Waiver of Premium Claim Form

(Please print clearly)

1 Life Assured details

Policy number

Full name

Date of birth (dd/mm/yyyy) / /

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

Contact details	Home phone	Work phone	Mobile

Email address

2 Off work details

a. On what date did you first seek medical assistance for your current condition/claim? Day / Month / Year / /

b. On what date did you totally cease work? Day / Month / Year / /

c. On what date were you medically certified to cease work? Day / Month / Year / /

d. Please describe your illness or injury

e. What diagnosis has been given?

f. What symptoms prevent you from working?

g. Have you ever suffered from the same or similar illness or injury? If Yes, please give full details

h. What medical investigations have been undertaken?

i. What treatment is being provided?

j. What medications are you currently taking?

k. What have you been told is the expected date of return to light/part-time work duties?

l. What have you been told is the expected date of return to full and unrestricted work duties?

m. If you have spent a period of time in hospital for your current condition/claim, please detail

Hospital name

Admission date (dd/mm/yyyy) / /

Discharge date (dd/mm/yyyy) / /

Hospital name

Admission date (dd/mm/yyyy) / /

Discharge date (dd/mm/yyyy) / /

n. In the case of an injury, is ACC being claimed? ☐ Yes ☐ No If No, please state why not

ACC Claim number

ACC Case Manager's name

ACC Case Manager's direct phone number

o. Your current GP details

Name

Medical practice

Address Street

Suburb

City Postcode

Phone Fax

Email address

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

Name

Specialty

Address Street

Suburb

City Postcode

Phone Fax

Email address

3 About your job

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

b. Describe your exact duties and the percentage of time spent on each duty

Duties	% of time on each duty

c. Number of hours usually worked per week

d. What duties are you able to perform?

e. What duties are you unable to perform?

f. Is your job available for you to go back to? If not, please provide details

4 Financial details

a. Please indicate how your income is obtained from all sources at the date of your disability.

Salaried Employment

☐ Full-time ☐ Part-time ☐ Seasonal

Name of Employer

Contact person

Contact number

Address Street

Suburb

City Postcode

Self Employment

		Name of Entity	% Profit share entitlement
☐	Sole proprietor		
☐	Contractor		
☐	Shareholder employee		
☐	Companies		
☐	Partnerships		
☐	Trusts		
☐	Other Please specify		

b. Please tick the appropriate box to advise if other compensation or income by way of regular payment or lump sum settlement is being or will be claimed for your current condition/claim by any of the following

	Yes	No	Amount	Start Date (dd/mm/yyyy)	End Date (dd/mm/yyyy)
Any sick leave				/ /	/ /
WINZ payments (Government support)				/ /	/ /
Other				/ /	/ /

Specify

c. If any of the above were ticked Yes, please provide the following

Name of organisation

Contact person's name

Contact person's phone number

Contact person's email address

d. If you have a Retirement Protection Benefit, please provide the following

KiwiSaver Scheme details

Are you currently a KiwiSaver member? Yes No

5 About payment

Please make any benefit payment into the following account

Name of account

Bank | Branch number | Account number | Suffix

Account

Full name of Policy Owner

Signature of Policy Owner X

Date DD/MM/YYYY

Full name of Policy Owner

Signature of Policy Owner X

Date DD/MM/YYYY

6 Consent

I, _____ , the **Life Assured**, consent and give authority to AIA New Zealand Limited ("AIA") 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:

- Dentists;
- Advisers;
- Employers (whether current or not);
- Medical laboratories;
- Accident Compensation Corporation;
- Banks and other financial institutions;
- Accountants and other financial advisers;
- Insurers or reinsurers (whether public or private);
- Counsellors, psychologists and therapists;
- Government departments, agencies, organisations and enterprises;
- Registered medical practitioners and Specialists (which may include an entire copy of my/our medical file)

I, the **Life Assured**, 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, the **Life Assured**, understand that my personal information will be stored at AIA's Auckland office, 74 Taharoto Road, Takapuna 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).

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 for the purposes of notifying ASB of issues or disputes arising in respect of my claim ☐ Yes ☐ No

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.

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 – Important, please read carefully

I, _____ , the **Life Assured**, declare that all occupational, medical and financial information pertaining to me has been provided and disclosed to AIA.

I understand that failure to provide full disclosure of all occupational, medical and financial information that AIA would deem 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 occupational, medical and financial 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

I/We, _____ hereby claim the benefit amounts payable on the basis of the statements and information provided by the Life Assured in this form which I/we believe to be accurate and complete in every respect.

Full name of Policy Owner

Signature of Policy Owner X

Date DD/MM/YYYY

Full name of Policy Owner

Signature of Policy Owner X

Date DD/MM/YYYY