Combined Insurance

Claim Form

New Zealand

Important Instructions on how to complete the attached Claim Form and how we assess claims. Please read these important instructions on how to complete the attached Claim Form. This may help us to assess your claim faster.

We refer to the Insured or Covered Person as "you" or "your"; and Combined Insurance a division of Chubb Insurance New Zealand Limited as "Combined Insurance", "we", "our" or "us", in the following instructions.

1. It is important that you contact us as soon as possible once you are aware of any circumstance or event giving rise to a claim and provide honest, complete, up-to-date and relevant information when completing this claim form.

2. You should complete Section 1 in full. If you do not fully complete the Claim Form this may result in delays processing your claim while we seek missing information. Please see the Important Notes for Particular Benefits.

3. Your Medical Practitioner, *and only your Medical Practitioner* should complete Section 2 in full. Your Medical Practitioner must also sign and date the Claim Form in the appropriate place.

4. We normally pay benefits up to the date that your Medical Practitioner has signed the Claim Form. If your disability is ongoing after that date, we will send you a Continuing Claim Form or Progress Form which your Medical Practitioner should sign and complete on your next visit.

   Once we have received this completed form, we can make a further payment up to the date your Medical Practitioner has signed the form. The reason we do not pay benefits in advance of when your Medical Practitioner signs a Claim Form, is that the future disability has not yet occurred, and insurance only pays for losses that have already occurred. We follow this procedure even if your Medical Practitioner states an 'approximate date' for your disability to end. Of course, all payments depend on your claim falling within the terms and conditions of your Policy.

5. We may ask you or your Medical Practitioner for more information concerning your claim, or we may arrange a further independent assessment by a Specialist of our choosing.

6. Please send this Claim Form together with all other necessary documents within 30 days of the commencement of your disability via post to Combined Insurance, Private Bag COMBINED, Remuera, Auckland 1541, via fax to 09-520-9009, or email the form to nz.service@nz.combined.com. If you do not report your claim within 30 days and we consider the delay has prejudiced our ability to assess your claim, this may affect and/or delay payment of your claim.

7. Our Claims Process.

   - We will acknowledge receipt of your claim within 5 business days of receiving your claim; and
   - Determine whether or not to accept your claim within 10 business days of the date we have all the information we need to determine your claim.
   - If we are unable to determine whether or not to accept your claim within 10 business days, such as when we request that you provide further information from your doctor or employer, we will advise you of the additional information we require. You must cooperate with us by providing the information we seek to settle your claim.
   - If we require information from an independent specialist, or a doctor or other third party which we request directly, then we will advise you of the information required and will provide you with an estimate of how long we expect it will take to determine your claim, once we have this information.
   - We will update you once every 20 business days, or another such interval as we may agree with you, until your claim is resolved.
   - With the exception of some circumstances, you have a right to access the information we have relied on in evaluating your claim and you can ask us to correct any mistakes or inaccuracies in that information.
   - If we decline your claim, we will clearly explain the reason or reasons. You have a right to access our Complaints and Disputes Resolution process which is summarised on the back page of this claim form.

8. Should you require any assistance in completing this Claim Form, or have any queries about claiming, or how we assess a claim, please contact us on **0800 COMBINED (266 246)** and we will be happy to assist you.

Important Notes for Particular Benefits

9. If your Policy covers you for benefits while you are **hospitalised**, please attach a copy of your hospital statement showing the dates of admission and discharge. If you were in intensive care during your period of hospitalisation, the Statement should indicate this.

10. If you are claiming for a **Fracture** Benefit, please attach a copy of the medical report verifying a fracture.

11. If you are claiming for **Covered Cancer** please attach a copy of a Pathology, Histology, or Histopathology Report, that medically verifies the diagnosis and a copy of your hospital statement showing any out-patient treatments if you are claiming an **Out-patient Treatment** benefit.

12. If you are claiming a benefit for **Skin Cancer**, please attach a medical statement verifying this.

13. If you are claiming a **Transportation** benefit please attach a receipt for your travel expenses.

14. If you are claiming a **Family Lodging** benefit please attach a copy of your hotel/motel bill.

15. If you are claiming a **Facial Disfigurement** benefit, please send a photograph of the relevant scar with your claim form. Please note that we may require you to submit a further photograph of your scar if your injury had not fully healed at the time you first lodged your claim.

16. If you are claiming an **Emergency Ambulance** benefit, please attach a copy of your ambulance statement or account.

COMBINED INSURANCE®

A division of Chubb Insurance New Zealand Limited

SECTION 1

Claimant to complete this page

(Please print using BLOCK LETTERS)

IMPORTANT. Write your Account Number here _____ *Office Use Only* ☐☐☐☐☐☐☐

Claimant's Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: Claimant's Full Name:

Date of Birth: / / Height: Weight:

Residential Address: Postcode:

Postal Address *(If different from above)*: Postcode:

Claimant's Telephone Number: Daytime: ( ) Mobile: ( )

Claimant's Email Address : Occupation:

Employer's Name: Employer's Address:

Employer's Contact Person:

Employer's Contact Telephone Number: ( )

Are you claiming under a Family Policy? ☐ Yes ☐ No ***If Yes, please provide Family Policy Account Number:***

It is our preference to make claims payments by Electronic Funds Transfer (EFT).

A Do you want us to make payments on this claim by EFT into your account?

☐ Yes ☐ No

B ***If Yes to 'A',*** is the account that you pay your premium from the Account you want us to pay your claim payments to?

☐ Yes ☐ No

C ***If No to 'A' and/or 'B',*** please provide name of preferred Financial Institution:

Account Name:

Bank Branch Number Account Number Suffix

Complete for Accident only

1. When did the accident occur? Date: / / at am / pm
2. Where did the accident occur? Street Number: Street Name:

   Suburb: City/Town:
3. Nature of Injuries: *(Please be specific)*
4. How did the accident occur? *(Please be specific)*

5. If it was a motor vehicle accident, please provide a description of the vehicle(s) involved.
   *(**Note:** if more than 2 vehicles involved attached details of other vehicles separately)*

   Your vehicle Registration No.: Make: Model:

   The other person's vehicle Registration No.: Make: Model:
6. Was the accident reported to the Police? ☐ Yes ☐ No Date: / / Police Station:

   Was anyone charged by the Police? ☐ Yes ☐ No ***If Yes, who was charged?***

   What was the charge? ***(Note:** You must provide us with a copy of the Police Report if we request you to)*
7. During the 24 hours before the accident, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

   *(**If Yes,** please provide details - state types and quantities)*

   Did you have a Blood Alcohol Test or Drug Test by the Police? ☐ Yes ☐ No ***If Yes, what was the result?***
8. Were you transported to Hospital by Ambulance after the accident? ☐ Yes ☐ No

   Name of Hospital you attended: ***(Note:** You must provide us with a copy of the Ambulance Report if we request you to)*
9. Eye witness details. Please provide details of any eye witness.

   Witness 1 - Full Name: Address:

   Email Address: Telephone Number: ( ) *Daytime*

   Witness 2 - Full Name: Address:

   Email Address: Telephone Number: ( ) *Daytime*

   Witness 3 - Full Name: Address:

   Email Address: Telephone Number: ( ) *Daytime*

Complete for Sickness only

10. Nature of sickness: *(Please be specific)*

11. When were the symptoms first noticed? Date: / /

12. Who was the first Medical Practitioner you consulted for this condition?

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

When did you first see the Medical Practitioner for this condition? Date: / /

13. Have you consulted any other Medical Practitioner for this condition? ☐ Yes ☐ No ***(If Yes,** please provide details)*

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

Dates of Consultations:

14. Did you go to Hospital in respect of this sickness? ☐ Yes ☐ No ***(If Yes,** please provide details)*

Hospital Name:

Address:

Date of Admission: / / Date of Discharge: / / Number of Days in Hospital:

15. Have you previously had the same sickness? ☐ Yes ☐ No ***(If Yes,** please provide details)*

Date(s):

Treatment Received:

Name of treating Medical Practitioner/Specialist:

Address of Medical Practitioner/Specialist who treated you:

Complete for Accident and Sickness

16. Which Medical Practitioner is currently treating you for your injury/illness? *(If the same as **'Q12'** write 'As above')*

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

When did you first see the Medical Practitioner for this condition? Date: / /

Other Dates of Treatment? ☐ Yes ☐ No ***(If Yes,** please provide details)*

17. Who is your usual family Medical Practitioner? *(If the same as **'Q16'** write 'As above')*

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

18. What other significant medical or surgical treatments have you received in the past 5 years? *(Please provide details)*

Date(s):

Nature of the condition(s) treated:

Name of treating Medical Practitioner/Specialist:

Address of Medical Practitioner/Specialist who treated you:

19. Are you affected by any other long term or chronic disability? ☐ Yes ☐ No ***(If Yes,** please provide details)*

20. Were you hospitalised? ☐ Yes ☐ No ***(If Yes,** please state date of hospitalisation)* From: / / To: / /
(Please also attach a copy of any hospital statements if you are hospitalised and claiming a confinement benefit)

21. Are you claiming for Transportation and Family Lodging Benefits?
☐ Yes ☐ No ***(Please attach receipts supporting your claim if you are claiming for these)***

22. If you are claiming a benefit as the result of the diagnosis of any covered Skin Cancer, please attach proof of diagnosis. ☐ Yes ☐ No

23. **'Total Disability'.** Between what dates were you unable to perform any duties? *(Refer to the **'Definitions'** at the top of **'Section 2'**)*
From: / / To: / /

24. **'Partial Disability'.** Between what dates were you able to perform only partial duties? *(Refer to the **'Definitions'** at the top of **'Section 2'**)*
From: / / To: / /

25. Date you returned to your normal duties. Date: / /

SECTION 2

Medical Practitioner only to complete this section

This section must be fully completed by a Legally Qualified Medical Practitioner, at the Claimant's expense.

Please read carefully before completing this section.

Definitions

Total Disability
The inability to perform each of the substantial duties of your business or occupation (usual activities if not employed).

Partial Disability
The inability to perform one or more, but not all of the substantial duties of your business or occupation (usual activities if not employed).

Medical Practitioner
Means a licenced medical practitioner operating within the scope of his or her New Zealand licence and who is not a member of your immediate family.

Patient's Full Name: _____ Date of Birth: / /

1. Please tick whether claim is for: ☐ Sickness ☐ Injury

   Diagnosis:

   Cause:

2. If the patient is suffering from an injury, how did the patient advise you that the injury occurred?

3. **Please Complete for Fractures only.** Was the Fracture confirmed by an X-Ray? ☐ Yes ☐ No *(Please attach a copy of the X-Ray report)*

   Describe the type of Fracture:

4. When did the symptoms first appear, or the accident happen? Date: / /

5. When did the patient first consult you for this condition? Date: / /

   Did Total Disability begin this day? ☐ Yes ☐ No ***If No, please state date total disability began*** Date: / /

6. Has the patient ever had this condition before? ☐ Yes ☐ No
   If Yes, please state if the present condition is an aggravation or recurrence of a previous injury or sickness.

   Recovery Date: / /

7. Has the patient ever had any other disease or infirmity that may be affecting the present condition? ☐ Yes ☐ No
   If Yes, what was the disease or infirmity?

   To what degree did this contribute to current disability?

8. Is the patient still under your care for this condition? ☐ Yes ☐ No
   If Yes, and the patient has not recovered, what is the expected recovery date? / /

   Please provide details of the Treatment Plan to assist the patient's recovery:

   If No, and the patient has recovered, please write the recovery date. Recovery Date: / /

9. Has the patient had surgery or is surgery anticipated? ☐ Yes ☐ No Date: / /

   Details of surgery:

10. Has the patient been referred to any other Medical Practitioner or Specialist? ☐ Yes ☐ No *(**If Yes,** please provide details)*

    Medical Practitioner's Name:

    Medical Practitioner's Address:

    Medical Practitioner's Telephone Number: ( ) Date Referred: / /

11. Are you the patient's usual Treating Medical Practitioner? ☐ Yes ☐ No ***If Yes, for how many years?***

    If No, please advise the details of the patient's usual Treating Medical Practitioner/Medical Practice.

    Medical Practitioner/Medical Practice's Name:

    Medical Practitioner/Medical Practice's Address:

    Medical Practitioner/Medical Practice's Telephone Number: ( )

12. Disability Periods. *(Refer to **'Definitions'** at top of the opposite page)*

a) Totally Disabled:

From: / / To: / / *(Inclusive)*

b) Partially Disabled

From: / / To: / / *(Inclusive)*

c) Hospitalised as an overnight In-patient

From: / / To: / / *(Inclusive)*

At: *(Hospital Name)*

d) Hospitalised as an overnight In-patient in Intensive Care

From: / / To: / / *(Inclusive)*

At: *(Hospital Name)*

e) Do you expect the patient to remain totally disabled for the next 12 months? ☐ Yes ☐ No

13. Is there any further medical information relevant to this claim?

Medical Practitioner's Declaration

WE RECOMMEND THAT A COPY OF THIS FORM IS TAKEN FOR YOUR FILES.

MEDICAL PRACTITIONER'S STAMP REQUIRED

Date: / / Provider Number:

Qualifications:

Address: *(If not on stamp)*

Telephone Number: *(If not on stamp)* ( )

Email Address: *(If not on stamp)*

Full Name of the Medical Practitioner's:

Signature of the Medical Practitioner's: X

Important information about our Complaints and Dispute Resolution process

We take the concerns of our customers very seriously and have detailed complaints handling and dispute resolution procedures that you can access, at no cost to you. If you are dissatisfied with our dispute determination or we are unable to resolve your complaint or dispute within 40 days, you may refer your dispute to Financial Services Complaints Limited, an approved dispute resolution scheme of which we are a member. Please refer to either your Policy Information Booklet, or the QFE Disclosure Statement, or our website www.combinedinsurance.co.nz or phone us on the number below for full information of our complaints and dispute resolution process.

MEMBER FAIR INSURANCE CODE

Combined Insurance is a division of Chubb Insurance New Zealand Limited

Chubb Insurance New Zealand Limited | Company No. 104656 | FSP No. 35924

Customer Service
Phone 0800 COMBINED (266 246)

Email
nz.service@nz.combined.com

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www.combinedinsurance.co.nz

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CU1-3, Shed 24, Princes Wharf, Auckland 1010

COMBINED INSURANCE®

A division of Chubb Insurance New Zealand Limited

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ChubbNZ11-22-0219

Combined Insurance Claim Privacy Consent / Medical Authority and Declaration

Privacy Consent

Combined Insurance collects, uses and retains your personal information only in accordance with the principles in the Privacy Act 1993. A copy of our Privacy Statement, which expands upon our privacy obligations and provides further information on your rights to access your personal information held by us is available on our website or by contacting our Privacy Officer on +64 (9) 377 1459 or Privacy.NZ@chubb.com.

Your personal information will be used by Combined Insurance, or any third party that Combined Insurance provides the information to, for the purpose of assessing your claim or your entitlement to benefits or attending to any complaints or disputes you lodge and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information includes:

(a) any information provided in relation to your claim;

(b) any information that is health information or sensitive information;

(c) any other personal information that you may provide to Combined Insurance or its third party contractors;

(d) any information relating to the insurance policy on your life, including terms and conditions and claims history;

(e) details of your employment including position, period of employment, remuneration, hours worked and duties performed; and

(f) any other information relating to your income and solvency.

To process your claim Combined Insurance may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by Combined Insurance, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the Parties). You agree that the Parties may disclose your personal information to Combined Insurance.

Combined Insurance may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies within the Chubb Group, other insurers, our reinsurers, and government agencies (where we are compelled to by law). These third parties may be located outside New Zealand. Combined Insurance may also disclose your personal information to witnesses in respect to your claim.

In providing your personal information to Combined Insurance in this form and in relation to the claim the subject of this form, you agree to us using and disclosing your personal information pursuant to Combined Insurance's Privacy Statement and this Privacy Consent. In the event of any conflict between the documents, this Claims Privacy Consent shall be determinative. This consent remains valid unless you alter or revoke it by giving written notice to our privacy officer.

If you do not consent to the terms of this Claims Privacy Consent or revoke your consent, Combined Insurance may not be able to process or assess your claim.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, Combined Insurance has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Combined Insurance using and disclosing my personal information pursuant to Combined Insurance's Privacy Statement and Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Combined Insurance's privacy officer.

I authorise any person or entity, including but not limited to Medical Practitioners and the Parties referred to in the Privacy Consent, to provide to Combined Insurance such personal information (including health information) as Combined Insurance in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to Combined Insurance in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim. I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint Combined Insurance to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Declaration of Claimant

Full Name of the Claimant:

Signature of the Claimant: X

Date: / /

Declaration of Witness

Full Name of the Witness:

Signature of the Witness: X

Date: / /