Claim

Policy number

partners life

Private Medical Cover

Adviser involvement

Would you like your financial adviser to be involved with the progress of your claim? Yes ☐ No ☐

1.0 Life assured's details

Name

Mr ☐ First name

Mrs ☐ Middle name(s)

Miss ☐ Surname

Ms ☐ Previous name

Dr ☐ Male ☐ Female ☐ Date

Postal address and contact details

Number

Street name

Rural delivery no. Suburb

Town/City Postcode

Email address

Home phone

Mobile phone

2.0 Claim details

a) Are you applying for prior approval? Yes ☐ No ☐

If **yes,** please give the date of expected treatment or procedure.

b) Please give details of the symptoms/disease/disorder/condition which has resulted in this claim.

c) Please state the name of procedure/surgery/investigation.

d) Please give the date the symptoms started. Date

e) Please give the date you sought medical advice. Date

f) Please give the name and address of the registered medical practitioner who referred you for treatment, procedure or to the hospital.

Name

Address

g) Details of your usual GP (if different from above).

Name

Address

3.0 If your claim is accepted, please tick one of the following payment options.

a) Reimburse the Medical Practitioner directly? Yes ☐

b) Direct credit into the account below Yes ☐

It's important that you complete this section properly. Please pay direct into the nominated bank account below.

Account holder

Bank/building society name

Bank Branch Account number Suffix

(Please attach an encoded deposit slip to ensure your number is loaded correctly)

4.0 Declaration and consent

Please read and sign this declaration.

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 Partners Life Limited ("the Company").

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 by contacting Partners Life on 0800 14 54 33.

Declaration

I am the policy owner and hereby claim the benefit amount 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.

As part of a medical insurance claim with the company, I, the life assured, consent and give authority to the company to seek from, and for all and any of the following, their officers and employees, to disclose to the company, 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 and collection agencies
- Employers (whether current or not)

I agree that a photocopy, facsimile or scan 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 Partners Life 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 Partners Life Limited at the address on this form, and/or by Partners Life's data storage providers, which includes cloud-based data storage providers (both in New Zealand and overseas).
- Under New Zealand privacy law, you have the rights of access to, and correction of, any information provided.

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide Partners Life Limited such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

Name/company name of first policy owner

Signature/authorised signature of first policy owner

Date

Name/company name of second policy owner

Signature/authorised signature of second policy owner

Date

Name of life assured

Signature of life assured

Date

Parent or guardian if life to be assured is under the age of 16.

Name of parent or guardian

Signature of parent or guardian

Date

5.0 Policy owner(s) details

a) Has your postal address changed? Yes ☐ No ☐

b) If yes, do you want Partners life to update your records? Yes ☐ No ☐

c) If yes, please provide your new postal address

Number

Street name

Rural delivery no.

Suburb

Town/City

Postcode

6.0 Registered Medical Practitioner questionnaire (To be completed at the client's expense)

Policy number

Life assured

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

First name

Middle name(s)

Surname

Date of birth

To the Registered Medical Practitioner:

The above life assured is claiming a private medical benefit from Partners Life Limited 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.

Registered Medical Practitioner

Title

First name(s)

Surname

Business phone

Address

Email address

Facsimile

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

Months

Years

b) Do you hold all medical records for the last five years? Yes ☐ No ☐

If **no,** please give details of the previous doctor(s) if known.

Name

Address

Name

Address

c) What is the medical condition or suspected condition requiring treatment or investigation?

d) When did the signs and/or symptoms of this condition become apparent to the life assured for the very first time? Date

e) When did the life assured first consult with a medical professional including you or your practice in regards to this condition? Date

f) What is the name and address of the treatment provider?

g) Please give date of referral to the treatment provider.
Please attach a copy of the referral letter.

Date

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 Partners Life 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.

Signature of registered medical practitioner

Date

Scan and email to claims@partnerslife.co.nz or post to:
Partners Life Limited. Private Bag 300995, Albany, Auckland 0752, New Zealand