

Superior Health Cover - Claim Form

Send completed claim form to: AIA, Private Bag 93510, Takapuna, Auckland.

Important information you must read before submitting this claim:

- Claims must be submitted to AIA within 12 months from the date of treatment.
- Please ensure that all attachments are originals.

1. Policy Owner Details

| | | | |
|----------------------|----------------------|----------------------|----------------------|
| Title | Last Name | First Names | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Street Address | | | |
| <input type="text"/> | | | |
| Phone No. (Private) | (Business) | (Mobile) | Date of Birth |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Policy Number: | <input type="text"/> | | |

2. Claimant Details (if different from above)

| | | | |
|----------------------|----------------------|----------------------|----------------------|
| Title | Last Name | First Names | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Street Address | | | |
| <input type="text"/> | | | |
| Phone No. (Private) | (Business) | (Mobile) | Date of Birth |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

3. Claim Details

Are you applying for prior approval? Yes No

Details of the condition or symptoms which has resulted in this claim

Have you claimed for this condition previously? Yes No

Date first sought medical advice

Date symptoms started

Provide details of the treatment (proposed treatment)

What is / was your date of admission?

What is / was your date of discharge?

Is this accident or work related? Yes No

ACC Number

Please tell us who the main providers are e.g. Your Doctor, their contact details and date registered.

(Please be aware that it may be necessary to request further information before completing assessment of your claim).



4. Receipt / Invoice / Estimate Details

| Date of treatment | Providers Name | Condition Treated | Pay Provider | Reimburse to claimant | Amount |
|-------------------|----------------|-------------------|--------------|-----------------------|--------|
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| | | | | | |
| Total Value | | | | | |

5. Refund Details to Claimant

By Cheque or by Direct Credit

Name of account (please attach deposit slip)

Bank

Branch Number

Account number

Suffix

(Note: We cannot reimburse on to credit cards)

6. Statement of Disclosure

1. This claim form collects personal information about you which will be used to: (a) Investigate and determine the validity of your claim: (b) confirm the information in your application for this insurance product: (c) maintain relevant statistical records.
2. This information is collected and held by American International Assurance at 5-7 Byron Avenue, Takapuna, Auckland.
3. You have a duty to provide American International Assurance with all the facts material to your claim and all information, which we may reasonably require in relation to your claim. If you fail to provide this information we may not pay your claim. If you provide false information this may result in your policy being voided from inception or cancelled.
4. Under the Privacy Act 1993 and the Health Information Code 1994, you have the right of access to, and correction of, any information held or provided.

Declaration and Authority to Obtain and Use Information

1. I authorise any doctor, medical specialist, Hospital, Clinic, Insurance Company, ACC, employers or any other authority to disclose to American International Assurance any and all information concerning my medical history. A photocopy or facsimile of this authorisation shall be valid as an original.
2. I have read and understood this information in this claim form including the section above relating to the Privacy Act 1993 and the Health Information Privacy Code 1994.
3. I declare that all information provided by me relating to this claim is true and correct, and no material information has been withheld.
4. I am authorised by each member named on this claim form to complete and sign on their behalf.

CHECKLIST Before sending to: American International Assurance Company (Bermuda) Limited.
Level 15, 5-7 Byron Avenue, Private Bag 93 510, Takapuna, New Zealand

Original copies of receipts/invoices. (Please attach to claim form).

Referral letter from GP or medical practitioner. (Please attach to claim form).

Medical report and estimate of costs from specialist if hospitalisation required. (Please attach to claim form).

Please ensure the Privacy Act and Health Information Privacy code declaration is signed and dated.

Have you attached the ACC letter of acceptance / decline for any accident/injury related claim?

Have you answered all relevant questions as fully as possible?

Signature(s)

Please Print Name

Date

Signature(s) of Parent/Guardian

Please Print Name

Date