Health Insurance Claim Form and / or Prior Approval Request (please print clearly)

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

Are you applying for prior approval? ☐ Yes ☐ No

Would you like to receive your prior approval confirmation letter by email ☐ Yes ☐ No

Is your claim ACC related? (If you answered 'Yes' please attach your ACC decision letter) ☐ Yes ☐ No

Have you attached a pre-printed bank deposit slip? ☐ Yes ☐ No

Is your referral letter attached? (if no referral letter, please have your doctor complete section 5 of this application) ☐ Yes ☐ No

Please ensure your referral letter contains the following:
☐ Initial consultation date ☐ History of condition
☐ Treatment received

Are all original itemised accounts or receipts attached if you are claiming a reimbursement? ☐ Yes ☐ 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				
Mailing Address				
Telephone	Home ( )		Home ( )	
	Business ( )		Business ( )	
	Mobile ( )		Mobile ( )	
Email				
Date of birth	/ /		/ /	

2 Claimant details

Patient (claimant) details (if different from above)

	First Name(s)	Last Name	
Mr/Mrs/Miss/Ms			
Mailing Address			
Telephone	Home ( )	Business ( )	Mobile ( )
Email			
Date of birth	/ /		

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 / / Sought medical advice / /

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 / /

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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, North Shore City 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;
- Hospitals (whether public or private);
- Dentists;
- Accident Compensation Corporation;
- Counsellors, psychologists and therapists;
- Insurers (whether public or private);
- Government departments, agencies, organisations and enterprises.

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

Please print full name of Claimant

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 Life Assured

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 / /

Details of first medical examination by any Doctor/Dentist for this condition | Date of consultations

	/ /
	/ /
	/ /
	/ /

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

Claim number (if known)

Patient (Claimant)

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
	$
	$
	$
	$
Sum of Invoices	$

Receipts enclosed (for reimbursement to you)

Provider of treatment (eg Doctors or Hospital)	Receipt Amount
	$
	$
	$
	$
Sum of Receipts	$
Total value of claim (= sum of invoices + sum of receipts)	$

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

Bank | Branch number | Account number | Suffix

Signature(s) of Policy Owner(s)

Date of birth / / / /

00443-10/09

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