Total Permanent Disability Claim Form

1 Details of Claimant

Title | First name(s) | Surname

Policy number | Date of birth (DD MM YYYY) / / | ☐ Male ☐ Female

Residential address
Unit / apartment / building / floor | Street
Suburb | Town/City | Postcode

Postal address (if different)
PO Box / Private bag | Street
Suburb | Town/City | Postcode

Phone No.
Home | Mobile | Business

Email

Pre Disability occupation (including any part-time work) | Hours per week

Description of pre disability duties | Hours per duty

Employer's name

Employer's address
Street
Suburb | Town/City | Postcode

Doctor's name

Doctor's address
Street
Suburb | Town/City | Postcode

2 Policy Owner's details (if the Policy Owner is not the Claimant)

Title | First name(s) | Surname

Date of birth (DD MM YYYY) / / | ☐ Male ☐ Female

Residential address
Street
Suburb | Town/City | Postcode

Postal address (if different)
Street
Suburb | Town/City | Postcode

Phone No.
Home | Mobile | Business

Email

3 Claimant's statement (To be completed by the Claimant)

a. Date sickness commenced or injury occurred — DD MM YYYY

b. Date of first medical consultation — DD MM YYYY

c. When did you cease work? — DD MM YYYY

d. Please describe your sickness or injury (in case of accident, describe the circumstances)

e. Please provide full details of the doctor and / or hospital where you were treated for your sickness or injury

Date / / Doctor/hospital/specialist

Address

Date / / Doctor/hospital/specialist

Address

Date / / Doctor/hospital/specialist

Address

f. Have you had this sickness or injury before? ☐ Yes ☐ No **If yes,** please provide details

Date / / Doctor/hospital/specialist

Address

Date / / Doctor/hospital/specialist

Address

Date / / Doctor/hospital/specialist

Address

g. Have you returned to work?

☐ No **If no:** date you expect to return to work — DD MM YYYY

☐ Yes **If yes:** returned on — DD MM YYYY

to ☐ regular work ☐ part-time work ☐ lighter or different duties

Please list the duties you are performing, the hours per week spent on each duty:

Description of duties	Hours per duty

h. Please state the names of all the entities you are involved in

What is your involvement in these entities?

4 Direct Credit Details (should your claim be accepted)

Which bank account would you like your claim paid into?

☐ Same bank account as the one my premium is paid from ☐ A different bank account

Name of account holder

Bank account number

Bank | Branch number | Account number | Suffix

5 Statement of Disclosure

A. This claim form collects personal information about you which will be used to; a) investigate and determine the validity of your claim, b) confirm the information in your application for this insurance product, c) maintain relevant statistical records; d) comply with relevant legislation.

B. This information is collected and held by AIA New Zealand at 74 Taharoto Road, Takapuna, Auckland.

C. You have a duty to provide AIA New Zealand with all the facts material to your claim and all information, which we may reasonably require in relation to your claim. If you fail to provide this information we may not pay your claim. If you provide false information this may result in your policy being voided from inception or cancelled.

D. Under the Privacy Act 2020 and Health Information Privacy Code 2020, you have the right to access to, and correction of, any information held or provided.

6 Declaration and Authority to Obtain and Use information

A. I authorise any doctor, medical specialist, hospital, clinic, insurance company, ACC, employers and any other authority to disclose to AIA New Zealand any and all information concerning my medical history, financial, occupational and insurance information and I authorise AIA New Zealand to collect such information from those persons. A photocopy or facsimile of this authorisation shall be as valid as the original.

B. I authorise AIA New Zealand to disclose any information collected about me to any relevant third party, including any doctor, medical specialist, hospital, clinic, insurance company, ACC, the Ministry of Health, employers or any other authority for the purposes set out in section 5A above.

C. I have read and understood the information in this claim form including the section above relating to the Privacy Act 2020 and the Health Information Privacy Code 2020.

D. I declare that all information provided by me relating to this claim is true and correct, and no material information has been withheld.

7 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

8 Declaration

Should your claim be accepted, your responsibilities to AIA New Zealand are:

I must notify AIA New Zealand before I return to any work, paid or unpaid, in any capacity.
I must advise AIA New Zealand immediately if I:

- have an increase in my work hours
- have an increase in any pay / weekly compensation that I receive
- receive any other income, such as holiday pay or sick leave pay that may affect my benefit

I acknowledge that I am required to co-operate with AIA New Zealand in the development and implementation of a rehabilitation plan in order to endeavour to terminate or reduce the extent of any disability, impairment or incapacity.
I acknowledge that I may be required to attend additional medical / vocational assessments, should this be necessary in the assessment and management of my claim.
I acknowledge that if I do not meet these responsibilities, AIA New Zealand may cease my benefit payments, cancel my policy, and / or take legal action against me.

I acknowledge that I may have to repay any overpayments made to me by AIA New Zealand if an overpayment occurs as a result of:

- not letting AIA New Zealand know about any matter relevant to my benefit payments
- deliberately making an incorrect statement on any matter relevant to my benefit

Full name of Claimant

Signature of Claimant X

Date DD/MM/YYYY

Full name(s) of Policy Owner(s) *(if different to Claimant)*

Signature of Policy Owner(s) X

Date DD/MM/YYYY

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