AMP Essentials – Temporary Disablement

Your checklist to making a Claim

Please send this completed form and any supporting documents to:

Email: **kiwisaver@amp.co.nz**
or
AMP Services (NZ) Limited
Freepost 170, PO Box 55,
Shortland Street,
Auckland 1140

If you have any questions, please contact your Adviser or call Customer Services on **0800 267 263**.

What are you covered for?

The Essentials Temporary Disablement Benefit is a monthly payment which is paid if you suffer sickness that prevents you from working or performing key daily living activities, and meet the other requirements of the Cover Terms.

Cover Terms are available at **www.amp.co.nz/essentials**.

Our commitment to you

We understand that making a claim often comes at a challenging time for you and your family.
Our insurer has a team of dedicated and experienced Case Managers to help support you and keep you updated throughout the process. If you are uncertain or need assistance please contact us.
We are here to help.

In order for AMP's insurer to assess your claim, we require the following to be returned to the Customer Claims Team

Immediate requirements (to start claim process)

- ☐ Statement of Claim Form – To be completed by customer
- ☐ Medical Certificate – To be completed by current treating doctor/specialist, you need to take the form to your current doctor/specialist for them to complete, and arrange payment of their fee for doing so.
- ☐ Any supporting medical information you may have e.g. medical/laboratory tests, x-rays/scans, histology and hospital discharge forms (if applicable)

Additional information (as available or if requested)

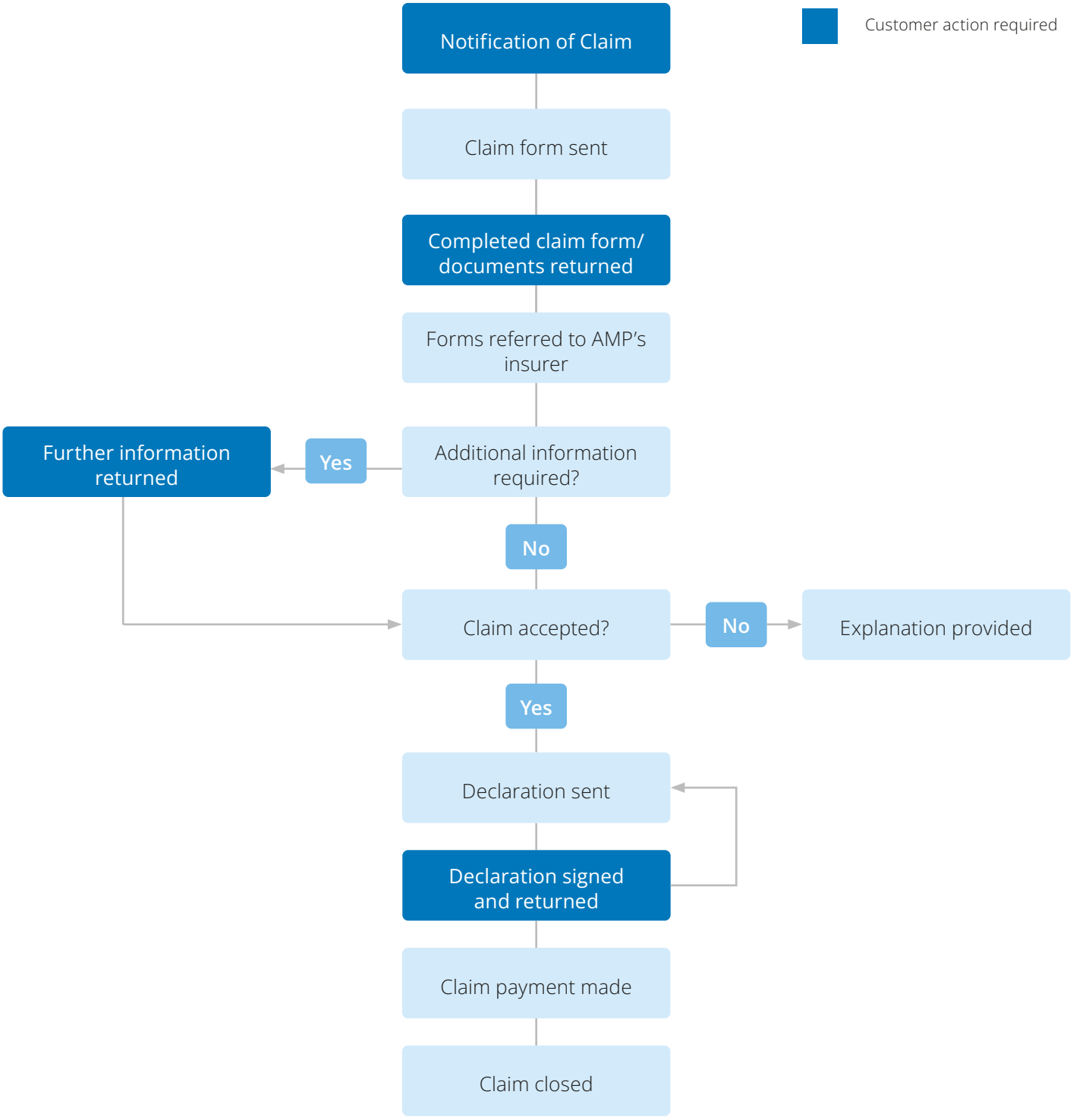
- ☐ Full Job Description
- ☐ If you are self-employed
  - ☐ Monthly profit/loss statement
  - ☐ Financial information will be required (this will be discussed during the initial assessment)
- ☐ If you are a wage or salary earner
  - ☐ Monthly payslips (most recent)
  - ☐ Copy of employment contract
- ☐ Bank account proof such as deposit slip or bank statement

Once we have received the above requested information, we will send you a confirmation within 3 working days, at which point one of our insurer's dedicated Case Managers will guide you through the following process.
We will consider the claim, which may include assessing medical details against the forms completed when the cover was first applied for. We may also seek further information from you or your doctor before making a final decision. The Case Manager will be in contact again with an outcome or if further information is required.

AMP Essentials – Temporary Disablement

Claims Process

The following diagram provides an indication of the steps that AMP will follow when processing your Temporary Disablement claim



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Resolution Life

Customer Claims Team Contact
Phone: 0800 267 425
Email: claimsmailbox@resolutionlife.co.nz
Website: resolutionlife.co.nz
Post: ReplyPaid 259236
Resolution Life Claims
PO Box 1692, Wellington 6140
New Zealand

AMP Essentials - Temporary Disablement
Statement of Claim Form

Your Guide to Making a Claim

This claim is being made by AMP on your behalf as a Life Insured under their AMP Essentials Policy.

The details you provide in this form will assist in managing your claim. The more accurate your information is, the better placed our team of dedicated and experienced Case Managers will be to support you and keep you updated throughout the process.

Resolution Life is not responsible for payment of any fee for the completion of the Medical Certificate or any supporting information required.

Resolution Life can guide you through this form over the phone. Please contact us if you need assistance.

*These fields must be completed

Personal details – *(Person Insured to complete)*

AMP Kiwisaver Scheme member number

K | | | | | | | |

*Title

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

*First name(s) (please print)

*Surname

*Residential address

Postcode

*Please provide at least one contact number

Contact phone number ( )

Mobile number ( )

*Date of birth D D M M Y Y Y Y

Personal email

What is the best method for us to contact you?

Illness details – *(Person Insured to complete)*

1. Please describe the nature of your illness

2. When did you first become aware of your illness?

D D M M Y Y Y Y

3. When was the illness first diagnosed?

D D M M Y Y Y Y By whom?

Name and address of your treating doctor

Name

Address

Postcode

Date last consulted

D D M M Y Y Y Y

Date of next appointment

D D M M Y Y Y Y

Phone number

( )

Email

Please indicate specific dates on which you have consulted your doctor(s) regarding this illness

Name and address of your specialist ☐ *not applicable*

Name

Address

Postcode

Date last consulted

D D M M Y Y Y Y

Date of next appointment

D D M M Y Y Y Y

Phone number

( )

Email

Please indicate specific dates on which you have consulted your specialist regarding this illness

4. Are you entitled, or have you made, or do you intend to make a claim for this illness from any of the following sources?

- ☐ ACC
- ☐ Your Employer
- ☐ Your Business
- ☐ Any other insurance policy
  e.g. income protection, bill protection, credit card insurance
- ☐ Income support services
- ☐ Any superannuation fund or group scheme
- ☐ Health insurance policy
- ☐ Other source

If yes to any of the above, please provide details in the table below

Name and contact details of the benefit provider	Type of claim	Policy/Claim number	Status (accepted, denied, pending, under appeal)	If accepted, state amount and frequency of payments
				$
				$
				$
				$
				$
				$

Resolution Life wishes to understand more about the nature of your illness, including treatment you have undertaken with other healthcare practitioners, as well as initiatives you may have undertaken on your own. Please complete the information below to assist us in understanding your treatment plan as well as your response to treatment.

5. If you have been hospitalised as a result of your condition, please provide details below

Name and address of hospital	Reason for hospitalisation	Date admitted	Date discharged

6. Please complete the table below with the relevant details of your healthcare practitioners (including doctors, specialists, physiotherapists, psychologist, etc)

Name	Specialty	Contact details	First attended	Last attended

7. Please list all prescribed medications you are taking, including those not associated with this condition

Medication	Date prescribed	Dosage/ Frequency	Prescribed by whom	Effectiveness

8. If you are also taking non-prescription based remedies, please provide details of these below

9. Please provide details of any other treatment you have undertaken to help you recover and return to work (i.e. increasing activity at home, change in diet, quit smoking, online self help tools, etc)

10. Over time or since commencing treatment has your condition improved?

☐ Yes ☐ No

If Yes, please provide details

11. Please outline any pending investigations

Test/Investigation	Date scheduled	Reason for test

12. Please provide details of any other physical, psychological, or medical conditions you have

Nature of condition	Date diagnosed	Treatment for condition	Impact on your activity levels

Daily activities – *(Person Insured to complete)*

13. Has your illness impacted your capacity to perform any of the activities of daily living?

Activity impacted		Describe how it is impacted	Expected improvement with time/treatment
The ability to bathe or shower without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to dress and undress without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to use a toilet without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to get in and out of a bed or chair without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to eat and drink without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No

14. Please outline details of your usual hobbies and/or social/community activities? (e.g. volunteer work, community organisations, sport)

15. What activities are you able to continue, or how has your participation in these activities been impacted by your condition?

16. Do you need to drive to perform your normal job?

☐ Yes ☐ No

Employment – *(Person Insured to complete)*

If you are an employee please provide

Name of employer

Employer contact details

Name

Address

Postcode

Phone number ( )

Mobile number ( )

Email

Employees and self employed

17. What was your main occupation immediately prior to the onset of your illness?

18. If you had another occupation immediately prior to the onset of your illness, please advise what it was?

19. Have you changed your current occupation in the 3 months prior to your illness?

☐ Yes ☐ No

If Yes, can you please explain why?

20. In what capacity were you employed immediately prior to your illness?

☐ Casual ☐ Part-time Permanent ☐ Full-time Permanent ☐ Contractor

21. Do you work from home?

☐ Yes ☐ No

If Yes, what percentage of time do you work from home and what duties do you undertake from home?

%

22. If casual or part-time, please indicate the average number of days worked per week and average number of hours per shift

Average number of days per week Average number of hours per shift

22. Date commenced employment with current employer

D D M M Y Y Y Y

23. Monthly Income (Gross before tax)

$

24. Usual hours per week (weekly average over 3 months prior to illness)

25. Your illness may have meant you needed to make changes to the way you work.

Please provide details of how your illness has impacted your ability to perform your normal job

Reduced hours

On which date did this occur? D D M M Y Y Y Y

Alternative duties

On which date did this occur? D D M M Y Y Y Y

Ceased all work

On which date did this occur? D D M M Y Y Y Y

26. What is your current work status?

Are you still employed with your pre-illness employer?	Yes	No
Are you still employed with your pre-illness employer but not currently performing your normal job?	Yes	No
Has your employment been terminated?	Yes	No
Have you resigned?	Yes	No
Have you been made redundant?	Yes	No

Other – please specify

27. Do you enjoy your work?

Yes No

Please tell us what you like about your work

Please tell us what you don't like about your work

28. Are you in contact with your employer (if not self-employed)?

Yes No

If Yes, how often and what have you discussed?

Work duties

29. Please provide details of the duties you are required to perform in your normal job. Please also provide a copy of your job description if you have one

30. Please select the following physical requirements of your occupation where applicable

	Never/rare	Occasional	Frequent	Continuous
Lifting, 20kgs and over	☐	☐	☐	☐
Lifting, 7-19kgs	☐	☐	☐	☐
Lifting, under 7kgs	☐	☐	☐	☐
Carrying, 20kgs and over	☐	☐	☐	☐
Carrying, 7-19kgs	☐	☐	☐	☐
Carrying, under 7kgs	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Climbing – ladders, scaffolding, etc	☐	☐	☐	☐
Climbing – ramps, steps, etc	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐
Office duties (admin, phone, clerical, photocopying)	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐

Never/rare (0%–10%)
Occasional (11% – 40%)
Frequent (41% – 70%)
Continuous (71% +)

31. In your occupation, what percentage of time do you spend performing the following types of duties

Sedentary/administrative	%
Supervising work	%
Light manual	%
Heavy manual	%

32. Would you be able to modify any of the manual handling tasks you perform by seeking assistance from others, using a lifting device or modifying the load?

☐ Yes ☐ No

If Yes, please provide details

33. Please indicate if your normal job involves any of the following

Skill	% of the day required	Can you still do this?
Supervising others	%	☐ Yes ☐ No
Conflict resolution and mediation	%	☐ Yes ☐ No
Planning and organising	%	☐ Yes ☐ No
Meeting tight deadlines or production/sales quotas	%	☐ Yes ☐ No
Analytical and abstract thinking	%	☐ Yes ☐ No

34. Please list any machines, tools or other equipment that you use on the job (e.g. a forklift, pallet jack, drill etc)

Description of equipment/tools	Duration/frequency per day (i.e. hours per day, number of times per day or % of day)

35. Do you hold any specific certifications, licences, or training required to perform your usual duties?

if Yes, please provide details

36. Please describe any other mental or physical demands required to perform your normal job that have not been covered

Self employed

37. Are you self-employed, or do you own a business or a company?

☐ Yes ☐ No (go to question 40)

If Yes, what is the type of business undertaken?

38. Are you ☐ Sole trader ☐ Partnership ☐ Company ☐ Trust Other - please advise

Business name

Business phone number ( )

Business address

Postcode

When did the business last trade?

D D M M Y Y Y Y

Total number of employees excluding yourself Full-time Part-time

I receive remuneration from the company by way of ☐ Shareholder ☐ Salary ☐ Dividends ☐ Directors fees ☐ Other—please explain

Provide Gross Income less business expenses in the last 12 months

$

39. Provide details of accountant

Name

Work planning and recovery – *(Person Insured to complete)*

Resolution Life understand the value and importance of work to your recovery. The information you provide in this section will assist us to consider options relating to your ongoing employment. Our Case Managers will work with you, your employer and ACC (where appropriate) and your healthcare practitioners to assist you through this process.

40. If you are an Employee or Self-Employed, please describe any factors related to your work duties and/or workplace that may have contributed to

- **the development of your condition and/or**
- **the reason you are no longer able to carry out your normal job**

41. Are you currently performing any work activities?

☐ Yes ☐ No

If Yes, please provide details

If Yes, when did you return to work?

D D M M Y Y Y Y

With respect to this return to work, please provide details in relation to employer, occupation, duties and hours

42. Are you aware if your employer can accommodate modified duties and/or hours?

If Yes, please explain

43. If self-employed, are you able to gradually resume work with modified duties and/or hours?

☐ Yes ☐ No

If Yes, please provide details of possible return to work options

44. When do you anticipate returning to work in a part-time capacity?

D D M M Y Y Y Y

45. When do you anticipate returning to work in a full-time capacity?

D D M M Y Y Y Y

46. If you are uncertain as to your return to work date, please explain what needs to change for you to be able to initiate a partial or full return to work and if you require any assistance to facilitate this change

Declaration – *(Person Insured to complete)*

PRIVACY ACT ("the Act")

Any personal information collected in connection with your claim will allow Resolution Life to assess your claim and to administer any ongoing claim. Under the Act, you have the right of access to, and correction of, any personal information about you. The personal information will be held by Resolution Life, and may be held overseas.

Resolution Life follows a strict confidentiality code about all personal information it holds. This means that your personal information is held securely and access is limited to authorised individuals who need to see it. For further information regarding how Resolution collects, uses and stores your personal information please refer to our Privacy Policy which can be found at **resolutionlife.co.nz/privacy-policy**

COLLECTION OF INFORMATION

I authorise Resolution Life or its representatives to contact and obtain all documents it considers necessary from any source for the purpose of assessing the claim or any matters arising out of its assessment.

I also authorise any doctor, health practitioner, hospital or medical institution, who has or may be, consulted by me to give Resolution Life any information it may require.

RELEASE OF INFORMATION

You authorise Resolution Life to use your information to:

- assess, and administer the claim, including obtaining advice and/or approvals in respect of that claim, managing any complaint or dispute that may arise in respect of the claim, and coordinating with any other insurer in respect of the assessment of the claim; and
- administer any insurance policies held with Resolution Life, including arranging and administering reinsurance in respect of insurance policies issued by Resolution Life.

You authorise Resolution Life to disclose your information to its advisers, reinsurers and any other third party solely to the extent reasonably necessary for the above purposes. You also acknowledge that Resolution Life may be required to disclose your personal information if disclosure is required by law, for example where required by a government body or regulatory authority.

You authorise Resolution Life to disclose all medical information and any other relevant information pertinent to the claim to any person they require you to consult with in respect of the claim or any person engaged by Resolution Life in connection with the management of the claim.

A photocopy of this authority will be sufficient evidence of your consent to the disclosure of information in accordance with this authority.

ADVISER INVOLVEMENT

If you would like your Adviser to be involved with the progress of your claim, please advise their name below.

I authorise Resolution Life to release all relevant information pertinent to my claim to my Adviser.

Name of Adviser/company

DECLARATION

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide Resolution Life such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

I understand that failure to provide full disclosure of all occupational, medical, financial, and other information that Resolution Life regards as relevant to the assessment of my claim will be considered to be material misrepresentation and/or material non-disclosure. As such, Resolution Life is entitled to use legal remedies, should this occur. I further understand that the occupational, medical, financial, and other information provided is the basis on which Resolution Life will base the assessment of 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 understand that the policy may be cancelled, and I can be prosecuted if I make any fraudulent statements.

Throughout this form the term "Resolution Life" is used to refer to Resolution Life Australasia Limited.

Name of Person Insured

Date

D D M M Y Y Y Y

Signature

SIGN HERE

AUTHORITY TO COMPLETE

☐ Please tick the box if the Person Insured is medically unable to sign the Statement of claim form. Please also attach the relevant proof of authority.

First Name

Surname

Phone number

( )

AUTHORITY TO DISCUSS

As the Person Insured, Resolution Life requires you to advise if you would like Resolution Life to discuss your claim with someone other than yourself.

I declare that as the Person Insured of the above policies, I authorise Resolution Life to discuss aspects of the claim (checked below) with the following person.

First Name | Surname | Phone number

( )

Relationship (to Person Insured) e.g. spouse, son, friend

Private address

Postcode

(Please indicate clearly where permission is given by ticking the appropriate boxes)

- ☐ Details of my personal and business income where they are relevant to the claim(s)
- ☐ Details of my personal health history where it is relevant to my claim(s)
- ☐ Details of my policies, covers and benefits (only relevant if the Person Insured is the Owner of the policy)

This authority is valid

- ☐ for the duration of the assessment and/or payment of my claim(s), or
- ☐ only for the period (from) D D M M Y Y Y Y to D D M M Y Y Y Y

NEW ZEALAND BANK ACCOUNT DETAILS

If the claim is accepted, or Resolution Life is still assessing your claim but decides to make a payment at Resolution Life's discretion, any payment will be directly credited to this account. Write and include evidence of bank account that clearly states name and bank account number, such as a bank deposit slip or bank statement.

Funds can only be transferred to a New Zealand bank account.

Bank | Branch | Account | Suffix

ATTACH EVIDENCE OF BANK ACCOUNT HERE

Identity verification – *(Person Insured to complete)*

To protect the Person Insured(s) and Resolution Life from financial crime, Resolution Life needs to confirm the Person Insured's identity.

Please ensure each selected document (copy) has been sighted and signed by a trusted referee (as defined on the next page).

Identity document(s)

Please complete option 1 in the table below and attach copies of the requested document(s). If you cannot provide a document from option 1, then complete option 2 or 3 (please tick which document(s) you are providing).

Option 1 ONE document from this section

☐ NZ passport (Identity page)	☐ NZ firearms licence
☐ Overseas passport (Identity page)	☐ NZ certificate of Identity

Option 2 ☐ NZ Driver's Licence **PLUS** (ONE of the of the documents from this section)

☐ Super Gold card	☐ NZ full birth certificate/Birth certificate issued by foreign government
☐ NZ citizenship certificate/citizenship certificate issued by foreign government	☐ Bank statement or IRD statement issued in your name in the last 6 months

Option 3 ☐ 18+ identity card **PLUS** (ONE of the documents from this section)

☐ NZ full birth certificate/Birth certificate issued by foreign government	☐ NZ citizenship certificate/citizenship certificate issued by foreign government

IMPORTANT If you are providing previously certified identity documents, please ensure the documents have been certified not more than 3 months prior. Please attach only the certified photocopies of the original documents to this application.

We may use third party providers to perform services for us, on your behalf, or to manage some of our processes and services. To enable those services and processes to be performed, we may need to provide those third parties with your personal information. We may also engage, or be engaged by, third parties including government agencies in circumstances which require us to provide your personal information to them, or to another party, to meet our contractual, legal or regulatory obligations. You authorise us to disclose your personal information to third parties where needed or required for those purposes.

Trusted Referee Declaration

Your identity and address documents are required to be certified by a trusted referee (use the first box below), **or** verified by a Resolution Life employee acting as agent of Resolution Life (use the second box below).

DECLARATION BY TRUSTED REFEREE

I, FULL NAME OF TRUSTED REFEREE confirm that

1. I have sighted today the original of each document identified with a tick in the above section, verifying the identity of the named Person Insured, and attached to this statement are true copies of those documents initialled and dated by me.
2. The documents that have been provided represent the identity of the Person Insured named in this form.
3. I am a **(tick one of the following)**

☐ New Zealand lawyer	☐ Police constable	☐ Registered teacher	☐ Kaumātua
☐ Chartered accountant	☐ Minister of religion	☐ Commonwealth representative	☐ NZ Honorary Consul
☐ Justice of the Peace	☐ Notary public	☐ Registered medical doctor	

4. I am not related to and do not live at the same address as the Person Insured named in this form.

Signature of trusted referee

SIGN HERE

Dated

D D M M Y Y Y Y

OR

DECLARATION BY RESOLUTION LIFE EMPLOYEE (AS AGENT OF RESOLUTION LIFE)

I, FULL NAME OF ADVISER/RESOLUTION LIFE EMPLOYEE ADVISER CODE (if applicable) confirm that

1. I have sighted today the original of each document identified with a tick in the above section, verifying the identity of the named Person Insured, and attached to this statement, are true copies of those documents initialled and dated by me.
2. I have no reason to believe that this person is not who he/she claims to be.
3. Resolution Life has authorised me to be its agent to conduct customer due diligence procedures and obtain any information required for customer due diligence under the Anti-Money Laundering and Countering Financing of Terrorism Act 2009 and I acknowledge that Resolution Life is relying on me to perform those functions for it.

Signature of Agent of Resolution Life

SIGN HERE

Dated

D D M M Y Y Y Y

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Resolution Life

Customer Claims Team Contact
Phone: 0800 267 425
Email: claimsmailbox@resolutionlife.co.nz
Website: resolutionlife.co.nz
Post: ReplyPaid 259236
Resolution Life Claims
PO Box 1692, Wellington 6140
New Zealand

AMP Essentials - Temporary Disablement

Medical Certificate Information sheet

Resolution Life seeks input to assist us in managing your patient's claim.

Your patient currently holds an Income Protection policy with Resolution Life for illness that impedes their ability to perform their normal work duties. While Resolution Life is not the treatment provider, Resolution Life's approach is holistic and wide in its coverage. Resolution Life, at its discretion, may cover rehabilitation costs and generally replace 75% of their income to the extent that they are unable to work.

The more detailed your information is, the better placed we are to assist your patient. We at Resolution Life recognise every customer's situation is unique. We work with our customers transparently, fairly and with respect and empathy. We seek to provide the right support and management at the right time.

Resolution Life's claims management approach

During your interactions with us, you will come to appreciate that Resolution Life believes in the health benefits of work and activity. We seek to assist our customers to focus on what they can do, not on what they cannot do. You will sense our commitment to achieving healthy work outcomes for people with illness or disability.

In the ongoing management of your patients claim we wish to work collaboratively with you to ensure we understand your patient's condition and their progress towards recovery at work. If we require additional information or have information that may inform your clinical management, it is our preference to speak directly with you on the phone and we will book and pay for an appointment with you. If you believe this may lead to delays, then please indicate your preferred method of communication.

Our approach is informed by current research and the **Royal Australasian College of Physicians' Faculty of Occupational and Environmental Consensus Statement** to which we are a signatory, along with a wide ranging set of New Zealand organisations. (See **www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work**).

We support the evidence that long-term work absence, work disability and unemployment have a negative impact on health and wellbeing, and that recovering at work is a positive health choice.

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Resolution Life

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Phone: 0800 267 425
Email: claimsmailbox@resolutionlife.co.nz
Website: resolutionlife.co.nz
Post: ReplyPaid 259236
Resolution Life Claims
PO Box 1692, Wellington 6140
New Zealand

AMP Essentials - Temporary Disablement

Medical Certificate

Patient's details

First name(s) (please print)

Surname

Gender

☐ Male ☐ Female

Date of birth

D D M M Y Y Y Y

Doctor's details

Name

Specialty

Postal address

Postcode

Phone number

( )

Email

Preferred method of communication

☐ Phone ☐ Email ☐ Fax ☐ In person meeting

Doctor/patient relationship

1. How long has this person been your patient?

2. If you are not this patient's regular treatment provider, please provide the name and address of this patient's regular treatment provider.

Name and address

3. Have you provided information to any other insurer/any bank/WINZ or ACC for this patient?

☐ Yes ☐ No

If Yes, please provide details below

Organisation/Person	Date provided	Information provided

Details and history of condition

4. Please outline below the diagnosis associated with your patient's condition

Diagnosis	Date first consulted	Made by whom

5. Has your patient's illness impacted their ability to perform any of the following activities of daily living?

Activity impacted		Describe how it is impacted	Expected improvement with time/treatment
The ability to bathe or shower without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to dress and undress without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to use a toilet without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to get in and out of a bed or chair without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No
The ability to eat and drink without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No

6. If your patient's condition is a result of illness, when did your patient first become aware of the condition that lead to cessation of work?

D D M M Y Y Y Y

7. When did the patient first consult you for this condition?

D D M M Y Y Y Y

8. What was the initial diagnosis and why?

9. What was your initial medical advice?

10. What treatment has been employed to date? Please give details of referrals to other doctors or specialists or surgeries

11. What treatment is planned for the future and what other treatment or rehabilitation options are available?

12. Has your patient previously suffered with the same or similar condition or symptoms of the condition?

☐ Yes ☐ No

If Yes, please provide details below.

Approximate date(s)

Details of clinical presentation

Did your patient require time off work?

☐ Yes ☐ No

If Yes, please provide details

Treatment

13. Has your patient always been compliant with recommended treatment?

☐ Yes ☐ No

If No, please provide details of the non-compliance, including your understanding of the reasons

14. Is your assessment and treatment complicated by any of the following?

- Atypical or variable presentation ☐ Yes ☐ No
- Subjective reporting of symptoms that are inconsistent with objective clinical findings ☐ Yes ☐ No
- Work related or workplace issues ☐ Yes ☐ No
- Substance abuse ☐ Yes ☐ No
- Family or interpersonal stressors ☐ Yes ☐ No
- Financial stressors ☐ Yes ☐ No
- Other ☐ Yes ☐ No

If Yes, to any of the above, Resolution Life may be able to assist. Please explain and detail any steps taken to address the complication.

15. Is there any form of intervention that Resolution Life should consider supporting which might assist your patient's recovery at work?

Medical restrictions

At Resolution Life we believe that work plays an important part in your patient's recovery. Our expert staff will work collaboratively with you, your patient, and the workplace to assist your patient wherever possible to recover at work or achieve an early, safe and sustainable return to work. To assist us in this regard, please complete the following

16. What is your patient's current occupation and their specific duties?

17. Did you advise your patient to cease work?

☐ Yes ☐ No

18. What date did you advise your patient to cease work?

D	D	M	M	Y	Y	Y	Y

19. What objective evidence did you base this decision on?

20. Does your patient have any other ongoing health conditions that impact or may impact on their ability to work? If Yes, what and how?

Medical restrictions - continued

21. Is it reasonable to expect your patient to attend work regularly? If so, how many hours per day and in what capacity could be expected?

22. If your patient is currently unable to to attend work, when do you think a return to work part time or gradual return to full-time would be expected? Please explain

23. Describe your patient's motivation to return to work

Declaration

I hereby certify that the above information is correct to the best of my knowledge.

Name

Signature

SIGN HERE

Date

D D M M Y Y Y Y

Please attach the following items with your completed form

- ☐ Copies of all test results (X-rays, CT scans, MRI, Pathology, Blood tests, Urine tests, Ultrasound, etc)
- ☐ Copies of any medical reports related to the medical condition
- ☐ Any other information that will assist us in understanding your patient's medical status and current needs
- ☐ Detail of all medication that is currently taken by your patient

Resolution Life is not responsible for payment of any fee for the completion of this report. Any fees incurred will be at the expense of your patient.

This is an important document. Please complete fully and return to

Customer Claims Team Contact
Phone 0800 267 425
Email claimsmailbox@resolutionlife.co.nz
Website resolutionlife.co.nz
Post ReplyPaid 259236
Resolution Life Claims
PO Box 1692, Wellington 6140
New Zealand

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WEL233027 03/23