Terminal Illness Claim Form

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.

- Complete sections 1, 2, 4 and 5 (and section 3 if you purchased your cover through ASB)
- Section 6 must be completed by your Treating Specialist/Attending Physician
- If you have any medical information please feel free to submit this with your claim form. Otherwise we will request this on your behalf on return of this claim form.
- Certified copy of your birth certificate **or** passport **or** driver licence*

* The following can certify the document: Lawyer, Solicitor, Chartered Accountant, Registered Medical Doctor, Justice of the Peace, Police Officer, Notary Public or anyone else by law authorised to administer an oath.

1 Life Assured details

Claim number

Policy number

Full name

Date of birth DD / MM / YYYY

Address

Street

Suburb

City

Postcode

Contact details

Home phone

Work phone

Mobile

Email address

Are you claiming with another insurer ☐ Yes ☐ No

Name of Insurer

2 Medical information questions (for completion by or on behalf of the Life Assured)

a. What is your current diagnosis/condition?

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

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

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			

3 Consent

As part of an insurance claim with AIA New Zealand Limited (AIA), I, the **Life Assured** consent and give authority to AIA and any of its related entities and agents to request any of my medical or other personal information affecting my insurance or the assessment of my claim from any third party which AIA reasonably considers may hold that information. I also authorise those third parties to disclose that information to AIA, its advisers and reinsurers, and to any legal tribunal before which any question concerning my insurance may arise. Those third parties may include:

- Registered medical practitioners and Specialists (which may include an entire copy of my/our medical file)
- Medical laboratories and testing facilities
- Accident Compensation Corporation, governmental departments or bodies
- Insurers or reinsurers (whether public or private)
- Counsellors, psychologists and therapists, and
- any other person or organisation which holds information which is relevant to my insurance or the assessment of my claim.

I understand that the supply of the information gathered from the above sources is voluntary and that AIA may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my Insurance. I understand that AIA may share my claims details with related insurers to enable co-ordination of claims resolution. I understand that my personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.

I understand that my personal information will be stored at AIA's Auckland office, 74 Taharoto Road, Takapuna, Auckland and/or other premises in New Zealand occupied by AIA and by AIA's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I understand that AIA will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).

I consent and give authority to ASB Bank Limited and AIA to request from AIA International Limited (trading as AIA New Zealand `AIA'), or disclose to AIA, any information pertaining to me and relevant to the assessment of my insurance claim.

I understand that AIA may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of my personal information may be requested by me.

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following :

I consent to the disclosure of my claims information to ASB Bank Limited ('ASB') for the purposes of notifying ASB of issues or disputes arising in respect of my claim ☐ Yes ☐ No

4 Declaration – important, please read carefully

I declare that all medical information pertaining to me and relevant to my insurance claim has been provided and disclosed to AIA.

I understand that failure to provide full disclosure of all medical information that AIA considers as relevant in the assessment of my claim would be considered to be material misrepresentation and/or material non-disclosure and as such AIA is entitled to use legal remedy, should this occur.

I further understand that the medical information provided is the basis on which AIA will assess and manage my claim and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed.

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

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

Full name of Life Assured

Signature of Life Assured X

Date DD/MM/YYYY

5 Consent to disclose personal information to a third party

This section is to be used when you want AIA to give details about you to a third party.
e.g. spouse, partner, broker etc

Name of person that information is to be released to

Their address

Phone number

Email Address

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

6 Medical details – (To be completed by the Life Assured's attending physician, at the expense of the Life Assured)

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?

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

b. On what date was the diagnosis and by whom? 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

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