OneChoice

# Accidental Serious Injury Insurance Claim Form

- To help ensure you receive a prompt assessment, please complete all the required sections of this booklet. If you need assistance please call **0800 005 806**. Please note however, that a claim cannot be assessed until all required documents (including this original and completed claim form) are received.
- Please note that the information required to be completed in this document is in relation to the Life Insured, unless otherwise stated.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this document are fully addressed and answered. Responses such as "refer to doctor", "see above", etc., are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

## Filling in this form:

- Use a black or blue pen
- Mark boxes like this ☐ with ✓ or ✗
- Where you see a box like this ☐▶ **Go to 5** skip to the next questions and go to the number indicated. You do not need to answer the questions in between.

There are 2 parts to the claim form:

- **Part A** is to be completed by the claimant.
- **Part B** is to be completed by the registered Medical Practitioner treating the Life Insured.

**Promoted and distributed by**
OneChoice, a trading name of
Greenstone Financial Services NZ Limited
(NZBN 9429047013582).

**Issued by**
Pinnacle Life Limited
(NZBN 9429030397248)
PO Box 1471
Auckland 1140

**Please return this form to Reply Paid OneChoice, Reply Paid DX Box EP71505, Penrose, Auckland** (no stamp required).

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# PART A: Accidental Serious Injury Insurance Claim Form

## Privacy

Greenstone Financial Services NZ Limited ("Greenstone") collects personal information about you on behalf of Pinnacle Life Limited ("Pinnacle", "we", "us" or "our"). All information collected throughout the claims process by Greenstone or Pinnacle will be shared with both companies.

The information we collect will be used to assess and process your claim and any procedures associated with this. If you fail to provide us with all or part of the information we require, we will be unable to assess and process your claim. Personal information will be collected from you or, where that is not practicable, from other organisations such as Medical Practitioners and government agencies.

The information we collect may be disclosed to other organisations, including but not limited to medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation organisations, or any organisation that is duly appointed to manage the administration of such insurance Policy or interpreters. Pinnacle or Greenstone will share your information with associated companies in Australia but are unlikely to send your personal information to any other foreign jurisdiction.

You can read more about how Greenstone collects, uses and discloses your personal information in its Privacy Policy, which is available on the New Zealand Seniors website or you can request a copy by contacting us. You can also obtain the Privacy Policy of Pinnacle on their website, pinnaclelife.co.nz. If you wish to access your information (including correcting or updating your information), please call **0800 005 804** Monday to Friday, 8am to 8pm.

## Section A – Policy Information

Policyowner | Policy Number

## Section B – Policyowner Details

Title | First name | Surname

Residential address

Postal address

Phone (home) | (work) | (mobile)

Email

## Section C – Accidental Serious Injury Insurance Claim

### 1. Personal details of the Life Insured

First name | Surname

Date of birth (DD / MM / YYYY) | Weight | Height

### 2. Medical details of the Life Insured

**a.** Which condition have you suffered? (Please tick one)

☐ Quadriplegia /Tetraplegia ☐ Paraplegia ☐ Hemiplegia ☐ Blindness ☐ Deafness

☐ Total and Permanent Loss of Use of Two Limbs

**b.** On what date did your symptoms first commence? (DD / MM / YYYY)

**c.** The date when you were diagnosed? (DD / MM / YYYY)

**d.** Has the insured previously had the same or similar condition or symptoms?

No ☐ Yes ☐ ▶ Please provide full details:

**e.** The doctor the Life Insured first consulted about the claimed condition:

Name

Address

Phone number

Date of first consultation (DD / MM / YYYY) Date of last consultation (DD / MM / YYYY)

**f.** Is the doctor named in (e) above i.e. the usual doctor the Life Insured attends?

Yes ☐ No ☐ ▶ Please provide details of your usual doctor:

Doctor's name

Address

Phone number

**g. Disclosure of information – doctor's authority**

For the purpose of assessing my claim for a serious illness benefit, I authorise my current Medical Practitioner, and any other Medical Practitioner or health professional I have consulted or may consult in the future, or that Pinnacle Life Limited appoints to examine me, to disclose information about my health and related matters to Pinnacle Life Limited. A photocopy of this authorisation will be valid as the original.

SIGN HERE ✗

Signature of Policyowner/Life Insured | Date (DD / MM / YYYY)

☐ ▶ **Go to Section D – Checklist** **Page 4**

☐ ▶ **Go to Section E – Policy Discharge** **Page 4**

☐ ▶ **Go to Section F – Declaration** **Page 4**

☐ ▶ **Go to Accidental Serious Injury – Confidential Medical Report** **Part B (end of this form)**

## Section D – Checklist

**Copies of the relevant documentation related to this claim are attached as follows:**

☐ A copy of the claimant's identity (e.g. Driver's Licence or Passport)

## Section E – Policy Discharge

**(Please note this section of the form will only be used if Pinnacle Life Limited accepts liability for the claim)**

☐ I/We hereby request payment of the benefit payable for the Insurance Policy (details on page 2 of this document), in full satisfaction for all claims whatsoever under the Policy for the Life Insured

Life Insured name, and do hereby discharge Pinnacle Life Limited from all liability there under other than for payment of the benefit.

## Section F – Declaration

As the Policyowner/Life Insured/Claimant I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim.

I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Pinnacle Life Limited requires to assess this claim it will not be assessed and processed.

SIGN HERE ✗ Signature of Policyowner DD / MM / YYYY Date

## Section G – Direct Credit Authority

**Completing the details below will assist us in getting your claim payment to you as quickly as possible.**

Once your claim has been assessed, the Benefit Amount payable will be credited to the account below.

Account number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account name

Name of bank/ financial institution

Branch name/location of financial institution

NB. If your account is held with a Credit Union, it may take longer for the Benefit Amount payable to be cleared. May we suggest you contact your nominated Credit Union.

SIGN HERE ✗ Your signature DD / MM / YYYY Date

**This page is intentionally left blank.**

# PART B: Accidental Serious Injury – Confidential Medical Report

**This section is to be fully completed by the registered Medical Practitioner treating the Life Insured.**

- Please note that the information required to be completed in this document is in relation to the Life Insured.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this section are fully addressed and answered. Responses such as "refer to doctor", "see above", etc., are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

## 1. Life Insured details

First name _____ Surname _____

Date of birth DD / MM / YYYY

Residential address _____

## 2. Medical details

**a.** Are you the Life Insured's usual medical attendant? Yes ☐ No ☐

**b.** What is the exact diagnosis of the condition? (Please attach copies of all pathology, test results, etc. that confirm the diagnosis).

**c.** What is the date of diagnosis? DD / MM / YYYY

**d.** Date of the first consultation in connection with the current condition: DD / MM / YYYY

**e.** Provide the dates and results of any X-rays, ECG, blood pressure or other tests performed.

| Date | Test | Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**f.** What treatment is currently being given, including surgery and medication, if any:

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**g.** Please provide the names and addresses of any consulting specialist(s) or medical services the Life Insured has been referred to:

| Name | Speciality or medical service |
|---|---|
| | |
| | |
| | |
| | |

**h.** If the Life Insured has been hospitalised, provide the following dates:

| Admission date | Discharge date | Name of hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**i.** Have you ever treated the Life Insured before for any condition? No ☐ Yes ☐ ▶ Please supply details:

| Date consulted | Nature of the condition |
|---|---|
| | |
| | |
| | |
| | |

**j.** Please provide details if the Life Insured has a previous history of the current condition, or any impairment likely to be connected with the current condition.

## 3. Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended the above named Life Insured and that all the information supplied by me in this Report is true. I agree that Pinnacle Life Limited may provide copies of this Report to any Medical Specialist from whom Pinnacle Life Limited seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom the Insurer is obligated by law to give access to this Report.

Name

Qualifications

Address

Telephone

Facsimile

SIGN HERE ▶ ✗

Medical Practitioner's signature

DD / MM / YYYY

Date