Premium Cover Benefit Claim Form

nib

Note: Please complete all of this form. Medical information provided is at the expense of the insured.

1.0 About your policy

Policy number

2.0 Details of insured person (to be completed by the insured)

Date of birth d d m m y y y y

Contact details	Address details
Name	Street / Box number
Phone ( )	Street name
Mobile ( )	Suburb
Fax ( )	Town / City
Email	Postcode

2.1 Please tick one of the circles below, indicating the basis for your Premium Cover Claim

- ◯ **Total Disablement** (Please complete sections 3.0 and 3.1)
- ◯ **Partial Disablement** (Please complete sections 3.0 and 3.1)
- ◯ **Redundancy** (Please complete sections 4.0 – 4.2)
- ◯ **Adjudicated Bankrupt** (Please complete sections 4.0 – 4.2)
- ◯ **Bereavement Loyalty Benefit** (Please provide the information requested in section 4.0)

3.0 About your total disablement or partial disablement claim

Is this the first time you have applied for premium cover for this condition	◯ Yes ◯ No
Start date of period of disability	Date d d m m y y y y
Total or Partial Disability	◯ Total ◯ Partial
Please provide full medical notes of the condition causing your disability including all related medical / health information	◯ Attached
While you are on claim, will you receive or are you entitled to receive any income from the following sources? ▪ ACC ▪ Your employer ▪ Any other insurance policy* ▪ Income support services ▪ Any other sources	◯ Yes ◯ No

*If you have any other insurance benefits please complete the following:

Type of benefit

Name of Insurer

Start date of your policy d d m m y y y y Start date of your claim d d m m y y y y

3.1 Additional medical information (from your GP and / or specialist(s))

Note: Please attach a copy of any referral letter / forms (GP to specialist and / or specialist to specialist). Please also attach any additional supporting documentation of this health condition that has been requested and may be important to this claim.

Current doctor's details

Doctor's name

Phone ( )

Fax ( )

How long have you attended him / her?

Doctor's address

Street name and number

Suburb

Town / City

Postcode

Previous doctor's details (if known)

Doctor's name

Phone ( )

Fax ( )

How long did you attend him / her?

Doctor's address

Street name and number

Suburb

Town / City

Postcode

Registered specialist's details

Specialist's name

Phone ( )

Fax ( )

Email

How long have you attended him / her?

Specialist's address

Street name and number

Suburb

Town / City

Postcode

4.0 About your Redundancy, Adjudicated Bankrupt or Bereavement claim

Please attached evidence to support your claim as noted under the relevant claim type below.

Redundancy

- Evidence of Redundancy Letter from your employer

Bankruptcy

- Attach copy of confirmation from Official Assignee

Bereavement

- Copy of Death Certificate (please note this must include the cause of death. If cause of death is subject to coroner's findings, nib will require a copy of the coroner's report).

4.1 Bank account details for any premium refund (should a premium refund be applicable to your claim)

Name on account

Account number

4.2 Occupation

What is your occupation?

Did you work before becoming disabled? ◯ Yes ◯ No

How many hours per day / week were you working prior to your disability?

Please list your duties before you became disabled: eg: staff supervision 20%, administration 10%, manual labour 30% sales 40% = 100%

Since your injury have you been able to:

a. perform your usual occupation? ◯ Yes ◯ No

b. do partial work? ◯ Yes ◯ No

When do you expect to return to your usual occupation? d d m m y y y y ◯ Part time ◯ Full time

5.0 Important information and declaration (to be completed by the policyowner(s) and the insured person)

Duty of Disclosure

You and anyone else named in this claim form must tell us everything you know (or ought to know) which would influence the decision of a prudent insurer whether to accept this claim, and if so, on what terms. When in doubt, disclose.

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 collect information from or 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.
- Your previous employer if applying for the redundancy benefit.

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.

All information is true and correct

Each policyowner and insured person signing below declares that all information given by them is true, correct and complete. If it is not, we may, at our discretion, cancel this policy from the commencement date, effective date or join date (as applicable). If we cancel this policy, any premiums paid may be retained by us. If we have already made any claims payments, we may recover these from the policyowner.

If you have provided information on behalf of another person, you confirm that you are authorised to do so.

Signature

Before signing please ensure that you have answered all the questions and have read and understood the 'Important information and declaration' above.

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	

5.1 Important reminders

- Please ensure you have completed all the relevant sections and signed and dated section 5.0.
- Please note that completion and submission of this form is not an acceptance of your claim.
- Medical information provided is at the expense of the insured person.
- On acceptance of your claim nib will need to assess the ongoing validity of your claim. nib will require additional ongoing information to enable assessment or your claim to continue.

About your representative (if applicable – to be completed by the insured person)

I give my authority for any details of this claim to be provided to:

My adviser

Adviser's name

Or:

Contact details

Name and relationship to patient

Phone ( )

Mobile ( )

Fax ( )

Email

Address details

Street number

Street name

Suburb

Town / City

Postcode

Please send this form to: nib nz limited, PO Box 91 630, Victoria Street West, Auckland 1142, Phone: 0800 123 nib (0800 123 642), Email: claims@nib.co.nz