Claim Form

Personal Accident & Illness

RESET FORM

Please help us to help you by:

- completing all relevant questions in full as this can avoid the need for further enquiry and possible delay in settling your claim
- enclosing evidence of the amount(s) you are claiming (receipts, invoices, proofs or certificates)
- signing and dating pages 2 & 3 of this form

Issued by

Date / /

Office

INSURANCE FRAUD IS A CRIME - PLEASE ENSURE ALL INFORMATION IS CORRECT

1. Policyholder(s) details

Policy/Client number

Claim number *(if known)*

Full or company name Mr Mrs Miss Ms

Postal address

Date of birth / /

Telephone Home Business Mobile

Email Home Business

Occupation

Employer

2. Insured persons details

Full name Mr Mrs Miss Ms

Postal address

Date of birth / /

Telephone Home Business Mobile

Email Home Business

Occupation

3. Accident/Illness details

1. Place, date and time of accident or when first taken ill

Place

Date / /

Time

am pm

2. Please describe the nature and extent of injuries or illness

Note: Any claim for non-physical conditions will require a diagnosis and report by a registered psychiatrist

3. Have you ever suffered the same or similar injury or illness before? Yes No

If Yes, please give details and dates below

Were you off work? Yes No

How long for?

Did you see a doctor for this previous injury/illness? Yes No

If Yes, please provide name and address of doctor below

4. Did you consume any alcohol or take any drugs in the 12 hours prior to the accident or illness? Yes No

If Yes, please give details

5. Give the names and addresses of witnesses to the accident

4. Treatment details

1. Name and address of the doctor whom you are attending

Name and address of your usual doctor (over the past 5 years) if different from the one you are attending now

Name and address of any other doctor/treatment person for this accident/illness

Name and address of any specialist attended for this accident/illness

2. Are/were you hospitalised? Yes ☐ No ☐

If Yes, please provide name of hospital

5. Claim details

1. On which date did you cease work? / /

2. Are you able to attend any portion of your business affairs? Yes ☐ No ☐

If Yes, to who and for what alleged offence?

3. On which date do you estimate you will be able to resume the whole of your usual occupation? / /

4. Are you claiming, or entitled to claim, compensation from any other source? Yes ☐ No ☐

If Yes, please give details (e.g. ACC/Income Support)

please provide confirmation of your gross income, certified by an accountant $

If No, why did you not claim?

(Attach ACC or Income Support Payment Advice)

6. Direct crediting authority

If your claim is accepted and there are payment(s) to you, we can pay this amount direct into your bank account by direct credit. If you would like us to make this direct credit, please complete details below. You will be advised if a payment has been made following acceptance of your claim.

Do you wish to use this facility? Yes ☐ No ☐ Name of Account

I/We authorise the payment to be made into this bank account. (Please attach a deposit slip)

Bank Branch Account Number Suffix

7. Declaration/Privacy Act 1993/Insurance Claims Register

I/We declare that to best of my/our knowledge and belief these particulars are complete and correct.

I/We

(a) agree to give any further information that may be required;
(b) understand you require this personal information, which will be retained by you at 48 Shortland Street, Auckland, before you can evaluate my/our claim;
(c) authorise the disclosure of this personal information regarding this claim to other parties;
(d) authorise the obtaining by you from any other party personal information about me/us that is in your view relevant to this claim;
(e) authorise the obtaining by you from Insurance Claims Register Limited (ICR Ltd), which holds details of claims made by me/us under policies with other insurers, personal information about me/us that is in your view relevant to this claim;
(f) authorise you to place details of this claim on the database of ICR Ltd, PO Box 474, Wellington, where it will be retained and be available to other insurance companies to inspect;
(g) understand that I am/we are entitled to certain rights of access to and correction of the personal information held by you at ICR Ltd.

The collection of this information is required under the terms of your policy. Failure to provide it may result in your claim being declined.

Date / /

Signature of the Policyholder(s)

Date / /

Signature of the person making the claim

8. Medical authority (to be completed for all claims)

AMP's general insurance products are underwritten by Vero Insurance New Zealand Limited (Vero). I hereby agree to give permission to Vero to obtain any information they may require relative to the illness/accident as stated above

Date / /

Signature of Insured Person

If the claim is admitted by Vero, the weekly disablement allowance will, usually, be paid in progress payments up to the date on which the medical certificate has been signed. ***No advance payments will be made***.

Note: The doctor should be informed that they will be required to fill in, free of expense to the Company, a certificate which may be sent to them from our office.

MEDICAL CERTIFICATE

To establish a claim, the insured person must obtain and forward to the Company, at their own cost, a certificate from a duly qualified and registered medical practitioner.

In the case of non physical conditions a registered psychiatrist's report and diagnosis is required.

The medical practitioner is requested to complete the following details.

1. Patient details

Patient's name in full

Gender M F

Address

Occupation

Date of birth / /

2. Accident/illness details

1. When did you first attend the patient for this injury or illness? / / Time am pm

   When, in your opinion, did the symptoms first appear?

2. Are you their usual doctor? Yes No If Yes, how long have you known them? Years Months

3. What is the exact nature of the illness or injury?

   What is the extent of the injuries/illness sustained? (If a hand, arm, leg or foot, please state whether it is **right** or **left**).

   Region of injury(ies)

4. Have they ever suffered from the same, or similar ailment before? Yes No

   If Yes, when? / / Did it require time off work? Yes No How long for?

5. Have they ever suffered, or are now suffering, from any constitutional or other illness or physical infirmity? Yes No

   If Yes, please state the nature of the illness, disease or infirmity and to what extent it has operated to prolong the disablement of this current condition

6. What is the degree of disablement from usual occupation or business?

   Total - unable to do any part of business Partial - please state degree and which duties unable to perform below

7. If partial, how many hours per week can the patient be expected to work?

8. Are there any other contributing factors? e.g. availability of work, depression, etc.

9. Have you given any certificate to another insurance company, the Accident Compensation Corporation, or in connection with welfare benefits or sick leave benefits from the patients employer, or for any other reason? Yes ☐ No ☐

If Yes, who to?

10. Have you any reasons to suspect that the patient was under the influence of alcohol or drugs at the time of the accident? Yes ☐ No ☐

If Yes, please give details

3. Claim details

1. For which period has the patient been totally disabled to date? From to

For which period has the patient been partially disabled to date? From to

2. How long, in your opinion, will disability continue? (indicate which applies)

Totally months weeks days

Partially months weeks days

3. When will patient be referred to specialist?

Name and address of Specialist

If available, please enclose copies of any specialist opinions.

4. Has / will the patient require hospitalisation? Yes ☐ No ☐

If Yes, where and for how long?

4. Declaration

I certify that I have, by personal examination, satisfied myself that the patient has sustained the illness/injuries described above and that the foregoing statements are correct:

Name, address, and qualifications of medical practitioner completing this form (please print)

Name

Address

Qualifications

It is essential, in the interest of the patient, that this form be completed as fully as possible so we may assess the amount payable fairly and quickly.

Date / /

Doctor or Medical Practitioner Signature

Privacy Act 1993

AMP's general insurance products are underwritten by Vero Insurance New Zealand Limited (Vero). This information is being collected and will be held by Vero. It is intended for use by Vero employees who require access to this information for administering the claim. Your patient has authorised Vero to collect this personal information from you.