

HEALTH INSURANCE CLAIM FORM AND/OR PRIOR APPROVAL REQUEST (please print clearly)



If you need help filling out this form please contact Sovereign on 0800 500 108

Are you applying for prior approval?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your referral letter attached? <small>(If your referral letter does not include the below, please have your doctor complete section 5 of this form)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to receive your prior approval confirmation letter by email	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please ensure your referral letter contains the following:	
Is your claim ACC related? <small>(If you answered 'Yes' please attach your ACC decision letter)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Initial consultation date	<input type="checkbox"/> History of condition
Have you attached a pre-printed bank deposit slip?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Treatment received	
		Please attach all original itemised accounts or receipts if you are claiming a reimbursement	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. Policy Owner(s) Details

Policy number

Policy Owner 1

Policy Owner 2

	First Name(s)	Last Name	First Name(s)	Last Name
Mr/Mrs/Miss/Ms	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address	<input type="text"/>		<input type="text"/>	
	<input type="text"/>		<input type="text"/>	
Telephone	Home ()		Home ()	
	Business ()		Business ()	
	Mobile ()		Mobile ()	
Email	<input type="text"/>		<input type="text"/>	
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	

2. Claimant details

Patient (claimant) details

	First Name(s)	Last Name
Mr/Mrs/Miss/Ms	<input type="text"/>	<input type="text"/>
Mailing Address	<input type="text"/>	
	<input type="text"/>	
Telephone	Home ()	Business ()
	Mobile ()	
Email	<input type="text"/>	
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	

3. Claim details

Details of the condition or symptoms which have resulted in this claim
(please be specific)

Have you claimed for this condition before?

 Yes No Claim number (if known)

Symptoms started	<input type="text"/> / <input type="text"/> / <input type="text"/>	Sought medical advice	<input type="text"/> / <input type="text"/> / <input type="text"/>
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Treatment performed/to be performed
(please delete one if not applicable)

Name of provider/facility where treatment is to be performed

Date of admission

 / /

Date of discharge

 / /

4. Declaration and consent

This application collects personal information about you and any Life Assured for whom you are claiming under your Policy for the purpose of assessing the health insurance claim(s) under your policy.

The intended recipient of this information is Sovereign Assurance Company Limited ("the Company") and the information collected will be held at the head office of the Company at 74 Taharoto Road, Takapuna, Auckland 0622.

Failure to provide this information may result in your claim being declined or unable to be assessed. You and any Life Assured have the right to request access to, and correction of, your respective personal information at any time.

I, the Policy Owner, hereby claim the benefit amounts payable on the basis of the statements and information provided by the Life Assured in this claim form which I believe to be accurate and complete in every respect. I understand payments approved by the Company will be forwarded to me on receipt of accounts specifying the service provided and the amount payable.

As part of a health insurance claim with the Company, **I, the Life Assured**, consent and give authority to the Company and any of its related companies to seek from, and for all and any of the following, their officers and employees, to disclose to the Company, their advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical or other personal information affecting such insurance which they may hold in respect of me:

- Registered Medical Practitioners and specialists;
- Accident Compensation Corporation;
- Insurers (whether public or private);
- Government departments, agencies, organisations and enterprises.
- Hospitals (whether public or private);
- Counsellors, psychologists and therapists;
- Dentists;

I agree that a photocopy of this authority will be valid as an original.

Please print full name of Claimant (Life Assured)

If a claim is being made by a child under 16 years of age, a parent or guardian must sign on the child's behalf. Please insert parent's or guardian's full name and sign below.

Signature of Claimant (Life Assured)

Date

Please print full name of Policy Owner(s)

Signature(s) of Policy Owner(s)

Date

5. Medical Certificate (please print clearly)

To be completed by a Registered Medical Practitioner or Dentist (at client's expense) if no referral letter provided

Name of client

Name and address of General Practitioner/Dentist

I confirm that I am the Patient's General Practitioner/Dentist and that I referred the Patient to the Specialist for tests, e.g. x-rays

Date of referral

/ /

How long have you been the patient's medical attendant?

Medical condition requiring treatment

Date of first medical examination by **any** Doctor/Dentist for this condition

Date of consultations

Details of first medical examination by any Doctor/Dentist for this condition and any subsequent consultations for this condition

Details of the recommended treatment/test

Is this accident related?

Yes

No

If YES, has an application been made to ACC? (please provide details including ACC Claim number below)

Signature of General Practitioner/Dentist

Date



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Request for payment (please print clearly)

When the medical services for which you are claiming are completed, please attach all original itemised accounts and list below:

Policy number	<input type="text"/>
Claim number (if known)	<input type="text"/>
Patient (Claimant)	<input type="text"/>

Return to Sovereign Assurance Company Limited
 Private Bag Sovereign
 Victoria Street West, Auckland 1142

Invoices enclosed (to be paid to provider)

Please note - payment will be made directly to the treatment provider unless receipts attached.

Provider of treatment (eg Doctors or Hospital)	Invoice Amount
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
Sum of Invoices	\$ <input type="text"/>

Receipts enclosed (for reimbursement to you)

Provider of treatment (eg Doctors or Hospital)	Receipt Amount
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	\$ <input type="text"/>
Sum of Receipts	\$ <input type="text"/>
Total value of claim (= sum of invoices + sum of receipts)	\$ <input type="text"/>

Reimbursement details (please note: reimbursement can only be made to a bank account, not a credit card)

Please provide bank account details for reimbursement. Please attach a pre printed bank deposit slip.

Name of Account			
<input type="text"/>			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bank	Branch number	Account number	Suffix

Signature(s) of Policy Owner(s)

Date / /



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