Application / Policy No.

REAL Health / Superior Health
Claim Form

Are you applying for prior approval? ☐ Y ☐ N

Prior approval requires five working days to be processed, provided all requested information is submitted.
Please be aware that it may be necessary to request further information before completing the assessment for your claim.

SECTION 1. Personal Details

Title **First name** **Surname**

Postal address

Unit/apartment/building/floor | Street
Suburb | Town / City | Postcode

Contact Phone 1 **Contact Phone 2**

Email **Date of birth**

SECTION 2. Claim Details

Details of the condition or symptoms which has resulted in this claim (please be specific)

When did you first have symptoms? When did you first seek medical advice?

Have you claimed for this condition previously? ☐ Y ☐ N

Provide details of the investigation / treatment performed / to be performed

Date of admission Is this work or accident related? ☐ Y ☐ N **ACC reference number**

Are these expenses claimable under another insurance policy? ☐ Y ☐ N If yes, please provide your insurer's name and your policy number.

Please supply the name and contact details of your doctor who holds your medical records. (Please be aware that it may be necessary to request further information before completing the assessment of your claim.)

Receipt / Invoice details

Date of treatment	Provider's Name	Condition treated	Pay provider (please tick)	Pay client (please tick)	Amount
				Total value ($)	

SECTION 3. Direct credit details (should the claim be accepted)

Name of account holder

Bank account number

Bank | Branch number | Account number | Suffix

SECTION 4. Disclosures and Declarations

1. Statement of disclosure

A. This claim form collects personal information about you which will be used to; a) investigate and determine the validity of your claim, b) confirm the information in your application for this insurance product, c) maintain relevant statistical records; d) comply with relevant legislation.

B. This information is collected and held by AIA New Zealand at 5-7 Byron Avenue, Takapuna, Auckland 0622, New Zealand.

C. You have a duty to provide AIA New Zealand with all the facts material to your claim and all information, which we may reasonably require in relation to your claim. If you fail to provide this information we may not pay your claim. If you provide false information this may result in your policy being voided from inception or cancelled.

D. Under the Privacy Act 1993 and Health Information Code 1994, you have the right to access to, and correction of, any information held or provided.

E. AIA New Zealand is a member of Health Funds Association of New Zealand (HFANZ). On behalf of its members, HFANZ managed an Integrity Registry for the purposes of detecting and preventing fraud and other serious probity concerns. The Integrity Registry is operated by PricewaterhouseCoopers (PwC).

F. You have rights of access to, and correction of, information held on the Integrity Registry. The contact details for doing so are by writing to AIA New Zealand or HFANZ Integrity Registry Privacy Officer, Health Funds Association of New Zealand, PO Box 25161, Wellington 6146.

2. Declaration and Authority to Obtain and Use information

A. I authorise any doctor, medical specialist, hospital, clinic, insurance company, ACC, employers and any other authority to disclose to AIA New Zealand any and all information concerning my medical history, financial, occupational and insurance information and I authorise AIA New Zealand to collect such information from those persons. A photocopy or facsimile of this authorisation shall be as valid as the original.

B. I authorise AIA New Zealand to disclose any information collected about me to any relevant third party, including any doctor, medical specialist, hospital, clinic, insurance company, ACC, the Ministry of Health, employers or any other authority for the purposes set out in section 4.1.A.

C. I have read and understood the information in this claim form including the section above relating to the Privacy Act 1993 and the Health Information privacy Code 1994.

D. I declare that all information provided by me relating to this claim is true and correct, and no material information has been withheld.

E. I am authorised by each member named on this form to complete and sign on their behalf.

SECTION 5. Declaration to AIA New Zealand

Full name of Claimant

Signature of Claimant **Date**

(To be signed by the parent / legal guardian if claimant is a child under 16 years.)

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

My Adviser ☐ Y ☐ N **Adviser's Name:**

Checklist: Please ensure all the relevant information is supplied to enable us to assess your claim.

- ☐ Referral letter from GP or medical practitioner (please attach a claim form)
- ☐ Medical report and estimate of costs from a specialist if hospitalisaton (including day stay facilities) and / or surgical treatment is required (please attach to claim form)
- ☐ ACC letter of acceptance / decline for any accidental / injury related claim
- ☐ All sections of the claim form are completed in full, including the Privacy Act and Health Information Code declaration

Please return completed claim form with relevant documentation to the address below, email to nz.claims@aia.com or fax to 0800 181 234.

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