Claim Form Medical Partnersuff



Private Medical Cover

Policy number	
1.0 Life assured's details	
Title Surname	First name(s)
Male Female Date of birth / /	
Street address	Suburb
Town/city Postcode	
Postal address (if different from above)	
Email address	Business phone ()
Home phone ()	Mobile ()
2.0 Policy owner(s) details	
First owner	Second owner
	Second owner Title First name(s)
First owner	
First owner Title First name(s)	Title First name(s)
First owner Title First name(s) Surname or company name	Title First name(s) Surname or company name
First owner Title First name(s) Surname or company name Postal address	Title First name(s) Surname or company name Postal address
First owner Title First name(s) Surname or company name Postal address Town/city Postcode	Title First name(s) Surname or company name Postal address Town/city Postcode
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First owner Title First name(s) Surname or company name Postal address Town/city Postcode Email address Contact phone number () Male Female Date of birth / / a) Are you notifying a change of address?	Title First name(s) Surname or company name Postal address Town/city Postcode Email address Contact phone number () Male Female Date of birth / /

)	Claim details Please give details of the disease/disorder/condition which has resulted in this claim.		
	Please give details of your symptoms.		
	Please give the date the symptoms started.		/ /
)	Please give the date that you sought medical advice.		/ /
)	Please state the name of procedure/surgery/investigation.		
	Please give the name of the hospital/clinic where the treatment/procedure is to be undertaken.		
)	Please give the name of the specialist/surgeon who has performed or will perform the treatment or pro	ocedure.	
)	Please give the name and address of the registered medical practitioner who referred you for treatmen	t, procedure or to the ho	ospital.
Nar	me Address		
	Details of your usual GP. If different from above.		
Var	me Address		
	Please give the date of admission/procedure/surgery/investigation.		/ /
	Date of discharge.		/ /
)	Has this claim resulted from an accident or injury?		Υ
	If yes please give the date of the accident or injury.		/ /
	Have you, or are you claiming any amounts from ACC or any other insurer in relation to this procedure/ If yes please give details of the organisation/insurer and what the amounts are of the claim(s). Please attained to the claim (s) are the claim (s) are the claim (s).		Y documentation.
De	etails of organisation/insurer	Amount \$	
_			
.)	What is the estimated cost of the procedure/surgery/investigation or admission? Please attach a copy of	f the estimate if available	
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De C		Amount \$	
De 's	If your claim is accepted, please note payment will be made by direct crimportant that you complete this section properly	Amount \$	
De l.C	If your claim is accepted, please note payment will be made by direct crimportant that you complete this section properly ase pay direct into the nominated bank account below	Amount \$	
De ''s lea Acco	O If your claim is accepted, please note payment will be made by direct creimportant that you complete this section properly ase pay direct into the nominated bank account below count holder	Amount \$	

5.0 Adviser involvement

Would you like your financial adviser to be involved with the progress of your claim?

Υ	ĺ	N

6.0	Final	checklist	of c	documents	you need	to	send	to L	JS
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	Medical questionnaire section on the back page completed by your medical provider.
	Original/copy of the referral letter from your medical provider.
	Copies of other medical information in support of your claim. (Such as a report from a specialist)
	Copy of the estimate.
	Copy of the ACC letter of acceptance/decline for any accident/injury related claim.
	Copies of any receipts/invoices.

7.0 Declaration and consent

Please read and sign this declaration

This application collects personal information about you and any life assured for whom you are claiming under your policy. The intended recipient of this information is Partners Life Limited ("the Company").

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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 by contacting Partners Life on 0800 14 54 33.

Declaration

I am the policy owner and hereby claim the benefit amount 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.

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

- · Registered medical practitioners and specialists
- Dentists
- · Counsellors, psychologists and therapists
- Government departments, agencies, organisations and enterprises

- · Hospitals (whether public or private)
- Accident Compensation Corporation
- Insurers (whether public or private)
- · Credit rating and collection agencies
- Employers (whether current or not)

I agree that a photocopy, facsimile or scan of this authority will be valid as an original.

Privacy Act requirements

- This claim form and any supplementary material which may be required in connection with this claim is a collection of personal information.
- This information will be used to: assess and administer this claim; service and administer the policy; maintain relevant statistical records; and provide you with information about other products and services offered by Partners Life Limited.
- You are required to provide the medical information which has been requested so as to comply with your common law duty to disclose all matters material to the insurance.
- The information will be held by Partners Life Limited at the address on this form.
- Under the Privacy Act 1993 you have the rights of access to, and correction of, any information provided.

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide Partners Life Limited such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

Name/company name of first policy owner						Name/comp	pany nam	ne of second	d policy ov	vner					
Signature/authorised signature of first policy owner						Signature/a	uthorised	d signature	of second	policy own	er				
	Date		/	/							Dat	e [/	/	
Name of life assured															
Signature of life assured															
	Date		/	/											
Parent or guardian if life assured is under th	ie age of	f 16.													
Name of parent or guardian															
Signature of parent or guardian															
	Date		/	/											

Partners Life Limited Private Bag 300995, Albany Auckland 0752 New Zealand 0800 14 54 33 partnerslife.co.nz

How long has the patient been under your care? Months Years Do you hold all medical records for the last five years? If no please give details of the previous doctor(s) if known. Name Address What is the medical condition or suspected condition requiring treatment or investigation? Please also provide the ICD 10 reference code. When did the signs and/or symptoms of this condition become apparent to the life assured for the very first time? // When did the life assured first consult with a medical professional including you or your practice in regards to this condition? // If yes please give the date the accident or injury or symptoms of this condition occurred. // How often has the life assured consulted a medical practitioner regarding this condition? Please give dates. Name of medical practitioner Date // / Has the life assured consulted you, or any other treatment provider for any other symptoms or conditions	Policy number			
To the medical attendant: The above life assured is claiming a private medical benefit from Partners Life Limited and we require the following information from you, as the registered medical practitioner for the life assured, in order to assess this claim as quickly as possible. Thank you for your assistance. Octoar/dentist die Surrame Partners Life Limited and we require the following information from you, as the registered medical practitioner for the life assured, in order to assess this claim as quickly as possible. Thank you for your assistance. Octoar/dentist die Surrame Partners Life Limited Life Life Life Life Life Life Life Life				
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How long has the patient been under your care? How long has the patient been under your care?	itle	Surname	First name(s)	
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that may be associated with the condition they are claiming for?				
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	Please attach a copy of the referral letter and the specialist report received in response.
j)	Please give details of any other treatment options that have been, or may be considered.
	Declaration • I declare that the above information, and other information supplied by me in relation to this form, is true and correct and that no information
	relevant to the life assured has been omitted from this form.
	 I declare that I am registered as a medical practitioner with the Medical Council of New Zealand and am not the patient, the policy owner or either of their respective partners or relatives.
	• I consent and authorise Partners Life Limited to disclose to its associated companies, advisers, reinsurers or any other party authorised by the life assured, any information provided by me in connection with this form for any of the purposes authorised by the life assured.
	Signature of doctor/dentist
	Date / /

Partners Life Limited Private Bag 300995, Albany Auckland 0752 New Zealand 0800 14 54 33 partnerslife.co.nz

i) Please give date of referral to specialist.