Application / Policy No.

Superior Health Cover - Claim Form

Important information you must read before submitting this claim

- **A GP referral letter must be attached to this claim form**
- **An estimate of costs must be attached to this claim form for surgical procedures**
- **Claims must be submitted within 12 months from the date of treatment.**

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 of your claim.

Section 1: Personal Details

Policy Owner

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

Claimant *(if claimant is not the Policy Owner)*

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

Physical address

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

Postal address *(if different from physical address)*

PO Box / private bag number
Street
Suburb
Town / city | Postcode

Home phone ( )

Business phone ( )

Mobile phone

Fax No ( )

Email

Date of birth

Section 2: Claim Details

Policy Owner

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

Have you claimed for this condition previously? Y N

When did you first have symptoms?

When did you first seek medical advice?

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

Date of admission

Date of discharge

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.)

Is this work or accident related? Y N

ACC reference number

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)*

Which bank account would you like your claim paid into?

☐ Same bank account as the one my premium is paid from (Credit cards cannot be reimbursed)

☐ A different bank account Name of account holder

Bank Branch number Account number Suffix

Section 4: Disclosures and declarations

1. Statement of disclosure

1. 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.
2. This information is collected and held by AIA New Zealand at 5-7 Byron Avenue, Takapuna, Auckland 0740, New Zealand.
3. 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.
4. Under the Privacy Act 1993 and Health Information Code 1994, you have the right of access to, and correction of, any information held or provided.

Declaration and Authority to obtain and use information

1. I authorise any doctor, medical specialist, hospital, clinic, insurance company, ACC, employers or any other authority to disclose to New Zealand any and all information concerning my medical history. A photocopy or facsimile of this authorisation shall be as valid as an original.
2. 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.
3. I declare that all information provided by me relating to this claim is true and correct, and no material information has been withheld.
4. I am authorised by each member named on this form to complete and sign on their behalf.

2. Declaration to AIA New Zealand

I declare that the answers to the above questions are true and correct.

Full name of Policy Owner

Signature of Policy Owner **Date**

Full name of Claimant

Signature of Claimant **Date**

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

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 to claim form)

☐ Medical report and estimate of costs from a specialist if hospitilisation (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

☐ Original copies of invoices / receipts

☐ 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: it to nz.claims@aia.com or fax to 0800 181 234.