OneChoice

Terminal Illness Claim Form

- To help ensure you receive a prompt assessment, please complete all the required sections of this form. 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 fully assessed, and to avoid any delays to this process, please ensure that all the relevant 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 ✗

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)
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Auckland 1140

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

OneChoice®
INSURANCE FOR KIWIS

PART A: Terminal Illness Benefit 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** Monday to Friday, 8am to 8pm.

Section A – Personal information of the Life Insured

Title | First name | Surname

Policy number

Residential address

Postal address

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

Email

Section B – Medical Details of the Life Insured

1. What condition are you claiming for? (Please give as many details as you can)

2. Please provide details of the doctor you first consulted about your claimed condition:

Name of doctor	
Address	
Phone	
Date of first consultation	
Date of most recent consultation	

3. Date the symptoms first began: DD/MM/YYYY

4. Have you ever had similar symptoms at any time in the past?

No ☐ Yes ☐ ▶ Please give details and dates of the doctor or hospital that treated you and the treatment received:

If you have any test results in your possession please ensure they are attached to this form.

5. Disclosure of information – doctor's authority

For the purpose of assessing my claim for a Terminal 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 ✗ _____ DD/MM/YYYY

Life Insured's signature Date

Section C – Policy Discharge

(Please note this section of the form will only be used if the Insurer accepts liability for the claim)

☐ I/We hereby request payment of the benefit payable for the above insurance Policy, in full satisfaction for all claims whatsoever under the Policy for the above Life Insured, and do hereby discharge the Insurer from all liability there under other than for payment of the benefit.

Please ensure that all questions have been answered before you proceed further. If you fail to do so we will be unable to assess and process your claim.

Section D – Declaration

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 this Declaration is part of a claim for a Terminal Illness benefit and that the making of a false statement may invalidate my claim, that if I fail to provide all or part of the information the Insurer requires to assess this claim it will not be assessed and processed.

SIGN HERE ✗ _____ DD/MM/YYYY

Signature of Policyowner/Life Insured Date

Section E – Checklist

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

What is a certified copy?
This is a signed copy 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, Solicitor of the High Court, Notary Public or Deputy Registrar at a court. It means you keep the original as we do not require it.

The certified copy must include a statement "I certify that this is a true copy of the original document". The certifier must include their full name, signature, date, registration number (if any) and qualification or occupation on each page of the photocopied documents.

☐ A CERTIFIED COPY of proof of Claimant's/Life Insured's identity (e.g. Birth Certificate, Driver's Licence or Passport)

☐ A CERTIFIED COPY of proof of the Policyowner's identity (e.g. Birth Certificate, Driver's Licence or Passport)

Section F – Direct Credit Authority

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

- This section of the form must be completed by the Policyowner.
- If your claim has been approved, 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

SIGN HERE

✗

Policyowner's signature

DD/MM/YYYY

Date

This page is intentionally left blank.

PART B: Terminal Illness Claim Form – Specialist Medical Report

This document is to be completed by the treating specialist.

- Please note that the information required to be completed in this document is in relation to the Life Insured.
- Please note that it is the Life Insured's responsibility for the payment of all fees associated in the completion of this document.
- In order to ensure that the claim may be fully assessed, and to avoid any delays to this process, please ensure that all the items in this document are fully addressed and answered. Failure to address and answer all items in this document may result in refusal or delay in claim assessment.
- 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.
- Please provide copies of all reports, results and/or discharge summaries in support of the information supplied in this form.

Section A – Personal Details of the Life Insured

Title | First name | Surname

Address

Suburb | Region | Postcode

Occupation | Date of birth DD/MM/YYYY

Section B – Medical Details of the Life Insured

1. When did you first see your patient (the Life Insured) for this condition?

2. What is the date and diagnosis of the condition?

3. What is the date the condition became a terminal illness (less than 12 months life expectancy)? DD/MM/YYYY
4. What are your patient's current symptoms and objective signs?

5. Please provide the date and results of any tests you have performed? Please provide a copy of all results.

Date	Test	Result
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		

6. What treatment is being administered, including surgery and medication?

7. What is the prognosis?

8. In your opinion, would the life expectancy be 12 months or less? Please provide details of objective medical evidence on which your opinion is based.

9. Have you referred the Life Insured to other doctors for further opinion, investigation or treatment?

   No ☐ Yes ☐ ▶ Please give details:

10. Was the Life Insured admitted to hospital for this condition?

    No ☐ Yes ☐ ▶ Please give details:

Section C – Declaration

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 under law to give access to this Report.

Name

Qualifications

Address

Telephone

Facsimile

Email

SIGN HERE ▶ ✗ Medical Practitioner's signature

DD/MM/YYYY Date