

Personal Accident and Major Burns

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): employeeinsurance@asteronlife.co.nz, or

Post: Freepost 198921, PO Box 894, Wellington 6140

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 808 101, or talk to your adviser.

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

PART 1 – Members statement

To be completed by the member.

1. Member's details

Plan name	<input type="text"/>	Plan number	<input type="text"/>
Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other	Please specify:	<input type="text"/>
Surname	<input type="text"/>	Date of birth*	<input type="text"/> / <input type="text"/> / <input type="text"/>

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

Given name(s)	<input type="text"/>		
Home address	<input type="text"/>		Post Code <input type="text"/>
Home phone	<input type="text"/>	Business phone	<input type="text"/>
Mobile (if applicable)	<input type="text"/>	Fax (if applicable)	<input type="text"/>
Employer Name	<input type="text"/>		
Employer Address	<input type="text"/>		

2. Compulsory details

1. Which condition are you claiming for?

2. When did you first seek medical treatment?

3. Please provide details of your treatment providers including usual GP's (name, address and contact details).

4. Are you insured with or have you previously made a claim against any other entity in respect of this condition? Yes No

If 'Yes', please give details and date of claim.

Date of claim

3. Privacy and Declaration

Privacy Act 1993

For the purpose of the Privacy Act 1993, 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 by companies within the Suncorp Group and 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, please refer to the "Asteron Life Privacy Policy" which is specific to New Zealand law and the Suncorp Group's "Suncorp Privacy Policy". The "Asteron Life Privacy Policy" is available at www.asteronlife.co.nz, by phoning 0800 808 101, 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 the 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.

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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 808 101

Employer Statement

To be completed by the current or most recent Employer of the Life Insured

Plan name	<input type="text"/>	Plan number	<input type="text"/>
Name of employee	<input type="text"/>	Date of birth	<input type="text"/>

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?

Payment Instructions and signature

Asteron Life prefers to make payments directly to a bank account

Payee (please attach a deposit slip)

Bank account number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
BANK	BRANCH	ACCOUNT NUMBER	SUFFIX

Privacy and Declaration

Privacy Act 1993

For the purpose of the Privacy Act 1993, 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 by companies within the Suncorp Group and 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, please refer to the "Asteron Life Privacy Policy" which is specific to New Zealand law and the Suncorp Group's "Suncorp Privacy Policy". The "Asteron Life Privacy Policy" is available at www.asteronlife.co.nz, by phoning 0800 808 101, 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 the claim.

Employer Signature

Name of authorised employer representative	<input type="text"/>	Position	<input type="text"/>
Contact phone	<input type="text"/>	Contact email	<input type="text"/>
Signature	<input type="text"/>	<input type="button" value="Sign here"/>	Date <input type="text"/>

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PART 3 – Treating Doctor Form

To be completed by the treating doctor.

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 808 101

Plan name Plan number

Your patient is claiming for a lump sum benefit that becomes payable if s/he meets a defined condition. To assess this, we require the underlying test results which may include histology reports, ECG reports, blood tests (troponin levels) and supporting specialist reports.

1. Details

Family name Given name(s)

Are you the usual GP? Yes No

Are you the treating doctor? Yes No

Are you a specialist? Yes No

If 'Yes', what is your speciality?

2. Patient's details

1. Please advise current diagnosis?

2. Please advise of current symptoms and objective signs?

3. Please advise on prognosis

3. Doctor's Signature

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

Name and Qualifications	<input type="text"/>		
Address	<input type="text"/>		
Contact phone	<input type="text"/>	Contact email	<input type="text"/>
Signature	<input type="text"/>	<input type="button" value="Sign here"/>	Date <input type="text" value="/ /"/>

Important Note

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