

Cancer Cover

Claim Form

Pages 1-3 to be completed by the insured person.

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 your claim.

- Please have all the policy owners sign and date the declaration page.
- Page 4 has additional space if you run out of room answering these questions, or if you need to provide any information not covered by the questions.
- We encourage you to attach supporting medical records or any other information you have that will help us in assessing your claim.

We're happy to help if you have any queries about this form. Please call us on 0800 808 101, or talk to your adviser.

A. Your details

Policy number(s)	<input type="text"/>					
Please tick one	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>	Other <input type="checkbox"/>	Please specify <input type="text"/>
Surname	<input type="text"/>		Given names	<input type="text"/>		
Home phone number	<input type="text"/>		Date of birth	<input type="text"/>		
Business phone number	<input type="text"/>		Email address	<input type="text"/>		
Mobile phone number	<input type="text"/>		Postal address (if different)	<input type="text"/>		
Residential address	<input type="text"/>			<input type="text"/>		
	<input type="text"/>			<input type="text"/>		
	<input type="text"/>			<input type="text"/>		
	Post Code			Post Code		

B. Claim Details

1. Which 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.

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 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.

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 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](#)

Policy Owner(s) 1

Full name
Date

Signature [Sign here](#)

Policy Owner(s) 2

Full name
Date

Signature [Sign here](#)

