

<b>1 About your policy</b>				
Policy Number				
Name of Policy owner 1			Email	
Address	Street no./name			
	Suburb	Town/City	Postcode	
Telephone	Home ( )	Mobile ( )	Email	
If your details listed here are incorrect or incomplete, please update them in the space provided below				
Address	Street no./name			
	Suburb	Town/City	Postcode	
Telephone	Home ( )	Mobile ( )	Email	

Please answer the applicable sections fully before you date and sign this form. If you need assistance in completing this form please phone us on 0800 754 754 or refer to [www.tower.co.nz](http://www.tower.co.nz) (Health & Life Insurance)

<input checked="" type="checkbox"/>	<b>Please tick one of the boxes below indicating what type of health claim you are making.</b>
<input type="checkbox"/>	<b>PRE-APPROVAL REQUEST</b> for surgery, private hospitalisation, chemotherapy, radiation therapy, diagnostic investigation (including CT and MRI) and/ or specialist consultation ( <i>Please complete sections 1, 2a, 2b, 2c and 6</i> ) (PAF)
<input type="checkbox"/>	<b>PAYMENT REQUEST for a claim that has NOT been pre-approved</b> - For surgery, private hospitalisation, chemotherapy, radiation therapy, diagnostic investigation (including CT and MRI), and/or specialist consultation ( <i>Please complete sections 1, 2a, 2b, 2c and 6</i> ) (HCFUS)
<input type="checkbox"/>	<b>PAYMENT REQUEST for a claim that has been PRE-APPROVED.</b> (Please attach the pre-approval letter to the invoices and submit or supply Pre-Approval Number here: <i>and complete sections 1, 2b and 6</i> ) (HFCD)
<input type="checkbox"/>	<b>PAYMENT REQUEST for GP, dental, optical or other medical expenses</b> ( <i>Please complete sections 1, 4 and 6</i> ) (OHCF)
<input type="checkbox"/>	<b>PAYMENT REQUEST for a specialist consultation (not related to surgery)</b> ( <i>Please complete sections 1, 2c, 4 and 6</i> ) (OHCF)

Please complete section 3 if you wish to nominate a person who can help administer the claim on your behalf and/or section 5 if your claim is being refunded to you rather than the Provider/s.  
Please note there will be a delay in processing your claim if all relevant sections are not completed.

<b>2a About your claim</b> (to be completed by the patient)			
→ NB: YOU MUST ATTACH A COPY OF YOUR SPECIALIST CONSULTATION LETTER and the quotation for the treatment/operation/diagnostic investigation			
Name of Patient (Insured person)		Date of birth	/ /
Proposed treatment /operation / diagnostic investigation		Proposed date	/ /
Proposed length of hospital stay	(number of days)	Day stay? (please tick)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any current health insurance policy or other policy you could claim against?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide details			

<b>2b About the cost</b> (treatment/operation/diagnostic investigation costs as quoted by your specialist – to be completed by the patient)				
→ NB: Please attach <u>original</u> paid invoices, proof of payment (receipts) or quotes obtained				Claim payable to <input checked="" type="checkbox"/>
Provider/service	Cost	Name of Hospital & Specialist	Provider	Claimant
Specialist	\$		<input type="checkbox"/>	<input type="checkbox"/>
Anaesthetist	\$		<input type="checkbox"/>	<input type="checkbox"/>
Radiology (i.e. MRI scan, CT scan)	\$		<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis	\$		<input type="checkbox"/>	<input type="checkbox"/>
Hospital costs	\$		<input type="checkbox"/>	<input type="checkbox"/>
Other	\$		<input type="checkbox"/>	<input type="checkbox"/>
<b>Total procedure cost</b>	\$			

**2c Medical report** (to be completed **only** by your usual family doctor /GP, dentist or optometrist)

- 
- Please attach a copy of the Referral Letter to the Specialist
  - Please also attach any supporting documentation stating when symptoms or signs of this health condition first became apparent to you

Name of family doctor/GP, dentist or optometrist	
Business Address	Street no./name
	Suburb Town/City Postcode
Telephone	Business ( ) Fax ( )
How long has the patient been under your care? Number of years?	
If less than 3 years, please detail the previous doctor consulted (if known)	
Name of previous doctor	
Business Address	Street no./name
	Suburb Town/City Postcode
What is the underlying health condition that made the surgery/treatment/diagnostic necessary?	
What was the date the patient first noted the symptoms?	
What was the date the patient first sought investigation or medical advice?	
Please provide details of any subsequent consultations /investigation /treatment /surgery including dates. (Please also provide copy of GP referral letter and first consultation letter)	
If the patient has required surgery/treatment/investigations for this or a similar condition before, please provide details including dates.	
Is this condition ACC related <input type="checkbox"/> Yes <input type="checkbox"/> No Please attach the ACC Acceptance/Decline Letter	
Please attach a histology report, if applicable, regarding the above health condition. <input type="checkbox"/> Attached	
Signature of : Family doctor/GP, dentist or optometrist	Date: / /

**3 About your representative** (if applicable – to be completed by the patient)

I give my authority for any details of this claim to be provided to:

Name and relationship to patient	
Postal Address	Street no./name
	Suburb Town/City Postcode
Telephone	Home ( ) Mobile ( ) Email

Or

My adviser	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adviser's name	



**6 Important information and declaration** (to be completed by the policy owner(s) and the patient)

**Duty of Disclosure**

You and anyone else named in this claim form must tell TOWER Health & Life Limited ("TOWER") everything you know (or ought to know) which would influence the decision of a prudent insurer whether to accept this claim, and if so, on what terms, (For example, you must disclose any health conditions you have currently or have had in the past.) You must tell TOWER immediately about any changes to the information you have currently or have had in the past. If you fail to do so, TOWER can avoid or cancel the policy from the commencement/reinstatement date and not pay any claim. TOWER may retain all the premiums paid and any claims paid by TOWER may be recovered from you. When in doubt, disclose. TOWER treats all information confidentially.

**Privacy Act 1993**

TOWER is collecting information about you and anyone named in this claim form to evaluate, administer and assess this claim.

You must provide this information as part of your legal duty to disclose all relevant facts to TOWER. If you fail to do so TOWER may decline your claim or avoid or cancel your policy from the commencement/reinstatement date and not pay any claim. TOWER may release information, from this form or received from others, relating to this claim to your adviser, ACC, your previous insurers, anyone who assisted you or TOWER in arranging this insurance, any/all of your medical/health providers, and anyone reasonably necessary to assist TOWER in relation to this claim.

You have certain rights of access to and correction of the information under the Privacy Act 1993 and the Health Information Privacy Code 1994. TOWER's contact details are set out at the bottom of this page.

**DECLARATION**

**We, the people named in this claim, declare that:**

- If we are signing this claim form on behalf of children under the age of 16, we are authorised to do so.
- Anyone assisting us to complete this claim form is acting as our agent.
- All the information given in support of this claim (whether in this claim form or separately from it) is correct and complete.
- All relevant facts have been disclosed.
- I/We understand that we must tell TOWER immediately about any changes to the information I/we have already given to TOWER.
- I/We the policy owner(s) understand any premium paid on this policy does not bind TOWER to accept the claim.
- Where premiums are in arrears, I/We the policy owner(s) authorise TOWER to deduct the outstanding premiums from the claim payable to speed up claim processing.
- If this claim form is not completed by all policy owners, I confirm that I am authorised to complete this claim form and provide the authorities on each of their behalf.

**AUTHORISATION**

**(On whom the claim is being made. If the patient is 16 years or younger, the patient's parent or legal guardian must sign this declaration)**

**I, the claimant, authorise TOWER to:**

- Obtain any personal and health information about me and authorise anyone else to disclose this information to TOWER, but only to the extent this is reasonably necessary to consider, process and manage this claim. This specifically includes any medical and lifestyle information held by any health or medical practitioner, dentist, medical laboratory, hospital, ACC, a previous insurer, or other relevant entity or organisation.
- Disclose the information above to any other person, body or agency but only to the extent this is reasonably necessary for the purposes mentioned above. I understand this may include disclosure to the parties and for the purposes named above in the Privacy Act 1993 section.
- Disclose this information and other information about me and my claim to the adviser who helped arrange the insurance.
- Use a photocopy of this signed declaration and authorisation as confirmation of these authorities.

Claimant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(if different to policy owner below)*

Policy owner signature 1 \_\_\_\_\_ Date \_\_\_\_\_

Sign Here

Sign Here

**7 Important Reminders**

- Please ensure you have completed all the relevant sections and signed and dated section 6
- Please note that completion and submission of this form is not an acceptance of your claim
- For payment requests please supply original invoices

**8 Send this form to**

**Contact Details**

TOWER Health & Life Limited,  
PO Box 6547  
Wellesley Street,  
Auckland 1141

For Pre-approval only  
Fax: 0800 345 134

Tel - 0800 754 754  
Email: healthandlife@tower.co.nz