Application/Policy No.

Trauma Cover Claim Form

This claim form is to be used for all Trauma claims, including the Additional Female Cancer Rider benefit and Male Prostate Removal Rider benefit.

Important information you must read before submitting this claim:

- **Claims must be submitted to AIA New Zealand within three months from the date of diagnosis.**
- **Please ensure that all attachments are originals. You may wish to make copies for your records.**
- **Upon completion, please give the entire form to the treating doctor for completion of section 5 and 6.**
- **Please complete the Authority to Act Form (page 5) if applicable.**

Section 1. Details of Claimant (if the Claimant is not the Policy Owner)

Policy Number

Title **First Name** **Surname**

Date of Birth / / Male Female

Residential Address

Suburb **City** **Postcode**

Phone No. Home ( ) Mobile ( ) Business ( )

Email **Fax** ( )

Section 2. Details of Policy Owner (if the Policy Owner is not the Claimant)

Title **First Name** **Surname**

Date of Birth / / Male Female

Street Address

Suburb **City** **Postcode**

Phone No. Home ( ) Mobile ( ) Business ( )

Email **Fax** ( )

Postal Address (if different)

Suburb **City** **Postcode**

Please turn over.

Section 3. 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.

B. This information is collected and held by AIA New Zealand at 5-7 Byron Avenue, Takapuna, North Shore City 0752, New Zealand.

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 1993 and Health Information Code 1994, you have the right of access to, and correction of, any information held or provided.

Declaration and Authority to Obtain and Use Information

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

B. I have read and understood the information in this claim form including the section above relating to the Privacy Act 1993 and the Health Information Privacy Code 1994.

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

Section 4. Declaration

I acknowledge that I may be required to attend additional medical assessments, should AIA New Zealand deem this necessary to complete the assessment of this claim.

I acknowledge that if I do not meet this responsibility, AIA New Zealand may be unable to assess and pay the claim.

I acknowledge that I may have to repay any overpayments made to me by AIA New Zealand.

Full Name of Policy Owner	**Signature of Policy Owner**	**Date**
		/ /

Full Name of Claimant	**Signature of Claimant**	**Date**
		/ /

(To be signed by the parent/legal guardian if claimant is a child under 16 years.)

Section 5. 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

Bank account number ☐☐ – ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐☐☐

To be completed by your attending Doctor or Specialist

Section 6. Claim Details

A. Details of the condition or symptoms that have resulted in this trauma claim (include clinical details).

B. Date symptoms first arose / /

C. Date medical advice first sought / /

D. Date sickness/injury first diagnosed / /

E. Please provide full details of consultation and treatment

Date	Treatment	Treated By

F. Has the client ever in the past suffered from this injury or illness? Yes ☐ No ☐ If yes, please provide details

Date	Diagnosis	Doctor/Hospital

G. Please give any other information and attach all relevant medical reports which may be helpful in assessment of this claim.

Section 7. Family History

A. Is there anything in the client's medical, social or family history which would have increased the risk of this illness occurring? Yes ☐ No ☐

If yes, please give details

B. Relationship to claimant

C. Age when disorder diagnosed

D. Nature of illness/condition

E. Outcome of the illness/condition

Section 8. Medical Attendant

I declare that the answers to the above questions are true and correct.

Full Name of Medical Attendant	Signature of Medical Attendant	Date
		/ /

Phone

Facsimile

Professional qualifications

AIA New Zealand
Level 15, 5-7 Byron Avenue, Takapuna
Private Bag 300981, Albany, North Shore City 0752, New Zealand
AIA.CO.NZ
T: +64 9 488 8800
F: +64 9 488 8810

Application/Policy No.

Trauma Cover Claim Form
Authority to Act Form

Please complete the relevant section of this form if either of the following circumstances apply:
Please ensure that the witness section is completed in either case.

1. You are the Life Assured (Claimant) and wish to give consent for a third party (Spouse/Broker/Policy Owner) to act on your behalf for the duration of this claim.
2. You are the Policy Owner and wish to give consent to a third party (Spouse/Broker/Life Assured (Claimant)) to act on your behalf for the duration of this claim.

A. Statement from Life Assured (Claimant)

Policy Number

Title **First Name** **Surname**

Date of Birth / / Male Female

I give consent that all information and/or communication pertaining to my claim may be released to:

(full name of representative) and I appoint him/her to represent me in all matters pertaining to my claim. My representative will be identified by the use of the following identification:

(password/ID type/other)

Completed by: **Signature of Claimant** **Date** / /

B. Statement from Policy Owner (if the Policy Owner is not the Claimant)

Policy Number

Title **First Name** **Surname**

Date of Birth / / Male Female

I give consent that all information and/or communication pertaining to my claim may be released to:

(full name of representative) and I appoint him/her to represent me in all matters pertaining to my claim. My representative will be identified by the use of the following identification:

(password/ID type/other)

Completed by: **Signature of Policy Owner** **Date** / /

Witnessed by:

Witness Name (cannot be a direct family member) **Signature of Witness** **Date** / /

Witness occupation

Witness address

Suburb City Postcode

Phone Best time to call

AMPM121640-09/10

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