# Health Insurance Claim Form

**Health insurance claim form and/or prior approval request**

## 1 Details

Policy number

Please tick one of the boxes to explain what you are applying for:

- ☐ Prior approval (application for a future surgery or procedure - please also attach estimate of costs)
- ☐ Payment for a claim already prior approved — # ____ Claim number
- ☐ Payment for a new claim not prior approved

Is your treatment within the next 5 days? ☐ Yes ☐ No

## 2 Who is this claim for?

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname ____ First name ____

Date of birth ____ / ____ / ____ Best contact phone number ( )

Email address

Postal Address

Street

Suburb

City ____

## 3 Claim details

**Please provide a referral letter from your GP or Dentist containing the first consultation date for this condition by any medical practitioner and the history of condition or treatment. If you do not have this, please have a GP or Dentist complete Appendix A.**

Have you claimed for this condition before? ☐ No ☐ Yes ____ Claim number (if known)

Symptoms started ____ / ____ / ____ Sought medical advice ____ / ____ / ____

Details of symptoms/conditions

Medical service required

Name of provider/facility

Date of admission ____ / ____ / ____ Date of discharge ____ / ____ / ____

Do you have a health policy with another provider you could claim on for this condition? ☐ Yes ☐ No

Is this condition ACC related? ☐ Yes, please attach decision letter from ACC regarding this condition. ☐ No

## 4 Authority for Information

As part of an insurance claim with AIA, I consent and give authority to AIA and any of its related entities and agents to collect, use and disclose, any medical, financial or other personal information about the life assured for the purposes of assessing and managing the insurance claim.

This information may be collected from/disclosed to external agencies and service providers ('agencies') for the above purpose including:

- Registered medical practitioners and Specialists (which may, where required, include an entire copy of my/our medical file)
- Medical laboratories and testing facilities
- Accident Compensation Corporation, governmental departments or bodies
- Advisers
- Insurers or reinsurers (whether public or private)
- Any other person or organisation which holds information which is relevant to my insurance or the assessment of my claim.

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following :

I consent to the disclosure of my claims information to ASB for the purposes of notifying ASB of issues or disputes arising in respect of my claim ☐ Yes ☐ No

## 5 Acknowledgement

I acknowledge, understand and agree that:

- In the collection, disclosure, use and storage of information, AIA will at times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.
- The supply of the information gathered from the above sources is voluntary and that AIA may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on the insurance. I understand that the personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.
- That in collecting information relevant to assessing and managing the insurance claim, AIA may receive/collect information that is not relevant to that purpose (for example where the life assured's entire file is provided) and that AIA will only use/disclose the relevant information and not any other.
- AIA may share my claim details with related insurers to enable co-ordination of claim resolution.
- The personal information will be stored at AIA's head office, 74 Taharoto Road, Takapuna and by AIA's data storage providers, including cloud-based data storage providers (whether New Zealand or elsewhere). I understand that AIA will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).
- Access to and correction of the personal information may be requested by me.
- AIA may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities.
- Medical information can be included in the emails sent to the email address detailed on this claim form or subsequent addresses I provide to AIA claims.
- Financial information, along with any subsequent payment details can be sent to the email address detailed on this claim form or subsequent addresses I provide to AIA claims.

## 6 Declaration - important, please read carefully

I declare that all medical information pertaining to me and relevant to my insurance claim has been provided and disclosed to AIA, and understand that making any false or fraudulent claim could result in cancellation of my policy and/or oblige me to repay any claims.

I further understand that the medical information provided is the basis on which AIA will assess and manage my claim and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed.

I declare that all the answers to questions in this form are true and complete. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I further agree that a digital copy of this authority will be valid as an original.

Please print full name of person claiming

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 or guardian's full name and sign below.

Signature of person claiming | Date / /

Please print full name of policy owner

Signature of policy owner | Date / /

**AIA House,**
74 Taharoto Road,
Takapuna,
Auckland 0622

**Private Bag AIA,**
Victoria Street West,
Auckland 1142

**Freephone** 0800 500 108
**Freefax** 0800 500 196
**Email** healthclaims@sovereign.co.nz
**Web** www.aia.co.nz

# Health Insurance Payment Form

## Health insurance payment form and/or claim

This form can only be used for Health Insurance claims. Page 3 is to be completed once treatment/procedure is complete and payment is required.

| | |
|---|---|
| Policy number | |
| Claim number | |
| Claimant name | |

### 1 Refund for claims

Please provide a copy of accounts or invoices (and receipt, if paid).
Payment will be made directly to the bank account you provide in section 9 below unless you elect have payment directly to provider by ticking the right-hand column of this section.

| Provider | Amount | Pay to provider (tick) |
|---|---|---|
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |
| | $ | Yes |

### 2 Account details

(Please note: Reimbursement can only be made to a bank account, not a credit card).

If we haven't paid into this account before please provide evidence of bank details such as a printed bank statement.

Please provide bank account details for reimbursement.

Name of account

| | Bank | | Branch | | Account number | | Suffix |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Signature of Bank Account Holder

Date / /

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# Health Insurance Medical Information Form

## Complete by GP or Dentist

This form can only be used for Health insurance claims. Page 4 is only to be completed if a referral letter does not confirm the history of this condition. This information is required for AIA to complete assessment of your claim, this must be completed by your GP or Dentist.

### A Appendix A - Medical Certificate

To be completed by a GP or Dentist (at client's expense) if a complete referral letter is not provided.

**Policy Number**

**Name of client**

Mr/Mrs/Miss/Ms/Mx

Surname | First name

**Name and address of GP/Dentist**

Mr/Mrs/Miss/Ms/Mx/Dr

Surname | First name

Mailing address

Address — Street

Suburb

City

I confirm that I am the Patient's GP/Dentist and that I referred the Patient to the Specialist for tests, e.g. x-rays — Yes / No — / / Date of referral

How long have you been the patient's medical attendant? — years — months

Do you hold their previous medical records? — Yes / No

Medical condition requiring treatment

Date of first medical examination by any GP/Dentist for this condition and any subsequent consultations for this condition — / /

Details of the recommended treatment/test

Is this accident related? — Yes / No

If yes, has an application been made to ACC? — No / Yes — Please provide details including ACC number

Signature and stamp of GP/Dentist — Date / /

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