TERMINAL ILLNESS CLAIM FORM

SOVEREIGN

Guide to completing this claim form

At Sovereign our aim is to process your claim in a timely manner. To help us, please ensure that you complete all the relevant sections and attach all the required information.

- Complete sections 1, 2, 4 and 5 (and section 3 if you purchased your cover through ASB)
- Section 6 must be completed by your Specialist.
- Attach any relevant medical information given by your GP, specialist, hospital or other medical provider. Sovereign will request any additional information that may be required
- Certified copy of your birth certificate **or** passport **or** driver licence*
- If your policy was issued prior to 29.10.2003 we will require the policy document or a completed Loss of Policy Declaration form.

* The following can certify the document: Lawyer, Solicitor, Chartered Accountant, Sovereign Adviser, ASB Insurance Manager, Registered Medical Doctor, Justice of the Peace, Police Officer, Notary Public or anyone else by law authorised to administer an oath.

1 Life assured claim details

	Claim number	Policy number
Mr/Mrs/Miss/Ms (please circle)	Last Name	First Name(s)
Date of birth	/ /	
Mailing address		
Telephone	Home ( )	Mobile
	Business ( )	
Email		
Are you claiming with another insurer	☐ Yes ☐ No	Name of Insurer

2 Medical information questions (for completion by or on behalf of the life assured)

(a) What is your current diagnosis/condition?

(b) When was the diagnosis first made and by whom?

(c) When did your symptoms first become apparent and what were they?

(d) On what date did you first seek medical assistance for your claim/condition?

Date / /

(e) Have you ever previously suffered from the same, similar or related condition? ☐ Yes ☐ No

If yes, please give full details including what the condition was, who you saw, and when it was?

(f) Name and contact details of your current GP. (If your GP does not hold all your medical notes, please provide contact details of who does).

Name

Medical practice

Address

Telephone number ( )

Fax number ( )

Email address

(g) Specialist details (continue on separate sheet if more than one specialist)

Name

Practice name

Specialty

Address

Telephone number ( )

Fax number ( )

Email address

(h) Hospital details

Name of hospital

Address

Telephone number ( )

Fax number ( )

Email address

(i) Please advise if any other settlement is/or will be claimed in relation to this claim. Whether it be from a public or private insurer.

Name of Insurer

Policy number

Contact person's name

Contact person's telephone number ( )

Contact person's fax number ( )

Contact person's email

Type of claim

3 Consent

As part of an insurance claim with Sovereign Assurance Company Limited (Sovereign), I, the life assured consent and give authority to Sovereign and any of its related entities and agents to request any of my medical or other personal information affecting my insurance or the assessment of my claim from any third party which Sovereign reasonably considers may hold that information. I also authorise those third parties to disclose that information to Sovereign, its advisers and reinsurers, and to any legal tribunal before which any question concerning my insurance may arise. Those third parties may include:

- Registered medical practitioners and Specialists (which may include an entire copy of my/our medical file)
- Medical laboratories and testing facilities
- Accident Compensation Corporation, governmental departments or bodies
- Insurers or reinsurers (whether public or private)
- Counsellors, psychologists and therapists, and
- any other person or organisation which holds information which is relevant to my insurance or the assessment of my claim.

I understand that the supply of the information gathered from the above sources is voluntary and that Sovereign may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my Insurance. I understand that Sovereign may share my claims details with related insurers to enable co-ordination of claims resolution. I understand that my personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.

I understand that my personal information will be stored at Sovereign's head office, 74 Taharoto Road, Takapuna and/or other premises in New Zealand occupied by Sovereign and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I understand that Sovereign will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).

I consent and give authority to ASB Bank Limited and Sovereign to request from AIA International Limited (trading as AIA New Zealand `AIA'), or disclose to AIA, any information pertaining to me and relevant to the assessment of my insurance claim.

I understand that Sovereign may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of my personal information may be requested by me.

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following :

I consent to the disclosure of my claims information to ASB Bank Limited ('ASB') for the purposes of notifying ASB of issues or disputes arising in respect of my claim ☐ Yes ☐ No

4 Declaration – important, please read carefully

I declare that all medical information pertaining to me and relevant to my insurance claim has been provided and disclosed to Sovereign.

I understand that failure to provide full disclosure of all medical information that Sovereign considers as relevant in the assessment of my claim would be considered to be material misrepresentation and/or material non-disclosure and as such Sovereign is entitled to use legal remedy, should this occur.

I further understand that the medical information provided is the basis on which Sovereign will assess and manage my claim and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed.

I declare that all the answers to questions in this form are true and complete. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I further agree that a photocopy of this authority will be valid as an original

Please print full name of life assured		
Signature of life assured		Date / /

5 Consent to disclose personal information

If you would like **Sovereign** to give details about you and your claim to any other person eg: your spouse, adviser, trusted family member, you must complete this section below:

Name of Person(s) that information is to be released to	Last Name	First Name(s)
Their address		

Authorisation

I authorise **Sovereign** to release any of my personal information, and to discuss any details of my claim, including medical or financial details, with the above named Person(s).

Signature of life assured		Date / /
Please print full name of life assured		

6 Medical details – (To be completed by the life assured's treating specialist, at the expense of the life assured)

Please note, if you are not able to get this section completed, Sovereign will obtain this information on your behalf.

	Claim number	Policy number
Client name	Last Name	First Name(s)
Date of birth	/ /	NHI number
Client address		
Are you the life assured's usual medical attendant? If so, for how long?		
(a) What is the client's diagnosis/problem list?		
(b) On what date was the diagnosis made and by whom?		
(c) What were the signs and symptoms leading to the diagnosis?		
(d) When did the client first seek medical assistance for the claim/condition?	Date / /	
(e) Has the client ever suffered from the same, similar or related condition? If "yes" please provide full details including what the condition was, when it was and who the client consulted.	☐ Yes ☐ No	
(f) Current proposed treatment plan?		

(g) Please provide details of any other relevant treatment providers for the client.

(h) Prognosis of terminal illness, including life expectancy in terms of months, irrespective of any treatment he/she may receive and reasons for this

(i) Any other comments or observations you would wish to make?

To assist with the assessment of the claim, please attach copies of all relevant Specialist reports, clinical notes, hospital notes and other supporting documents.

Attending Physician's details

Name

Medical Specialty

Address

Telephone number ( )

Fax number ( )

Email address

Signature

Date / /

Sovereign House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag Sovereign,
Victoria Street West,
Auckland 1142

Freephone 0800 500 195
Freefax 0800 500 196
Email claims@sovereign.co.nz
Web sovereign.co.nz