Email completed form to nz.corporatesolutions@aia.com

Corporate Solutions

Income Protection Claim Form (Member)

1 Plan details

Policy number (if known)

Plan name

Employer's name

Claim number (for office use only)

2 Member details

Full name

Date of birth DD / MM / YYYY

Addresses		Residential Address		Mailing Address (if different to Residential)
	Street		Street	
	Suburb		Suburb	
	City		City	
	Postcode		Postcode	

Contact details			
	Home phone		Work Phone
	Mobile		
	Email address		

3 Member's medical details (to be completed for accident/injury claims only)

a. Date of accident/injury DD / MM / YYYY

b. Please state the full nature of the accident/injury

c. What diagnosis has been given?

d. Is ACC being claimed? ☐ Yes ☐ No ☐ Not sure — If Yes, please provide claim number, if known

e. Have you had a claim previously for the same or similar accident/injury? ☐ Yes ☐ No — If Yes, please give date and details DD / MM / YYYY

4 Member's medical details (to be completed for sickness claims only)

a. What medical diagnosis has been made by your doctor/specialist?

b. When did the symptoms first become apparent? DD MM YYYY / /

c. Have you ever previously suffered from the same or similar complaints? ☐ Yes ☐ No If Yes, please give date and details DD MM YYYY / /

5 Member's medical details (to be completed for all claims)

a. On what date did you first seek medical assistance for the condition you are claiming for? DD MM YYYY / /

b. Have you totally ceased work? ☐ Yes ☐ No On what date did you totally cease work? DD MM YYYY / /

c. On what date were you medically certified to totally cease work? DD MM YYYY / /

d. What duties at work are you not able to perform due to your condition?

e. Are you still completely unable to work? ☐ Yes ☐ No

f. On what date were you medically certified to work reduced hours, start part-time work/alternative duties (if applicable) DD MM YYYY / / ☐ Hours per week Describe duties able to be performed

g. Please advise the date you anticipate you will resume full-time work or, if applicable, have resumed full-time work / / DD MM YYYY

h. What is the name and address of your usual doctor?

i. How long have you been a patient of this doctor? years

If less than 3 years, please advise the name and address of any previous doctors

j. Does your usual doctor hold all of your medical notes? ☐ Yes ☐ No

If No, please advise the name and address of the doctor(s) holding all of your medical notes

k. State the names of all doctors, specialists, physiotherapists etc consulted by you for this disability, including any to whom you were referred for further opinion or investigations and the date of the first attendance with each one DD MM YYYY / /

6 Member's occupation details (to be completed for all claims)

a. What was your occupation immediately prior to you ceasing work due to disability?

b. Describe your main occupational duties and provide the percentage of time spent on each duty

	%
	%
	%

c. What percentage of these duties requires manual or physical work/driving? %

d. Number of hours worked before disability commenced? ____ per day ____ per week

e. Are any light/alternative or reduced hours/duties available? ☐ Yes ☐ No ☐ Not sure If Yes, please give details

7 Member's financial details (to be completed for Income Protection claims only, not required for Total Permanent Disablement claims)

a. Please tick if there is compensation or income by way of regular payment or lump-sum settlement received or being claimed for this disability under:

Please provide details where applicable

		Start date (DD MM YYYY)	End date (DD MM YYYY)
☐	ACC	/ /	/ /
☐	Any other insurance policy	/ /	/ /
☐	Any sick leave	/ /	/ /
☐	WINZ payment (eg sickness benefit)	/ /	/ /
☐	Other (eg medical retirement or redundancy)		
☐	Unsure or undecided		

If any of the above were ticked, please provide:

(i) Name of organisation or company making payment

(ii) Amount of monthly income, compensation or lump sum payment

Monthly amount ____ Lump sum ____ ☐ Gross of tax ☐ Net of tax

b. Has the disability caused you loss of income? ☐ Yes ☐ No If Yes, what was the monthly amount of loss?

If No, why has there been no loss?

8 Consent to disclose personal information (to be completed if you want AIA to give details about you to a third party i.e. spouse, partner, employer)

Name(s) of Person(s)/Company that information is to be released to

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

Full name of the Member (name of person consenting)

Signature of Member (signature of person consenting)

Date (DD MM YYYY) / /

9 Member's Consent

As part of a disability or lump sum claim with AIA, I, **the Member**, consent and give authority to AIA and any related entities 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, financial, or other personal information affecting such insurance which they may hold in respect of me/us:

- Accountant and other financial advisers;
- Accident Compensation Corporation;
- Banks and other financial institutions;
- Insurers (whether public or private);
- Laboratories;
- Government departments, agencies, organisations and enterprises e.g. IRD;
- Your adviser/broker/insurance agent;
- Employers (whether current or not);
- Hospitals (whether public or private);
- Counsellors, psychologists and therapists;
- Dentists;
- Registered Medical Practitioners and Specialists.

10 Member's Declaration

This claim form collects personal information about you the Member ("You") and the Policy Owner who is claiming under the Policy on your behalf. The intended recipient of this information is AIA New Zealand Limited ("AIA") and its related entities, the information collected will be held at AIA's Auckland office at 74 Taharoto Road, Takapuna, Auckland.

The information provided in this form will be used by AIA and/or any related entities for the purposes of assessing the claim made and any related issues to do with your insurance including any application, renewal or re-instatement of insurance.

Failure to provide this information may result in the claim being declined or unable to be assessed. You have the right to request access to and correction of your personal information at any time.

I, **the Member**, declare and agree:

I hereby claim the benefit amounts payable on the basis of the statements and information provided by us in this claim form which I believe to be accurate and complete in every respect. I consent and give authority to AIA and any of its related entities to seek from, and for all and any of the following, their officers and employees, to disclose to AIA and/or any of its related entities, their advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of us.

- Accountant and other financial advisers;
- Employers (whether current or not);
- Accident Compensation Corporation;
- Hospitals (whether public or private);
- Banks and other financial institutions;
- Government departments, agencies, organisation and enterprises eg IRD;
- Counsellors, psychologists and therapists;
- Insurers (whether public or private);
- Dentists;
- Registered Medical Practitioners and Specialists;
- Laboratories;
- Your adviser/broker/insurance agent.

I agree that AIA may communicate directly with the Policy Owner in relation to all matters pertaining to this claim, as they are making this claim on my behalf.

I agree that a photocopy of this authority will be valid as an original.

I declare that all the answers to questions in this claim form are true and complete. If any answer is not in my handwriting I declare that it has been written down at my dictation.

Full name of Member

Signature of Member X

Date DD / MM / YYYY

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