# Kids Claim Form

**Pages 1 – 4 to be completed by the legal guardian.**

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.

- This form should be completed by the parent / legal guardian of the insured child.
- You can nominate someone else for us to deal with during the claim process, but the policy owner will need to sign the relevant documentation.
- Please complete all sections as requested.
- Pages 5 – 6 provide additional space if you run out of room answering these questions, or 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. Child's details

Policy number(s)

*Please tick one* Miss ☐ Master ☐ Other ☐ *Please specify*

Surname

Given names

Residential address

Post Code

Date of birth

## B. Who is completing this form

*Please tick one* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ *Please specify*

Surname

Given names

Relationship to insured child

Home phone number

Work phone number

Mobile phone number

Email address

Residential address
(if different from child)

Post Code

Postal address
(if different from residential)

Post Code

SUNCORP
PART OF SUNCORP NEW ZEALAND

## C. Authorised contact person (if different from above)

*Please tick one* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ *Please specify*

Surname

Given names

Relationship to insured child

Home phone number

Work phone number

Mobile phone number

Email address

Residential address

Post Code

Postal address (if different from residential)

Post Code

## D. Claim details

1. What condition are you claiming for? (Please refer to your Policy Document for a full list of conditions covered)

2. a. If a **sickness**, when were the first symptoms noticed?

   b. Please describe these symptoms.

3. If an injury, when, where and how did it happen?

4. Has your child ever suffered from this condition or related condition(s) before?..... Yes ☐ No ☐
   *If 'yes' please provide all dates and details.*

| Dates | Specific Details |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

5. Has your child consulted any doctors/specialists with regard to these previous conditions?..... Yes ☐ No ☐
*If 'yes' please provide details.*

| Name | Address and phone number |
|---|---|
| | |
| | |
| | |
| | |

## E. Medical details

6. a. Please provide the date of the first consultation for your child's current condition and the result.

b. Please name the doctor(s)/specialist(s) your child consulted and provide contact details.

7. Please give dates of all investigations and treatments including medication, provided by your child's attending doctors for this condition.

| Dates | Treatment | Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Feedback, comments and suggestions

If there is anything more we can do to assist you during this time, please let us know in this section.

# F. Payment Details

If your claim is accepted, your payment will be made by direct credit. Please provide your bank account details below:

Account name

Account number

BANK BRANCH ACCOUNT NUMBER SUFFIX

Name of Bank and Branch

Signature of Account Holder(s) Sign here

Sign here

Please print name(s)

# Privacy Act 1993

This information is being collected and will be held by Asteron Life Limited ('Asteron Life'). It is intended for use by Asteron Life employees who require access to this information for administering your claim and policy. Under the Privacy Act 1993 you are entitled to request access to and request correction of any personal information about your child held by Asteron Life Limited. If you do not supply the information sought your claim may be declined.

In assessing and managing your claim we may need to disclose your child's personal information to other parties such as claims assessors, loss assessors, reinsurers, medical and financial professionals, judicial or dispute resolution bodies and Suncorp companies.

## 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 with the consent of the individual to whom it relates I confirm that I have the authority to act on behalf of the persons 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 Limited of any relevant information regarding my claim, Asteron Life Limited may refuse to pay and cancel my claim. I understand that I can be prosecuted if I make any fraudulent statements.

I hereby declare that I am the parent/legal guardian of,

a minor, and am duly authorised to act on their behalf.

## Medical and Information Authority

I hereby authorise any dentist, hospital, doctor or other person who has attended my child, to release to Asteron Life Limited 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 Limited or its representatives, all information which Asteron Life Limited 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.

**Policy Owner(s) 1**

Full name Signature Sign here

Date

**Policy Owner(s) 2**

Full name Signature Sign here

Date

**Witness**

Full name Signature Sign here

Date

**Asteron Life**
Level 13 Asteron Centre, 55 Featherston Street, PO Box 894, Wellington 6140, NZ
Ph: **0800 737 101** (Contact Centre hours: Mon–Fri 8am–6pm)
Fax: 0800 246 067 Email: claims@asteronlife.co.nz Web: asteronlife.co.nz

# Additional Information