Public Hospital Surgical Grant

nib

To be completed by the Policyowner

Policy number

1.0 Your details

Contact details

Full name

Home phone ( )

Mobile ( )

Fax ( )

Email

Address details

Street number

Street name

Suburb

Town / City and postcode

Country

2.0 Refund

Enter your bank account number to have a refund directly credited to your account

Name on account

Account number

Name of bank

Name of branch

2.1 Discharge summary

Name of patient

Date of birth d d m m y y y y

Date of admission d d m m y y y y

Date of operation / treatment d d m m y y y y

Date of discharge d d m m y y y y

Operation / treatment performed

What was the underlying condition that made the surgery / treatment necessary?

Please attach the discharge summary ◯ Attached

3.0 Privacy Act Requirements

Privacy Act 1993 and Health Information Privacy Code 1994

nib is collecting information about you or anyone named in this form to evaluate, administer and assess your benefits. We may be required to disclose an insured person's personal information to:

- Other nib companies.
- Your financial adviser.
- Health service providers including private health insurers, recognised private hospitals and public hospitals, doctors and medical specialists, and professional medical authorities, including the ACC and the Ministry of Health.
- Our contractors and service providers performing services including (but not limited to) legal services, mail house services and product development services.
- Our existing and future strategic partners in respect of co-branded covers and services.

You have the right to access and correct your personal information under the Privacy Act 1993 and the Health Information Privacy Code 1994. If you believe that any personal information we hold is not accurate, complete or up-to-date, you should contact us immediately. The information is being collected and held by nib whose contact details are set out at the bottom of this page.

Signature

Each policyowner and insured person signing below declares that:

- All the information given by them is true, correct and complete.
- If you have provided information on behalf of another person, you confirm that you are authorised to do so.

Full name	Date	Signature
Patient name	d d m m y y y y	
Policyowner (if different)	d d m m y y y y	

Sign here

PHGS 10-13

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