

# Accidental Injury Claim Form



## Guide to completing this claim form

To help us process your claim in a timely manner, please ensure that you have completed all the relevant sections of this form and attached all the required information.

**Step 1** Complete all the relevant sections of this form.

**Step 2** Attach the following documents:

- A copy of your Hospital Admission and Discharge Summary
- Evidence of the injury such as X-ray Report or GP notes
- Any other medical information which will assist in the assessment of your claim
- (ONLY if you want your claim payment made to a different bank account to the one your premiums are deducted from), an encoded bank deposit slip or a signed verification of the bank account number from your bank showing the account number.

**Step 3** Send your completed form and documents in the postage-paid envelope enclosed.

## 1 Life Assured's details Complete this section for all claims.

Policy number	<input type="text"/>	Claim number	<input type="text"/>
Full name	<input type="text"/>		
Street	<input type="text"/>	Suburb	<input type="text"/>
City	<input type="text"/>	Postcode	<input type="text"/>
Home phone	<input type="text"/>	Mobile	<input type="text"/>
Work phone	<input type="text"/>	Date of birth	<input type="text"/>
Email address	<input type="text"/>		

## 2 Injury details Please complete the following details as accurately as possible.

1. Date of injury	<input type="text"/>
2. What is your current diagnosis/condition?	<input type="text"/>
3. Please advise how the injury happened and what injuries were suffered	<input type="text"/>
4. Your current GP details	
Name	<input type="text"/>
Medical practice	<input type="text"/>
Address Street	<input type="text"/>
Suburb	<input type="text"/>
City	<input type="text"/>
Postcode	<input type="text"/>
Telephone	<input type="text"/>
Fax	<input type="text"/>

## 3 Optional Hospital Cash Benefit Complete this section only if you are claiming under this benefit

Name of hospital	<input type="text"/>		
Date of admission	<input type="text"/>	Date of discharge	<input type="text"/>

#### 4 Claim payment

Please confirm the bank account details you would like your claim payment paid to.

If this bank account is different to the one your premiums are deducted from, please also enclose an encoded bank deposit slip or a bank-signed verification of the bank account number.

Name of Bank

Bank account name

Bank account number

Bank	Branch number	Account number	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name of Policy Owner

Signature of Policy Owner

Date

/ /

Name of Policy Owner

Signature of Policy Owner

Date

/ /

#### 5 Declaration and Consent (to be completed by the Life Assured)

This claim form collects personal information about you, the Life Assured, for the purpose of assessing your insurance claim under the policy.

The intended recipient of this information is AIA New Zealand Limited ("AIA") and/or any of its related entities, their officers, their advisers, their agents and reinsurers and the information collected will be held at AIA's Auckland office, 74 Taharoto Road, Takapuna, Auckland and by AIA's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). AIA will take reasonable steps to keep such information secure. I understand that AIA may share my claims details with related insurers to enable co-ordination of claims resolution. AIA may be required to disclose personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. You have the right to request access to, and correction of, your personal information at any time.

As part of an insurance claim with AIA, I, the **Life Assured**, consent and give authority to AIA and any of its related entities and agents to seek from, and for all and any of the following, their officers and employees, to disclose to AIA, their advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical or other personal information affecting such insurance which they may hold in respect of me:

- > registered medical practitioners and specialists;
- > laboratories;
- > dentists;
- > hospitals (whether public or private);
- > Accident Compensation Corporation;
- > insurers (whether public or private);
- > government departments, agencies, organisations and enterprises;
- > counsellors, psychologists and therapists;
- > your adviser/broker/insurance agent;
- > accountants and other financial advisers;
- > banks and other financial institutions;
- > employers (whether current or not);
- > any other person or organisation which AIA reasonably considers may hold information about me relevant to this claim.

I, the **Life Assured**, declare that all the answers to the questions in this claim form are true and complete and disclosed in the utmost good faith and that the occupational, financial and medical information pertaining to me has been provided and disclosed to AIA. I understand that failure to provide the requested information or provision of incorrect information may result in my claim being declined and/or unable to be assessed and/or my policy being cancelled. If any answer is not in my handwriting I declare that this has been written down at my dictation.

(continued on next page)

I, the **Life Assured**, agree that a photocopy of this authority will be as valid as an original.

Full name of Life Assured

Signature of Life Assured

Date

/ /

**6 Consent to disclose personal information**  
(to be completed by the Life Assured)

If you would like to authorise AIA to give details about you and your claim to any other person e.g. your spouse or another family member, you **MUST** complete the section below.

Full name of person(s) information is to be released to

Their address

Street

Suburb

Town/City

Postcode

**Authorisation**

I authorise AIA to release any of my personal information, and to discuss any details of my claim, including medical or financial details, with the above named person.

Full name of Life Assured

Signature of Life Assured

Date

/ /

I consent to AIA sharing information regarding my claim with ASB Bank Limited

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