

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