OnePath
a company of ANZ

Major Medical Cover Claim Form

Policy number ☐☐☐☐☐☐

1 Policy Owner's name(s) and postal address

Mr/Mrs/Miss/Ms | Last name(s) | First name(s)

Postal address

Town/city

Home phone ( )

Business phone ( ) Mobile phone ( )

Email

Are you applying for Prior Approval? Yes ☐ No ☐

If **yes**, date of procedure/surgery /investigation or expected admission. DD / MM / YYYY

2 Life Assured's detail (or if as above please tick) ☐

Mr/Mrs/Miss/Ms | Last name | First name(s)

Home address

Town/city

Home phone ( ) Business phone ( )

Date of birth DD / MM / YYYY Mobile phone ( )

3 Claim details (For completion by the Life Assured)

(a) Details of the disease/disorder/condition which has resulted in this claim.

(b) Please give details of your symptoms.

(c) Date symptoms started DD / MM / YYYY

(d) Date sought medical advice DD / MM / YYYY

(e) Name of procedure/surgery/investigation.

(f) Name of hospital/clinic.

(g) Name of specialist/surgeon who has performed or will perform the procedure.

Important Information

All Major Medical Cover is insured by nib nz limited. OnePath continues to administer Major Medical policies on nib's behalf until further notice.

(h) Name and address of the Registered Medical Practitioner who referred you for treatment, procedure or hospital.

(i) Details of your usual GP (if different).

(j) Date of admission/procedure/surgery/investigation. DD / MM / YYYY

Date of discharge. DD / MM / YYYY

(k) Has this claim resulted from an accident/injury? Yes ☐ No ☐

Date of accident/injury DD / MM / YYYY

(l) Have you or are you claiming any amounts from ACC or any other insurer in relation to this procedure/surgery/investigation? Yes ☐ No ☐

(m) If **yes**, what are the details of the organisation/insurer and what are the amounts of the claim(s)?

(Please attach copies of the relevant documentation)

(n) Estimated cost of procedure/surgery/investigation or admission?

(Please attach a copy of the estimate if available)

4 If your claim is accepted, please indicate how you want this claim paid:

Please pay direct to my/our bank account (attach a pre-printed deposit slip) ☐

OR Bank account number

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Bank Branch Account number Suffix

Account name

Pay the provider directly ☐

Please post a cheque to the Policy Owner(s) ☐

5 Checklist before sending to OnePath Life (NZ) Limited, Private Bag 92131, Victoria St West, Auckland 1142

- ☐ Has the medical questionnaire section on the back page been completed by the GP/Dentist?
- ☐ Have you attached an original/copy of the referral letter from GP/Dentist.
- ☐ Have you attached any other medical information in support of your claim(such as report from the specialist)?
- ☐ Have you attached a copy of the estimate?
- ☐ Have you attached the ACC letter of acceptance/decline for any accident/injury related claim?
- ☐ Have you attached an original/copy of any receipts/invoices.

6 Declaration and consent

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 nib nz limited and to the extent required to administer your claim on behalf of nib nz limited, OnePath Life (NZ) Limited collectively "the companies".

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.

Declaration

I am the Policy Owner and 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 my approved claim payments will be forwarded to me on receipt of accounts specifying the service provided and the amount payable.

As part of a medical insurance claim, I, the Life Assured, consent and give authority to the companies to seek from, and for all and any of the following, their officers and employees, to disclose to the companies, 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 & Collection Agencies.
- Employers (whether current or not).

I agree that a photocopy 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 OnePath Life (NZ) Limited or nib nz 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 OnePath Life (NZ) Limited at 9-11 Corinthian Drive, Albany and nib nz limited at 48 Shortland Street, Auckland.
- Under the Privacy Act 1993 you have the rights of access to, and correction of, any information provided.

Full name(s) of Policy Owners

Signature(s) of all Policy Owners

Date DD / MM / YYYY

Date DD / MM / YYYY

Full name of 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 name of Life Assured

Date DD / MM / YYYY

7 Major Medical doctor's questionnaire (to be completed by a registered medical practitioner or dentist at client's expense)

Full name of Life Assured

Explanation: the above Life Assured is claiming a Major Medical benefit 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.

Doctor/Dentist name:

Address:

Phone:

Facsimile:

(a) How long has the patient been under your care?

(b) Do you hold all medical records for the last 5 years?
If **No**, please provide details of the previous Doctor(s)/Dentist(s) (if known) Yes ☐ No ☐

(c) What is the medical condition or suspected condition requiring investigation or treatment?
Please also provide the ICD 10 reference CODE:

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(d) When did the signs and/or symptoms of this condition become apparent to the Life Assured for the very fist time?
Please specify date(s).

(e) When did the Life Assured first consult with a medical professional including you or your practice in regards to this condition?

(f) Is this claim accident/injury related? Yes ☐ No ☐

If **yes**, on what date did the accident/injury or symptoms of this condition occur? DD / MM / YYYY

(g) How often has the Life Assured consulted a medical practitioner regarding this condition? Please state date(s).

(h) Has the Life Assured consulted you, or any other treatment provider for any other symptoms or conditions that may be associated with the condition they are claiming for? If **yes** please provide details. Yes ☐ No ☐

(i) Date of referral to Specialist.
(Please attach a copy of the referral letter & the specialist report received in response) DD / MM / YYYY

(j) Please give details of any other treatment options that have been or may be considered.

Doctor/Dentist signature: Date: DD / MM / YYYY

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 both nib nz limited and OnePath Life (NZ) 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.

Important Information
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OnePath Life (NZ) Limited (OnePath)
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