be held at AIA's Auckland office, 74 Taharoto Road, Takapuna, Auckland and by AIA's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). AIA will take reasonable steps to keep such information secure. I understand that AIA may share my claims details with related insurers to enable co-ordination of claims resolution. AIA may be required to disclose personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. You have the right to request access to, and correction of, your personal information at any time.

As part of an insurance claim with AIA, I, the **Life Assured**, consent and give authority to AIA and any of its related entities and agents to seek from, and for all and any of the following, their officers and employees, to disclose to AIA, their advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical or other personal information affecting such insurance which they may hold in respect of me:

- registered medical practitioners and specialists;
- laboratories;
- dentists;
- hospitals (whether public or private);
- Accident Compensation Corporation;
- insurers (whether public or private);
- government departments, agencies, organisations and enterprises;
- counsellors, psychologists and therapists;
- your adviser/broker/insurance agent;
- accountants and other financial advisers;
- banks and other financial institutions;
- employers (whether current or not);
- any other person or organisation which AIA reasonably considers may hold information about me relevant to this claim.

I, the **Life Assured**, declare that all the answers to the questions in this claim form are true and complete and disclosed in the utmost good faith and that the occupational, financial and medical information pertaining to me has been provided and disclosed to AIA. I understand that failure to provide the requested information or provision of incorrect information may result in my claim being declined and/or unable to be assessed and/or my policy being cancelled. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I, the **Life Assured**, agree that a photocopy of this authority will be as valid as an original.

Full name of Life Assured

Signature of Life Assured X

Date DD/MM/YYYY