Total and Permanent Disablement

Claim Form

Pages 1–4 to be completed by the insured person and pages 7–10 to be completed by the treating doctor.

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.

- Please have all the policy owners sign the declaration page.
- It is your responsibility to pay for any costs that might arise from the completion of the Treating Doctor's report.
- Page 5 and 6 have additional space if you run out of room answering these questions, or if you 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. Your details

Policy number(s)

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

Surname

Given names

Home phone number (0)

Date of birth

Mobile phone number (0)

Email address

Current home address

Fax number (0)

Post code

Important: Your duty of disclosure

You are required to advise Asteron Life of all information that may affect our assessment of your claim, including:

- health conditions,
- entitlement to monies,
- activities and work undertaken, and
- any changes in your circumstances when you are claiming benefits.

If you need assistance completing this form, please call us on 0800 808 101 or your adviser.

B. Condition

1. What condition are you claiming for? (Please give us as many details as you can)

2. What date were you first treated by a Doctor for this condition?

3. Describe your symptoms: (If an arm or leg is affected, please write left or right)

SUNCORP
PART OF SUNCORP NEW ZEALAND

4. When did you first experience these symptoms?

5. Have you ever had similar symptoms at any time in the past? ..... Yes ☐ No ☐
If 'yes' please provide details and dates of the doctor or hospital that treated you.

Dates	Specific Details	Doctor/Hopsital

C. Treatment

6. a. Please advise the date you were first treated for this condition.

b. Please advise the name, address and phone number of the doctor that treated you.

c. If this is not your usual doctor please give the name, address and phone number of your usual doctor.

7. Have you seen any other doctors about your condition? ..... Yes ☐ No ☐
If 'yes' please give names and addresses.

Doctor	Address

8. What treatment have you received for your condition?

9. What investigations/tests have you had? (e.g. x-rays, blood tests, ECG's, etc.)

Dates	Tests	Results

10. Do you have medical insurance?..... Yes ☐ No ☐
If 'yes' please provide details.

11. Please advise contact details of your previous doctor(s) and the approximate date of the last consultation for each doctor:

Details	Doctor	Contact Details

D. Occupation

Employer or Business name

Employer or Business address

Post code

Employer's phone number (0)

12. Please advise your usual occupation before your accident/sickness:

13. Please describe your work duties, including percentage of time spent performing each duty:

Duty	Percentage of time over a week %

14. Were you: *Please tick one*

☐ self-employed ☐ a salaried employee ☐ employed by a family company

☐ unemployed Date unemployed from Date unemployed to

Please provide details below.

15. What specific duties are you unable to perform now?

16. When did you first become unable to perform these duties?

17. Have you returned to work either on a full or part time basis? ..... Yes ☐ No ☐
If 'yes' please give details below.

Date	Duties performed	Hours worked

18. Are you currently undertaking any occupational duties at all? ..... Yes ☐ No ☐
If 'yes' please provide details below.

19. Have you ever made a claim under ACC or a disability policy before?..... Yes ☐ No ☐
If 'yes' please provide details below.

20. Please provide a list of any previous occupations and the approximate dates you performed each:

Occupation	Approximate dates

Privacy Act 1993

This information is being collected and will be held securely 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 you held by Asteron Life. 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 personal information to other parties such as claims assessors, loss assessors, reinsurers, medical and financial professionals, judicial or dispute resolution bodies, joint venture partners and Suncorp Group 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 it is with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the person as 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 of any relevant information regarding my claim, Asteron Life may refuse to pay my claim. I understand that I can be prosecuted if I make any fraudulent statements.

I hereby authorise any dentist, hospital, doctor or other person who has attended me, to release to Asteron Life Limited ("Asteron Life") 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 the Accident Compensation Corporation, any insurer, adviser/broker, accountant, institution, employer, business entity, medical institution, professional board or company, legal professional or entity, to release to Asteron Life or its representatives, all information which Asteron Life 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.

Medical and Information Authority

Person Insured

Full name _____ Signature _____ Sign here

Date _____

Policy Owner(s) 1

Full name _____ Signature _____ Sign here

Date _____

Policy Owner(s) 2

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

Total and Permanent Disablement

Treating Doctor Form

To be completed by the treating doctor.

Thank you for taking the time to complete this form.

- Your patient is making a claim as a result of sickness or injury.
- So that we can accurately assess the claim, we would appreciate you filling out this form in as much detail as possible and returning it to the patient.
- **The patient will pay any fee you may charge for this service.**

Regards,
Asteron Life Claims Team
Freephone Number: 0800 808 101

A. Patient details

Surname

Given names

Date of birth

Occupation

B. Condition

1. Is the present condition the result of: *Please tick one*

   ☐ sickness ☐ accident

2. What is your current diagnosis?

3. What are your patient's current symptoms and objective signs?
   Please describe these symptoms and signs below.

4. What tests have been performed? Please provide a copy of all results.
   Please provide test details below.

5. What treatment (including medication and dosage) is being administered?
   Please include details of the current treatment plan below.

6. What is your prognosis?

C. Medical history

7. Are you the insured's usual doctor? ..... Yes ☐ No ☐
If 'yes' please advise for how long and from what date you have records for your patient?

8. Have you treated this patient before for any sickness or injury? ..... Yes ☐ No ☐
If 'yes' please give dates and nature of sickness or injury.

9. Does your patient have a history of the same or similar sickness or injury, or any sickness or injury likely to be connected with the current condition? ..... Yes ☐ No ☐
If 'yes' please provide full details.

D. Current treatment

10. When did you first see your patient for the current condition?

11. How often have you seen your patient for this condition?

☐ weekly ☐ monthly ☐ Other *(please give details below)*

12. Do you expect to see your patient again for the current condition? ..... Yes ☐ No ☐
If 'yes' please state approximately when below.

13. Have you referred your patient to other doctors for further opinion, investigation or treatment? ..... Yes ☐ No ☐
If 'yes' please provide the dates and details below and send us copies of all reports.

Dates	Practitioner	Contact details

14. Was your patient admitted to hospital for this condition? ..... Yes ☐ No ☐
If 'yes' please give details and copies of discharge papers.

E. Occupation

15. Please list your patient's occupational duties:

16. Which specific occupational duties is your patient able to perform?

17. How many hours per week are they able to perform these duties?

18. Which specific occupational duties is your patient unable to perform and why not?

19. What date was your patient unfit to perform their occupation?

20. How has their work capacity changed since this date?

21. When do you consider the patient will be able to resume?

- ☐ Full time duties
- ☐ Part time duties (more than 10 hours a week)
- ☐ Lighter or different duties

22. To the best of your knowledge when did your patient last participate in work – paid or unpaid, full time or part time?

23. Have you given any information or report regarding the patient's present condition to any of the following:

any other insurance company	Yes ☐	No ☐
ACC	Yes ☐	No ☐
the patient's employer	Yes ☐	No ☐
WINZ	Yes ☐	No ☐
Superannuation fund or group scheme	Yes ☐	No ☐
any other source	Yes ☐	No ☐

24. Are you aware of any non medical factors that may be affecting your patients ability to return to work? ..... Yes ☐ No ☐

If 'yes' please provide detail below.

Important Note

When returning this form, please **send copies of the following:**

- All consultation notes regarding the current condition including when symptoms were first noticed
- Your original referral to the specialist – if applicable
- All specialist reports on file
- Any hospital notes on file e.g. hospital discharge summaries

I agree that I have personally examined the patient at the time of completing this report, and that all the information I have given in this report is true and correct.

Full name

Signature

Sign here

Date

Phone number (0)

Address

Post code

Doctors stamp