OneChoice

Income Protection Insurance Progress 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 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 Progress 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

Residential address

Postal address

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

Email

Section C – Progress Report

1. Symptoms and treatment

a. Please list all of your current symptoms:

b. What date did you last consult a registered Medical Practitioner in relation to the medical injury or illness you are making a claim for?

DD / MM / YYYY

c. What is the name of the last registered Medical Practitioner you consulted?

d. What is your current treatment and medication (including dosage)?

e. Please give details of all other healthcare providers (i.e. chiropractors, psychologists, physiotherapists, etc) you have consulted for your medical condition since completing the last claim form:

i) Name:

Address:

Specialty:

Date(s) of all consultation(s): DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY

ii) Name:

Address:

Specialty:

Date(s) of all consultation(s): DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY | DD / MM / YYYY

f. If you have been hospitalised since completing your last claim form, please give the following details:

Name of hospital:

Reason for hospitalisation:

Date of admission: DD / MM / YYYY

Date of discharge: DD / MM / YYYY

2. Work activity

a. Have you worked in any capacity, or engaged in any work activity, **since completing the last claim form**?

(You must tell us about all work you do, whether it is paid or unpaid) No ☐ Yes ☐

b. If you **have worked, or engaged in any work activity, since completing your last claim form**, when was this, what work duties have you performed, and in what capacity have you worked (i.e. full time, part time, dates, hours worked per day, etc)?

Dates worked	Work duties	No. 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			

c. If you have **not worked**, or engaged in any work activity since completing your last claim form, when do you expect to do this? Part time: DD / MM / YYYY Full time: DD / MM / YYYY

d. Have you received or earned any form of income since the commencement of your claim for disability benefits? No ☐ Yes ☐ ▶ If "yes" please provide details below

How much income (gross before tax)? **$**

What period of time (dates) does this cover? From: DD / MM / YYYY To: DD / MM / YYYY

From whom did you receive this income?

e. If you have not yet returned to work, do you have a return to work plan, or have you discussed one with your doctor? No ☐ Yes ☐

i) If **"yes"**, please give details of the return to work plan:

ii) If **"no"**, please advise why this is the case:

f. If you have not returned to work in any capacity, or you have returned to work in a part time capacity, please advise the following:

i) Which of your normal occupational duties are you **unable** to perform?

ii) Please list all the symptoms which are preventing you from performing the duties of your normal occupation?

iii) Which of your normal occupational duties are you **able** to perform?

g. Do you still have a job that you can return to? No ☐ Yes ☐

h. Have you made a claim for, or at any time during the course of this claim, have you received benefits from another source? No ☐ Yes ☐ ▶ If "yes" please provide details below

Who did you make a claim with?

How much income have you received? $

What period of time (dates) does this cover? From: DD / MM / YYYY To: DD / MM / YYYY

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

3. Daily activity

a. Please detail all your daily activities since the completion of your last claim form:

b. If you are limited or prevented from undertaking any of the following please tick the appropriate boxes:

Standing ☐	Walking ☐	Reading ☐	Housework ☐	Bending ☐
Sitting ☐	Socialising ☐	Concentrating ☐	Shopping ☐	Sport ☐
Driving ☐	Swimming ☐	Hobbies ☐	Lifting ☐	

c. Please detail how your symptoms and/or disability limit or prevent you from undertaking or participating in the above activities:

Section D – Declaration

As the Life Insured, 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 my 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 ▶ ✗ Life Insured's signature

DD / MM / YYYY Date

☐ ▶ **Go to Part B: Income Protection Insurance – Progress Medical Report**

- For your claim assessment to proceed please make sure **Part B: Income Protection Insurance – Progress Medical Report** is completed by your registered Medical Practitioners.
- Your registered Medical Practitioner should complete and sign Part B of the OneChoice Income Protection Insurance Progress Claim Form before it is sent to us for review.

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PART B: Income Protection Insurance – Progress 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 form.
- 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.
- 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 ☐

Residential address

2. Medical details

a. Since your last report to us, please list all dates the Life Insured has consulted you:

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

b. Please detail the **current** diagnosis?

c. Below please detail the Life Insured's current symptoms as a result of the above diagnosis:

Objective symptoms	Subjective self reported symptoms

d. If the Life Insured's disability has extended beyond the expected recovery period please detail the reasons for this:

e. Please detail all treatment provided to the Life Insured since your last report to us. **(If tests have been undertaken please provide us with a copy of the test results)**:

f. Please detail the planned future treatment and what objectives are hoped to be achieved through this, including the time frame:

g. Are there any other **medical**, or **non-medical**, circumstances that are limiting or preventing the Life Insured from returning to full or part time work? If so, please provide these full details:

h. Since your last report to us if you have referred the Life Insured to a specialist please detail the name and address of the specialist, their specialty, and the date of the referral:

Referral date	DD / MM / YYYY		
Name			
Address			
Phone		Email	
Specialty			

i. If the Life Insured has seen a specialist please detail their opinion and recommendations (if known):

j. In your opinion is the Life Insured able to undertake their usual occupation due to injury or illness?

i) If **"no"**, please detail the reason(s) for this:

ii) If **"yes"**, from what date has the Life Insured been able to undertake their usual occupation? Part time: DD / MM / YYYY Full time: DD / MM / YYYY

k. If able to return to part time work, please advise which duties of their usual occupation they are **incapable** of performing?

l. 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:

m. If the Life Insured has not yet returned to work, when do you anticipate they will be able to? Part time: DD / MM / YYYY Full time: DD / MM / YYYY

n. Have you given any certificate or report to (please tick the correct answer below)?

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:

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

3. 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 Pinnacle Life Limited may provide copies of this Report to any medical specialist from whom Pinnacle 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