Trauma/Major Health Problems

Claim Form

Use this form if you are the insured person and wish to make a claim as a result of trauma or a major health issue.

Please ensure all sections of the form are complete and correct. This will ensure we can assess your claim as quickly and as accurately as possible.

How to fill in this form

- Please complete all sections of the form with as much detail as possible.
- You can also download this form from **www.asteronlife.co.nz/documents/trauma-major-health-problems-claim-form.pdf** and fill it in electronically.
- Ensure all policy owners sign and date the declaration page.
- If you need more space to answer any questions or provide additional information, you can do so on page 4. We encourage you to attach any supporting medical records or other information that will help us to assess your claim.
- Return to us via email to claims@asteronlife.co.nz or post to Asteron Life, PO Box 894, Wellington 6140, Freepost 795.

If you have any questions about the form, we're here to help. Give us a call on 0800 737 101, or talk to your adviser.

Personal Information Disclosure

This form collects personal information which is necessary to assess and manage your claim. If you do not provide all the requested information we may not be able to accept or assess your claim correctly. Personal information you provide about yourself or other individuals will be used and stored by Asteron Life Limited, Level 13, 55 Featherston Street, Wellington and other members of the Suncorp Group. Under the Privacy Act individuals have certain rights of access to, and to request correction of, any personal information we hold about them. More detail about Asteron Life's privacy practices is contained in the Asteron Life Privacy Statement available at **www.asteronlife.co.nz/privacy** or on request.

A. Your Details

Policy number(s)

Please tick one Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ *Please specify*

Surname

Given names

Home phone number (0)

Date of birth

Work phone number (0)

Email address

Mobile phone number (0)

Residential address

Post Code

Postal address *(if different)*

Post Code

B. Claim Details

1. Which Trauma/condition are you claiming for? (Please give us as many details as you can)

2. When did you first notice symptoms?
Please describe these symptoms below.

3. Have you ever suffered from this condition or related condition(s) before? ..... Yes ☐ No ☐
If 'yes' please provide details.

Dates	Specific Details

4. a. Please advise the date you were first treated for this condition.

   b. Please advise the name, address and phone number of the doctor you consulted.

   c. If this is not your usual doctor please give the name, address and phone number of your usual doctor.

5. Please give details of all treatment you have received for your condition (e.g. x-rays, blood tests, ECG's, biopsies, etc)

Dates	Treatment	Doctor

6. Have you seen any other doctors about your condition?...Yes ☐ No ☐
If 'yes' please give names and addresses.

Doctor	Address

7. Have you lodged, or are you intending to lodge, any claims with any other insurers for your condition?
(e.g. medical, health, etc) ..... Yes ☐ No ☐
If 'yes' please provide details.

C. Payment Details

If your claim is accepted, your payment will be made by direct credit. Please provide your bank account details below:

Account name

Account number

BANK BRANCH ACCOUNT NUMBER SUFFIX

Privacy Act

This information is being collected and will be held securely by Asteron Life Limited ('Asteron Life') and my adviser. It is intended for use by Asteron Life employees who require access to this information for administering your claim and policy. Under the Privacy Act you are entitled to request access to and request correction of any personal information about you held by Asteron Life. If you do not supply the information sought your claim may be declined.

In assessing and managing your claim we may need to disclose your personal information to other parties such as claims assessors, loss assessors, reinsurers, medical and financial professionals, judicial or dispute resolution bodies, joint venture partners and Suncorp Group companies.

Consent and Declaration

I have read and understood and have made the other people named on this form aware of the privacy disclosure statement above. I acknowledge that where information is provided it is with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the person as named on this form.

I hereby declare that the information in this Claim Form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise Asteron Life of any relevant information regarding my claim, Asteron Life may refuse to pay my claim. I understand that I can be prosecuted if I make any fraudulent statements.

Medical and Information Authority

I hereby authorise any dentist, hospital, doctor or other person who has attended me, to release to Asteron Life Limited ("Asteron Life") or its representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records.

I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original. XI authorise any insurer, adviser/broker, accountant, institution, employer, business entity, medical institution, professional board or company, legal professional or entity, to release to Asteron Life or its representatives, all information which Asteron Life requests for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Person Insured

Full name

Date

Signature

Sign here

If electronically completing form, type your name here

Policy Owner(s) 1

Full name

Date

Signature

Sign here

If electronically completing form, type your name here

Policy Owner(s) 2

Full name

Date

Signature

Sign here

If electronically completing form, type your name here

Asteron Life
Level 13 Asteron Centre, 55 Featherston Street,
PO Box 894, Wellington 6140 NZ
Ph: **0800 737 101** (Contact Centre hours: Mon–Fri 8am–6pm)
Email: claims@asteronlife.co.nz Web: asteronlife.co.nz

Additional Information