OneChoice

Income Protection 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 original documents 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 relevant questions 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 questions and 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 question on this document you are addressing. Please ensure that you sign and date the piece of paper.
- Please note that it is the Policyowner's or Life Insured's responsibility for the payment of all fees associated in the completion of the Specialist Medical Report or Confidential Report.

Filling in this form:

- Use a black or blue pen
- Mark boxes like this ☐ with ✓ or ✗

There are 2 parts to the claim form:

- Part A is to be completed by the Life Insured.
- 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 OneChoice, Reply Paid DX Box EP71505, Penrose, Auckland (no stamp required).

OneChoice®
INSURANCE FOR KIWIS

PART A: Income Protection 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 OneChoice 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**.

Section A – Policy Information

Policyowner

Policy number

Section B – Life Insured's Details

Title

First name

Surname

Date of birth DD / MM / YYYY

Gender: Male ☐ Female ☐

Residential address

Postal address

Phone (home)

(work)

(mobile)

Email

Occupation

Are you: Right Handed ☐ or Left Handed ☐

Height cm

Weight kg

Are you a smoker? No ☐ Yes ☐

Country of Birth

How long have you lived in New Zealand years / months

Do you require an interpreter? No ☐ Yes ☐ ▶

Language

Section C – Income Protection Insurance Claim

1. General

a. Do you believe your condition(s) will result in you being unable to work for greater than 6 months?

No ☐ Yes ☐

b. Is your disability the result of an injury or an illness?

Injury ☐ ▶ Please go to Question 2. Illness ☐ ▶ Please go to Question 3.

2. Injury details

Only complete Question 2 if your disability was a result of an injury.

a. Where did this injury occur? (place/address)? Please include the exact place and address:

b. What date and time did this injury occur? DD / MM / YYYY TIME

c. Please provide a detailed description of how you were injured? Please ensure you provide as many details as possible:

d. Were there any witnesses to your injury, and if so, what are their names and contact details?

e. Did an ambulance, first aid officer or police attend following your injury? No ☐ Yes ☐ ▶ Who attended and what did they do?

f. Was the injury or accident related to your employment? No ☐ Yes ☐ ▶ How is it related to your employment?

3. Illness details

Only complete Question 3 if your disability was a result of an illness.

a. Please describe in detail the illness suffered: Please ensure you provide as many details as possible:

4. Symptoms

a. What date did the symptoms of your injury or illness first occur? DD / MM / YYYY

b. Please provide a full description of the symptoms resulting from your injury or illness in the area provided below. If there are more than 5 symptoms please attach a separate sheet with all details in the same format:

Symptom	How often does this symptom occur?	How does this symptom prevent you from working?
1		
2		
3		
4		
5		

c. Do you have any other medical conditions causing you to claim?

No ☐ Yes ☐ ▶ If 'Yes', please provide details:

5. Pre-existing

Have you ever had this, or a similar injury or illness before?

No ☐ Yes ☐ ▶ Please provide details and date: DD / MM / YYYY

6. Treatment

a. Please provide the details of the doctor you first consulted about your injury or illness:

Name & Qualification	
Telephone	
Doctor's address	
Doctor's email	

b. Date seen? DD / MM / YYYY

c. When did you first consult this doctor about the injury or illness? DD / MM / YYYY

d. What was the date of your last consultation? DD / MM / YYYY

e. Has a follow-up appointment been organised?

No ☐ Yes ☐ ▶ If 'Yes', date of next consultation is: DD / MM / YYYY

f. Is the doctor named in (a) your usual doctor? Yes ☐ No ☐ ▶ If 'No', please provide details of your usual doctor:

Name & Qualification	
Telephone	
Doctor's address	
Doctor's email	

7. Please provide details of all other treating practitioners and health care providers seen by you in connection with this condition: (if insufficient space please add an attachment)

Name & Specialty	Telephone	Doctor's address	Date seen
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

8. Current treatment

a. Are you currently receiving treatment?

Yes ☐ ▶ If 'Yes', date of next consultation is: DD / MM / YYYY No ☐ ▶ If 'No', please detail reason for ceasing treatment:

b. Current medications:

Medication name	Dosage	Date prescribed	Response	Expected duration
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY
		DD / MM / YYYY		DD / MM / YYYY

c. Details of any planned or recent surgery:

Hospital name	Surgery type	Date of admission	Date of discharge	Estimated recovery timeframe
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY

d. What is your response to treatment thus far?

9. Occupation

a. What is your job title/occupation?

b. How long have you been in your current job/occupation?

c. **(If self-employed)** How long has your business been operating for?

d. **(If self-employed)** Please provide NZBN and number of Employees?

e. How many hours per week were you working immediately prior to your disability?

f. Did you reduce your hours immediately prior to your last physical hours at work?

No ☐ Yes ☐ ▶ If 'Yes', from what date did your hours reduce: ☐ and what were the hours you worked? ☐

g. Please tick the amount of manual labour your occupation involves:

☐ Nil ☐ 1-20% ☐ 21-40% ☐ 41-60% ☐ 61-80% ☐ 81% or more

h. Please list all work duties performed in your occupation immediately prior to your disability: (*Please note that the percentage of working time must equal a total of 100%*)

Duty	Percentage of working time
	%
	%
	%
	%
	%

i. What percentage of time on average did you spend in the following activities while performing your usual occupation?

Sitting	Standing	Walking	Bending	Lifting	Driving
%	%	%	%	%	%
Climbing	**Kneeling**	**Reaching above shoulders**	**Other please specify:**		
%	%	%			

10. Working capacity

a. Have you stopped work completely?

No ☐ Yes ☐ ▶ What date and time did you stop all work completely? DD / MM / YYYY TIME

b. Please list all your work duties you are **unable** to perform due to your illness or injury:

c. Please list all your work duties that you are still **able** to perform:

d. Since completely stopping work have you undertaken any work, regardless whether it is paid work or not?

No ☐ Yes ☐ ▶ Please provide full details of the work that you have undertaken including all the dates, work duties, the number of hours per day worked, and the place of work:

Dates worked	Work duties	Number of hours worked per day	Place of work
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			
DD / MM / YYYY			

e. If you have not returned to work yet, when do you expect to be able to return to work? Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

11. Income

a. What was your average weekly income before your disability commenced? $ Per week

(*Please provide us with a copy of your last three months of payslips, or tax return if self-employed, immediately prior to you ceasing work due to your disability*)

b. Are you in receipt of any sick leave?

No ☐ Yes ☐ ▶ If 'Yes', on what date does sick leave end? DD / MM / YYYY

c. If you have returned to work in a reduced capacity, what is your weekly income? $ Per week

(*Please provide a copy of your payslips since returning to work*)

d. Do you have any other source of income?

No ☐ Yes ☐ ▶ Please provide details of the source of income, frequency and gross amount:

e. **(If self-employed)** Please provide accountant's details:

Accountant's name	
Accountant's telephone	
Accountant's address	
Accountant's email	

12. Have you ever made, intend to make, or are entitled to claim any benefits under any insurance policy or Government Benefit:

No ☐ Yes ☐ ▶ If 'Yes', please complete details below:

Income Protection ☐	Veteran's Affairs Benefits ☐	Unemployment benefits ☐
Supported Living Payment ☐	Trauma ☐	Accident Compensation Corporation (ACC) ☐
Total & Permanent Disablement ☐		

What is the organisation's name? _____

What is your reference number? _____

How much income have you received? $ _____ (gross before tax)

What period does this cover? From DD / MM / YYYY to DD / MM / YYYY

Please provide copies of all documentation verifying the above payment(s).

This should include any correspondence with ACC including acceptance and payment letters, or if an ACC claim has been declined your decline letter.

Please ensure that all questions have been answered before you proceed further.

Section D – Declaration and Doctor's Authorities

Please ensure you sign both the following Declaration and Doctor's Authorities

a. Declaration & Consent:

I have read and carefully considered the questions in this document and that all the responses are true and correct in relation to me.

I ACKNOWLEDGE that this Declaration is part of a claim for an Income Protection benefit and that the making of a false statement may invalidate my claim, and 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, and that I am the Insured Person of the Policy shown on this document.

I UNDERSTAND that in order to assess and process my application, Pinnacle may need information about me, including (but not limited to) medical, financial, legal and employment.

I CONSENT to Pinnacle obtaining information about me from any Medical Practitioner or health professional that I have consulted at any time and anyone that Pinnacle wishes to appoint to examine me, legal practitioners, legal tribunals and courts, investigation organisations, accountants or other consultants, Pinnacle's parent company, other insurance or reinsurance companies, my past and present employers, and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also CONSENT to Pinnacle disclosing information about me to any of the organisations mentioned above, insofar as such disclosures are necessary for Pinnacle to perform its functions.

SIGN HERE

✗ Life Insured's signature

DD / MM / YYYY Date

b. Disclosure of Information – Doctor's Authority

Releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **Pinnacle Life Limited**, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Doctor's Authority 1 – Release of information, excluding consultation notes

Explanatory notes: Through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Doctor's Authority 2 – Release of full record

Explanatory notes: Through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Doctor's Authority 1 – Release of information, excluding consultation notes

Release any of my health information except the consultation notes held by my General Practitioner/Practice.

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Pinnacle Life Limited, or to third parties they engage.

I agree to all of the following:

- My health information can be released in the form Pinnacle Life Limited asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers;
- Pinnacle Life Limited can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and New Zealand Privacy Principles;
- This Authority is valid only while Pinnacle Life Limited is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover; and
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Life Insured's name

Life Insured's signature

Date

Doctor's Authority 2 – Release of full record

Release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances.

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Pinnacle Life Limited, or to third parties they engage, only if Pinnacle Life Limited. has asked them for a report on my health and either:

- The General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all of the following:

- Pinnacle Life Limited can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and New Zealand Privacy Principles;
- This Authority is valid only while Pinnacle Life Limited is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover; and
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Life Insured's name

Life Insured's signature

Date

c. Disclosure of Information – Nominated Representative

The below authority is only to be completed if you are nominating someone to act or represent you on your behalf. Otherwise it is not required.

For the purpose of assessing my claim for an Income Protection benefit, I AUTHORISE the below nominated representative to receive information regarding my claim. I DECLARE that I have advised the nominated representative of this Authority and provided to them a copy of this Income Protection Insurance Claim. I acknowledge that the information provided may include any information that Pinnacle Life Limited holds about me in respect to my claim including, health, lifestyle, employment and financial. This representative is bound by the "Declaration and Consent" in this Income Protection Insurance Claim. I accept that this electronic authority replaces the need for a personally signed "Disclosure of Information – Nominated Representative".

Nominated Representative's Name

Nominated Representative's Date of Birth DD / MM / YYYY

Nominated Representative's Contact Number

Relationship to the Insured Person

Section E – Direct Credit Authority

Completing the details below will assist us in getting your claim payment to you as quickly as possible. The account needs to be in the name of the Life Insured only.

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

X

Life Insured's signature

DD / MM / YYYY

Date

Section F – Checklist

Certified copies of the relevant documentation related to this claim are attached as follows:

What is a certified copy?
This is a signed photocopy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, accountant, solicitor, doctor, bank manager or police officer. It means you keep the original.

Income Protection

- ☐ A certified copy of proof of the Life Insured's identity (e.g. Birth Certificate, Driver's Licence or Passport).
- ☐ Copies of your last 3 months of payslips, or if you're self-employed your most recent tax return, immediately prior to your illness or injury.
- ☐ If you have returned to work in a reduced capacity, copies of your last 3 payslips since returning to work.
- ☐ Any medical notes you currently hold which would support your claim.
- ☐ If you have submitted a claim to ACC please provide copies of any letters you have received regarding the acceptance, or decline, of your claim and payments.
- ☐ If you have claimed any benefits under any other insurance policy or government benefit, please provide any documentation that verifies any payment.

PART B: Income Protection Insurance Claim Form – 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 as indicated below.
- Please note that it is the Life Insured's responsibility for the payment of all fees associated in the completion of this document.
- To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the questions in this section are fully addressed and answered.
- 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's details

First name | Surname

Date of birth (DD / MM / YYYY) | Gender: Male ☐ Female ☐ | Height (cm) | Current weight (kg)

Residential address

2. Medical details

a. Please state the insured person's occupation/job title:

b. Please detail the date the insured person was first ever seen at your medical practice: (DD / MM / YYYY)
(*not just for the current medical condition*)

c. In the event that the insured person was referred to you please detail the name and address of the referring health professional:

First name | Surname

Address

d. What date did the insured person consult you in relation to the current medical condition? (DD / MM / YYYY)

e. Please advise the date and nature of the first symptoms related to this condition: (DD / MM / YYYY)

Nature of the first symptoms:

f. Please detail your diagnosis:

g. What process was undertaken in order to come to this diagnosis? **(If tests have been undertaken please attach a copy of all of these)**

3. Hospitalisation details

a. If hospitalisation was necessary, please advise:

i) Hospital attended:

ii) Name of treating Medical Practitioner:

iii) Date admitted: DD / MM / YYYY Date discharged: DD / MM / YYYY

b. Has the insured person ever consulted you, or any other Medical Practitioner, previously for a similar condition or symptoms? If so, please provide dates and doctors consulted:

Doctor	Consultation date
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY

c. Please detail all the current reported symptoms:

d. What specific effect do these symptoms have on the Life Insured's functional work ability?

e. Please detail the last date the Life Insured received any sort of treatment from you for their current medical condition:

f. What date are you next scheduled to treat the Life Insured? DD / MM / YYYY

g. If you have referred the Life Insured to any other medical professional(s) please detail their name, speciality, address and the date of the referral: *If you have received correspondence from other medical professional(s) please attach a copy to this document.*

Name of medical professional	Speciality	Address	Date
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

h. Please detail what treatment has been provided to date:
(If medication has been prescribed please detail the dosage and how often it is to be taken)

i. Is the Life Insured compliant with treatment? No ☐ Yes ☐ ▶ Please detail on what basis you believe this is the case:

j. Please detail the improvements in symptoms (if any) that have been achieved through the treatment to date:

k. If there has not been any improvements in the symptoms to date please detail the reason(s) for this:

l. Please detail the future treatment planned, and objectives hoped to be achieved through this treatment:

m. Please detail your understanding of the Life Insured's usual occupation and specific work duties:

a. Occupation:

b. Details of specific work duties:

n. If the current reported symptoms prevent the Life Insured from undertaking their work duties please detail which work duties they are prevented from undertaking and which symptom(s) is preventing this:

Work duties	Symptoms preventing undertaking work duties

o. In your opinion what date did the Life Insured first become unable to undertake their usual occupation due to injury or illness? DD / MM / YYYY

p. What date has the Life Insured reported to you that they totally ceased all work? DD / MM / YYYY

q. Do you consider the Life Insured currently capable of working either full time or part time?

No ☐ Yes ☐ ▶ Please advise from what date, and in what capacity (i.e. full time or part time):

r. If capable of returning to part time work, please advise which duties of their usual occupation the Life Insured is **incapable** of performing?

s. If the insured person has not yet returned to work, when do you anticipate they will be able to return: Full Time: DD / MM / YYYY Part Time: DD / MM / YYYY

t. Have you considered, or are you considering, implementing a return to work program or rehabilitation? If so, please provide a copy of the program or details. If not, please detail the reason(s) you don't consider this is an option at this time:

4. Medical Practitioner's final comments

a. Please detail all ongoing medical problems including current treatment, past history or other circumstances which you are aware are affecting the Life Insured's current condition and ability to work in their usual occupation:

b. Have you given any certificate or report to?

Another Insurance Company:	No ☐	Yes ☐
Accident Compensation Corporation (ACC):	No ☐	Yes ☐
Work and Income:	No ☐	Yes ☐
Third Party Insurer:	No ☐	Yes ☐
Solicitor:	No ☐	Yes ☐
Any other party:	No ☐	Yes ☐

If you have answered "yes" to any of the above, please detail the name of the organisation you have provided this information to and their address:

c. Please provide us with any other comments you may have to assist the Life Insured to return to good health and return to work:

5. Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended to the Life Insured named on page 1 and that all the information supplied by me in this Report is true. I agree that the Insurer 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 Pinnacle is obligated under the Privacy Act 2020 to give access to this Report.

Name			
Qualifications			
Address			
Telephone		Facsimile	
Email			

SIGN HERE

✗ Medical Practitioner's signature

DD / MM / YYYY Date