

B. Medical details

1. Please describe the illness, injury or condition to which this claim relates.

2. How did your injury occur?

3. Have you ever suffered the same or similar condition?

Yes No

If 'yes', please provide details including the name and contact details of the doctor(s) you consulted.

4. On what date did you first consult a doctor in relation to your claimed condition?

5. Please provide the name and contact details of all health care providers you have consulted for your current condition. (Health care providers include doctors, psychologists, physiotherapists, chiropractors, acupuncturists etc).

6. a. Please advise the name and contact details of your usual doctor.

b. How long have you been attending this doctor?

7. What treatment are you currently receiving? (Please include treatment type e.g. physiotherapy, medication/frequency/dosage, and the name and contact details of the treatment providers).

C. Other claim details

Has a claim been made or do you intend to make a claim for your claimed condition?

ACC?

Yes No

If yes, please provide your claim details (claim number and case manager's name).

Privacy and Declaration

Privacy Act

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 true, correct and complete. I understand and agree that if I make any false or fraudulent statements or fail to advise Asteron Life Limited New Zealand of any relevant information regarding my claim, Asteron Life Limited New Zealand may refuse to pay and cancel 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 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, ACC, 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.

Member Signature

Name	<input type="text"/>		
Contact phone	<input type="text"/>	Contact email	<input type="text"/>
Signature	<input type="text"/>		Date <input type="text"/>

PART 2: Members employer form

(To be completed by the members current employer)

Thank you for taking the time to complete this form.

- Your employee is making a claim as a result of an 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
Email: ei.asteronlife@gbtpa.co.nz

Employer statement

Plan name Plan number

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?

Please advise if the member is or was working overseas, and if so where and when?

Payment instructions and signature

Asteron Life makes payments directly to a bank account account

Payee name

Account number
BANK BRANCH ACCOUNT NUMBER SUFFIX

Privacy and Declaration

Privacy Act

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 the claim.

Name of authorised employer representative

Position

Contact phone

Contact email

	Signature	Date
Signature of Employer		

Sign here