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**.

AMP Essentials – Trauma

Your checklist to making a Claim

What are you covered for?

The Essentials Trauma Benefit is a lump sum amount which is paid if you suffer for the first time one of the 40 Traumas described in the AMP Essentials Cover Terms, 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 team of dedicated and experienced Customer Claims Consultants are here to 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 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 Form – To be completed by current treating doctor/specialist
- ☐ 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)

- ☐ Bank account proof such as deposit slip or bank statement

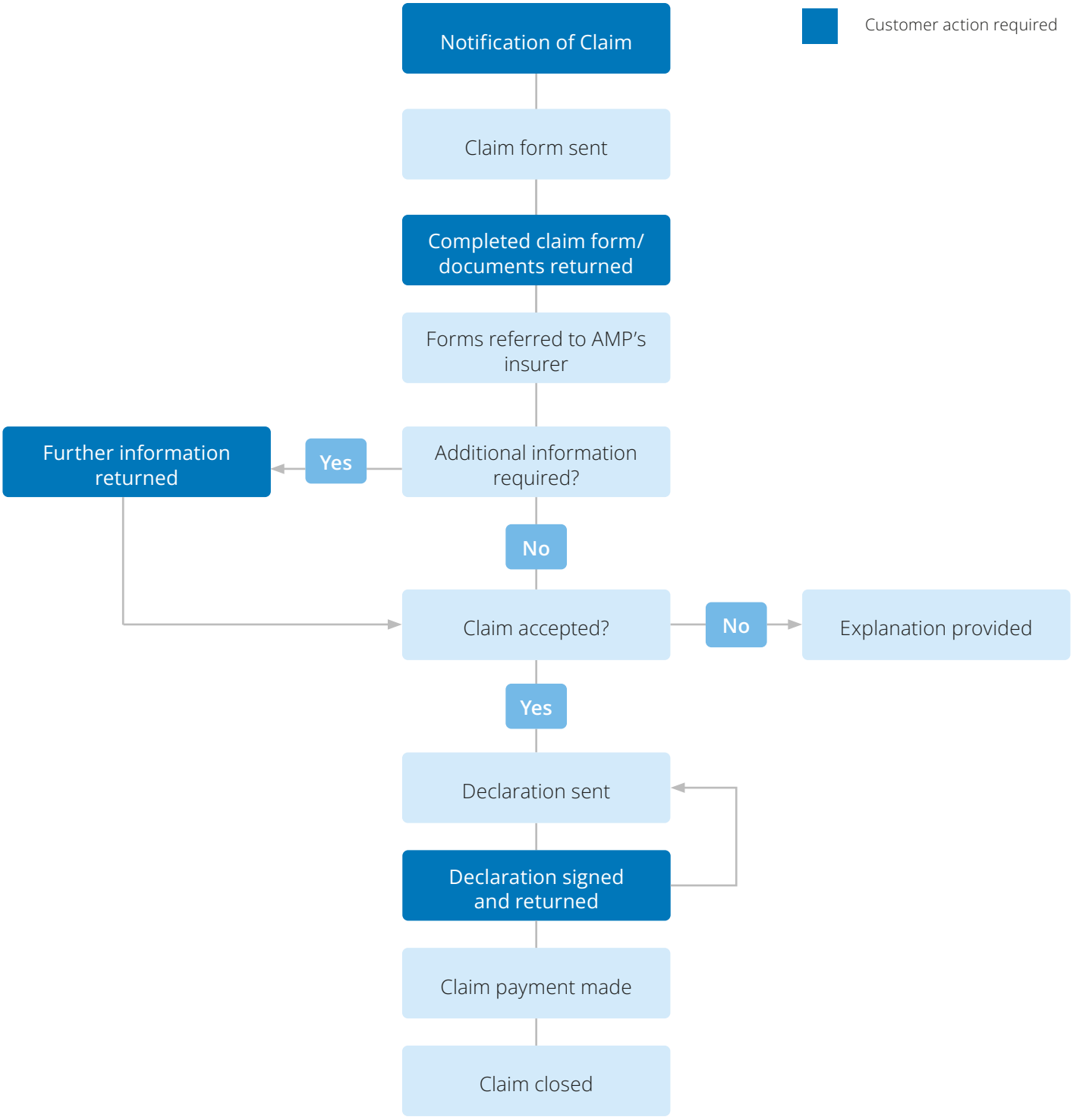
Once we have received the above requested information, we will send you a confirmation within 3 working days, at whichpoint one of our insurer's dedicated Customer Claims Consultants will guide you through the following process.

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 Customer Claims Consultant will be in contact again with an outcome or if further information is required.

AMP Essentials – Trauma

Claims Process

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



RESET

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 - Trauma
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 costs incurred 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

*Surname

*First name(s) (please print)

*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?

Injury/Illness details – *(Person Insured to complete)*

1. Please describe the nature of your injury/illness

2. If you sustained an injury, please explain how the injury occurred

3. When did your injury occur?

D D M M Y Y Y Y

4. If you are suffering from an illness, when did you first become aware of your illness?

D D M M Y Y Y Y

5. When was the injury/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 injury/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 doctor(s) regarding this injury/illness

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

- ☐ Your Employer
- ☐ Any superannuation fund or group scheme
- ☐ Any other 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)

Resolution Life wishes to understand more about the nature of your illness or injury, 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.

7. 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

8. 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

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

Medication	Date prescribed	Dosage/ Frequency	Prescribed by whom	Effectiveness

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

11. 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)

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

☐ Yes ☐ No

If Yes, please provide details

13. Please outline any pending investigations

Test/Investigation	Date scheduled	Reason for test

14. Please provide details of any other physical, psychological, or medical conditions you have in so far as they relate to the present claim

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

Daily activities – *(Person Insured to complete)*

15. Has your injury/illness impacted your capacity to perform your regular activities of daily living such as driving, household chores, errands, personal care, or childcare?

☐ Yes ☐ No

If Yes, please provide details

Activity impacted	Describe how it is impacted	Expected improvement with time/treatment?
		☐ Yes ☐ No ☐ Uncertain, please explain
		☐ Yes ☐ No ☐ Uncertain, please explain
		☐ Yes ☐ No ☐ Uncertain, please explain

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

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

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

☐ Yes ☐ No

19. Please indicate your average consumption of alcohol:

☐ **Nil** ☐ **<5 Drinks/week** ☐ **5-10 Drinks/week** ☐ **10-20 Drinks/week** ☐ **>20 Drinks/week**

20. Do you use or have you ever used recreational drugs or any drugs not prescribed to you (other than for coughs, colds, flu or similar minor ailments)?

☐ Yes ☐ No

If Yes, please provide details

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.

The personal information will be held by Resolution Life, and may be held overseas.

For further information regarding how Resolution Life 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 necessary as a result of injury or sickness. I will provide Resolution Life such further evidence of my claim as may be reasonably 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

Signature

SIGN HERE

Date

D D M M Y Y Y Y

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

( )

Declaration – *(Person Insured to complete) - continued*

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 health history where it is relevant to my claim(s)

☐ Details of my policies, covers and benefits

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

WEL233026 03/23

Resolution Life

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Resolution Life Claims
PO Box 1692, Wellington 6140
New Zealand

AMP Essentials - Trauma

Payment Authority & Proof of Identity Form

If your claim is accepted, your payment will be made by direct credit. Please provide your bank account details below:

Payment details

Account name

Account number

Person Insured

Full name

Date D D M M Y Y Y Y

Signature

SIGN HERE

Witnessed by *(please refer to page 2 "Who can certify my documents")*:

Full name

Date D D M M Y Y Y Y

Signature

SIGN HERE

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

Please include an encoded bank deposit slip or a true, certified copy of a bank statement showing the account name and number for payment of the benefit. Funds can only be transferred to a New Zealand bank account in the name of the Person Insured, unless otherwise agreed in writing with Resolution Life.

Provide your identification to verify your identity

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

Option 1 ☐ ONE document from this section

☐ NZ passport (identity page)	☐ NZ certificate of identity
☐ Overseas passport(identity page)	☐ NZ firearms license

OR

Option 2 ☐ NZ driver licence **PLUS** (ONE of the following)

☐ 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 six months

OR

Option 3 ☐ 18+ identity card **PLUS** (ONE of the following)

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

Proof of Address

As well as providing your identity documents you must also supply proof of your address. Tick one document option from this section. The document you supply needs to be addressed to you, and show the residential address detailed on page 1 of this form and dated within the last 6 months.

☐ Letter or invoice from utility company

☐ Bank statement

☐ Letter from government agency (eg. Inland Revenue or rates bill)

IMPORTANT:

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

Who can certify my documents?

☐ New Zealand Lawyer	☐ Justice of the Peace	☐ Notary Public	☐ Registered Medical Doctor
☐ Chartered Accountant	☐ Police Constable	☐ Registered Teacher	☐ Kaumātua
☐ Financial Adviser	☐ Minister of Religion	☐ Commonwealth Representative	☐ NZ Honorary Consul

Checklist

Please check you have completed the form correctly.

☐ Have you completed the Person Insured's payment authority form?

☐ Have you attached proof of your bank account in the form of an original pre-encoded bank deposit slip or a certified true copy of a bank statement?

☐ Have you attached any necessary verification of identity and proof of address documents?

Resolution Life

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Post: ReplyPaid 259236
Resolution Life Claims
PO Box 1692, Wellington 6140
New Zealand

AMP Essentials - Trauma

Medical Certificate

Resolution Life seeks input to assist us in managing a claim made in respect to your patient.

A Trauma or Crisis claim has been submitted with Resolution Life with respect to your patient's injury or illness.

The more detailed your information is, the better placed we are to assess the present claim. 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.

We wish to work collaboratively with you to ensure we understand your patient's condition. 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.

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

Details and history of condition

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

Diagnosis	Date first consulted	Made by whom

4. If your patient's presenting condition is as a result of an injury

a. When did the incident occur? D D M M Y Y Y Y

b. What was the mechanism of injury?

5. When did your patient first consult you for this condition?

D D M M Y Y Y Y

6. What was the initial diagnosis and why?

7. What was your initial medical advice?

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

9. Is any treatment planned for the future and what if any other treatment options are available?

10. 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

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

Privacy Act Declaration

The information you provide will be held securely by Resolution Life. The information will only be used 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.

You have the right to ask and see the information Resolution Life holds about you. If you believe the information is wrong you may ask that it be corrected by contacting **0800 808 267**.

For further information regarding how Resolution Life collects, uses and stores your personal information please refer to our Privacy Policy which can be found at **resolutionlife.co.nz/privacy-policy**

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