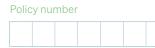
# Claim



# partners life

# Private Medical Cover

## Adviser involvement

Would you like your financial adviser to be involved with the progress of your claim?

Yes	No

# 1.0 Life assured's details

Name	Postal add	dress and contact d	etails			
Mr First name	Number					
Mrs Middle name(s)	Street name					
Miss Surname	Rural delivery no.		Suburb			
Ms Previous name	Town/City				Postcode	
Dr Male Female Date of birth	Email address					
	Home phone					
	Mobile phone					
2.0 Claim details a) Are you applying for prior approval? Yes No If yes, please give the date of expected treatment						
a) Are you applying for prior approval? Yes No	or pro	cedure.				
b) Please give details of the symptoms/disease/disorder/condition which has resulted in	b) Please give details of the symptoms/disease/disorder/condition which has resulted in this claim.					
c) Please state the name of procedure/surgery/investigation.						
d) Please give the date the symptoms started. Date						
e) Please give the date you sought medical advice. Date						
f) Please give the name and address of the registered medical practitioner who referred you for treatment, procedure or to the hospital.						
Name						
Address						
g) Details of your usual GP (if different from above).						
Name						
Address						

# 3.0 If your claim is accepted, please tick one of the following payment options.

a)	Reimburse the	Medical Practitioner directly?		Yes	b)	Direct credit into the account below	Yes
		<b>hat you complete this section</b> ect into the nominated bank a					
	Account holder						
	Bank/building society name						
	Bank	Branch	Account number		ç	Suffix	
	(Please attach an en	coded deposit slip to ensure your number	is loaded correctly)				

# 4.0 Policy owner(s) details

a)	Has your postal address changed?	Yes	No
b)	If yes, do you want Partners life to update your records?	Yes	No

#### c) If yes, please provide your new postal address

Number				
Street name				
Rural delivery no.	Suburb			
Town/City		1	Postcode	

## 5.0 Supporting Documents

#### Before you send your claim form back, please make sure you've supplied the following:

A copy of the referral letter from the GP/Dentist to the Specialist
A copy of the Specialist's report to you or your GP/Dentist
An estimate of costs for the procedure, if applicable

Copies of any paid invoices, along with proof of payment.

### Please read and sign this declaration.

This application collects personal information about you and any life assured for whom you are claiming under your policy. The intended recipient of this information is Partners Life Limited ("the Company").

Failure to provide this information may result in your claim being declined or unable to be assessed. You and any life assured have the right to request access to and correction of your respective personal information at any time by contacting Partners Life on 0800 14 54 33.

#### Declaration

I am the policy owner and hereby claim the benefit amount payable on the basis of the statements and information provided by the life assured in this claim form which I believe to be accurate and complete in every respect.

As part of a medical insurance claim with the company, I, the life assured, consent and give authority to the company to seek from, and for all and any of the following, their officers and employees, to disclose to the company, its advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me:

- Registered medical practitioners and specialists
- Dentists
- Counsellors, psychologists and therapists
- Government departments, agencies, organisations and enterprises
- Hospitals (whether public or private)

- Accident Compensation Corporation
- Insurers (whether public or private)
- Credit rating and collection agencies
- Employers (whether current or not)

I agree that a photocopy, facsimile or scan of this authority will be valid as an original.

#### **Privacy Act requirements**

- This claim form and any supplementary material which may be required in connection with this claim is a collection of personal information.
- This information will be used to: assess and administer this claim; service and administer the policy; maintain relevant statistical records; and provide you with information about other products and services offered by Partners Life Limited.
- You are required to provide the medical information which has been requested so as to comply with your common law duty to disclose all matters material to the insurance.
- The information will be held by Partners Life Limited at the address
   on this form, and/or by Partners Life's data storage providers, which
   includes cloud-based data storage providers (both in New Zealand and
   overseas).
- Under New Zealand privacy law, you have the rights of access to, and correction of, any information provided.

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide Partners Life Limited such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

Name/company name of second policy owner
Signature/authorised signature of second policy owner
Date
Parent or guardian if life to be assured is under the age of 16.
Name of parent or guardian
Signature of parent or guardian
Date
Date