Asteron Life

Early Payment of Life Cover

Claim Form

We'll assess your claim as quickly as possible. The information you provide will help us do this and make sure our assessment is accurate. Please complete all sections of the form as requested – an incomplete form could delay the assessment of the claim.

Step 1 – Complete the form
Fill in then print the form, sign it at the bottom, scan and email it, or send by post.

Step 2 – Include the following attachments
A copy of your birth certificate, passport or drivers licence

Step 3 – Send the form and attachments
Email (recommended): ei.asteronlife@gbtpa.co.nz, or
Post: PO Box 894, Wellington 6140, Freepost 795

The member is responsible for meeting any cost associated with the completion of the treating doctor's report.
If you have any questions we're happy to help – just call us on 0800 737 101, or talk to your adviser.

Please note: this claim form is not an admission of liability by Asteron Life Limited.

Member to complete

PART 1 – Members statement

To be completed by the member.

1. Member's details

Plan name _____ Plan number _____

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ *Please specify:* _____

Surname _____ Date of birth* _____

*please provide evidence of your date of birth e.g. copy of your birth certificate, passport or drivers licence

Given name(s) _____

Home address _____ Post Code

Home phone _____ Business phone _____

Mobile (if applicable) _____ Email (if applicable) _____

Employer Name _____

Employer Address _____

2. Condition details

1. Please state the exact nature of your condition.

_____

_____

Member to complete

2. Please state the name and address of any specialist you are currently attending for this condition (specialist's name, address and contact details).

3. When did you first attend a doctor or hospital for this condition? Please advise date, name, address and contact details of doctor and/or hospital.

4. Please advise the name, address and contact details of your usual medical practitioner if different from above.

5. Have you attended any medical practitioner during the last five years for any other reason? .....Yes ☐ No ☐
If 'Yes', please provide date, name, address and reason(s).

6. Have you made or do you intend to make, any other claim against Asteron Life Limited or any other insurance company in respect of this condition or any other condition? .....Yes ☐ No ☐
If 'Yes', please provide date, name, address and reason(s).

3. Privacy and Declaration

Privacy Statement

For the purpose of the Privacy Act, we confirm that we collect and use your personal information and may disclose your personal information to third parties for the purpose of administering your policy or in order to comply with legal requirements. Your details are stored securely within Asteron Life and may also be securely stored electronically on servers located in New Zealand or overseas, by third parties on our behalf. You can contact us at any time to request access to and correction of your personal information. The collection of this information is required under the terms of your policy.

For further information about how we deal with your personal information, please refer to Asteron Life's Privacy Policy. It is available online at www.asteronlife.co.nz by phoning 0800 737 101, or by writing to Asteron Life Limited, PO Box 894, Wellington 6140.

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 with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the personas named on this form.

I hereby declare that the information in this Claim Form is correct and complete. I understand and agree that if I have provided any information which is incomplete and incorrect, Asteron Life Limited may be unable to fairly assess the claim, and the claim, and any related claim, may not be payable in whole or in part, and we may also cancel your cover under the policy. 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 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.

I hereby 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 Limited or its representatives, all information which Asteron Life Limited 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.

I hereby authorise Asteron Life Limited to supply information relating to my claim to data matching services subscribed to by Asteron Life Limited.

4. Member Signature

Name

Contact phone

Contact email

Signature

Sign here

Date

*If the declaration is completed by a person other than the Life Insured, please specify the relationship with the Life Insured and the terms of authority (eg; Power Of Attorney or Next of Kin) held to act on his/her behalf.

5. Any Additional Information

Early Payment of Life Cover

Employer to complete

PART 2 – Members employer form

To be completed by the members current or most recent employer.

Thank you for taking the time to complete this form.

- Your employee is making a claim as a result of sickness or injury.
- So that we can accurately assess the claim, we would appreciate you filling out this form in as much detail as possible and returning it to the employee.

This form can be completed electronically **(recommended)**: Fill in then print the form, sign it at the bottom, and scan and email it.

Regards,
Asteron Life Claims Team | Freephone Number: 0800 737 101

Employer Statement

Plan name

Plan number

Name of employee

Date of birth

1. When did the member join the company?
2. Please advise whether member was at work on performing all the duties of his/her usual occupation without any restriction on the date of commencement of the policy or, if the member joined afterwards, on his or her first day?
3. Please advise if the member is or was working overseas, and if so where and since when?
4. Please state the exact nature of the employee's condition giving rise to this claim.
5. What is the member's current salary? *Please attach evidence.* $
6. When was the member's last day at work?

Payment Instructions

Asteron Life prefers to make payments directly to a bank account

Payee (please attach a deposit slip)

Bank account number

BANK BRANCH ACCOUNT NUMBER SUFFIX

Privacy and Declaration

Privacy statement

For the purpose of the Privacy Act, we confirm that we collect and use your personal information and may disclose your personal information to third parties for the purpose of administering your policy or in order to comply with legal requirements. Your details are stored securely within Asteron Life and may also be securely stored electronically on servers located in New Zealand or overseas, by third parties on our behalf. You can contact us at any time to request access to and correction of your personal information. The collection of this information is required under the terms of your policy.

For further information about how we deal with your personal information, please refer to Asteron Life's Privacy Policy. It is available online at www.asteronlife.co.nz by phoning 0800 737 101, or by writing to Asteron Life Limited, PO Box 894, Wellington 6140.

Declaration

I agree that:

- I am a representative of the employer of the above-named and am duly authorised to complete this form on behalf of my employer.
- All the information I have given in this Claim Form is complete and correct and that all answers have been written or dictated by me. I have not withheld any information that may be relevant to Asteron Life's assessment of the claim.
- I acknowledge and agree that if I have provided any information which is incomplete or incorrect, Asteron Life may be unable to fairly assess the claim and the claim in question, and any related claim, may not be payable in whole or in part, and we may also cancel the employee's cover under the policy.
- I give consent for Asteron Life to release information they have regarding this claim to anyone who may be involved in the management of this claim.

Employer Signature

Employer to complete

Name of authorised employer representative		Position	
Contact phone		Contact email	
Signature	Sign here	Date	

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PART 3 – Treating Doctor Form

To be completed by the treating doctor.

Attending doctor to complete

Thank you for taking the time to complete this form.

- Your patient is making a claim as a result of sickness or injury.
- So that we can accurately assess the claim, we would appreciate you filling out this form in as much detail as possible and returning it to the patient.

This form can be completed electronically **(recommended)**: Fill in then print the form, sign it at the bottom, and scan and email it.

The patient will pay any fee you may charge for this service.

Regards,

Asteron Life Claims Team | Freephone Number: 0800 737 101

Plan name _____ Plan number _____

1. Patient's details

Family name _____ Given name(s) _____

Home address _____ Post Code

2. Compulsory details

1. Please state diagnosis.

2. Date of diagnosis? _____

3. What is the current status of the condition?

4. What treatment has been employed to date?

5. What treatment is planned for the future?

6. How long do you expect your patient to live? _____ months

7. Has your patient suffered any other illnesses in the last five years? .....Yes ☐ No ☐
   If 'Yes', please provide condition, date, duration (if known) and name of Medical Attendant (if known)

8. Any additional Information

3. Doctor's Signature

I agree that all the information I have given in this report is true and correct.

Name and Qualifications

Address

Contact phone

Contact email

Signature

Sign here

Date

Important Note

When returning this form, please send **copies of all relevant specialist reports and documents in your possession** for Asteron Life Limited.