Corporate Solutions

Terminal Illness Claim Form (Member)

Guide to completing this claim form

At AIA our aim is to process your claim in a timely manner. To help us, please ensure that you complete all the relevant sections and attach all the required information.

› Section 7 must be completed by your Treating Specialist/ Attending Physician

› Attach any relevant medical information given by your GP, specialist, hospital or other medical provider. AIA will request any additional information that may be required.
› Attach proof of age e.g., a Certified Copy of Passport, Driver's Licence or Birth Certificate

1 Plan details

Policy Number (if known)

Plan name

Employer's name

Claim number (for office use only)

2 Your details

Full name

Date of birth DD / MM / YYYY

Addresses

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

Contact details

Home phone | Work phone | Mobile

Email address

What was your salary at time of disablement? $ Gross per annum

3 Member's medical details

a. What is your current diagnosis/condition?

b. When was the diagnosis first made and by whom?

Member's medical details continued...

c. When did your symptoms first become apparent and what were they?

d. On what date did you first seek medical assistance for your claim/condition?

DD MM YYYY
/ /

e. Have you ever previously suffered from the same, similar or related condition?

☐ Yes ☐ No

If Yes, please give full details including what the condition was, who you saw, and when it was?

f. Name and contact details of your current GP (If your GP does not hold all your medical notes, please provide contact details of who does).

Name

Medical practice

Address Street

Suburb

City Postcode

Phone Fax

Email address

g. Specialist details (continue on separate sheet if more than one specialist)

Name

Practice name

Specialty

Address Street

Suburb

City Postcode

Phone Fax

Email address

Member's medical details continued...

h. Hospital details

Name of hospital

Address

Street

Suburb

City

Postcode

Phone

Fax

Email address

i. Please advise if any other settlement is/or will be claimed in relation to this claim. Whether it be from a public or private insurer.

Name of Insurer

Policy number

Contact person's name

Phone

Fax

Email address

Type of claim

4 Consent to disclose personal information (to be completed if you want AIA to give details about you to a spouse/partner/employer)

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

I authorise AIA to 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 Member (name of person consenting)

Signature of Member (signature of person consenting)

X

Date DD / MM / YYYY

5 Consent

As part of a disability or lump sum claim with one of the Companies (as defined below), I, the **Member**, consent and give authority to the Companies and any related companies to seek from and for all and any of the following, their officers and employees, to disclose to the Companies, 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.

6 Member's Declaration and Consent

This application 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 companies, the information collected will be held at AIA's Auckland offices at 74 Taharoto Road, Takapuna, Auckland.

The information provided in this form will be used by AIA and/or any related companies 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 companies 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 companies, 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;
- Accident Compensation Corporation;
- Banks and other financial institutions;
- Counsellors, psychologists and therapists;
- Dentists;
- Laboratories;
- Employers (whether current or not);
- Hospitals (whether public or private);
- Government departments, agencies, organisation and enterprises eg IRD;
- Insurers (whether public or private);
- Registered Medical Practitioners and Specialists;

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

AIA House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag 92499,
Victoria Street West,
Auckland 1142

Phone (Int.): +64 9 487 9963
Freephone (NZ): 0800 500 108
Email: nz.corporatesolutions@aia.com
Web: aia.co.nz

7 Medical details – (To be completed by the Member's attending physician, at the expense of the Member)

Please note, if you are not able to get this section completed, AIA will obtain this information on your behalf.

Claim number | Policy number

Full name of Patient

Date of birth (DD MM YYYY) / / | NHI number

Patient address — Street | Suburb

City | Postcode

Are you the patient's usual medical attendant? If so, for how long? ☐ Yes ☐ No

a. What is the patient's diagnosis/problem list?

b. If the diagnosis is cancer, when was the primary cancer diagnosed?

c. What were the signs and symptoms leading to the diagnosis?

d. When did the patient first seek medical assistance (DD MM YYYY) / /

e. Has the patient ever suffered from the same, similar or related condition? If Yes, please provide full details including what the condition was, when it was and who the patient consulted. ☐ Yes ☐ No

f. Current proposed treatment plan

g. Please provide details of any other relevant treatment providers for the patient.

h. What is prognosis for patient, in terms of months. Please comment on the impact of any treatments on your patients life expectancy.

i. Any other comments or observations you would wish to make?

To assist with the assessment of the claim, please attach copies of all relevant Specialist reports, clinical notes, hospital notes and other supporting documents.

Attending Physician's details

Full name

Medical Specialty

Address Street

Suburb

City

Postcode

Contact details Phone

Fax

Email address

Signature of Attending Physician

X

Date DD / MM / YYYY

AIA House,
74 Taharoto Road,
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Victoria Street West,
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