Combined Insurance

Claim Form

COMBINED INSURANCE

A division of Chubb Insurance New Zealand Limited

Important Instructions

Important Instructions on how to complete the attached Claim Form and how we assess claims. Please read these important instructions on how to complete the attached Claim Form. This may help us to assess your claim faster.

In this 'Important Instructions' section we refer to the Insured or Covered Person as "you" or "your"; and Combined Insurance a division of Chubb Insurance New Zealand Limited (**Chubb**) as "Combined Insurance", "we", "our" or "us", in the following instructions.

We refer to Chubb Insurance New Zealand Limited (Company No. 104656 Financial Services Provider No 35924) as "Chubb".

1. It is important that you contact us as soon as possible once you are aware of any circumstance or event giving rise to a claim and provide honest, complete, up-to-date and relevant information when completing this claim form.

2. You should complete Section 1 in full to the extent relevant and attach any relevant invoices and other documents to support your claim. If you do not fully complete the Claim Form this may result in delays processing your claim while we seek missing information. Please see the Important Notes for Particular Benefits.

3. Your Medical Practitioner, *and only your Medical Practitioner* should complete Section 2 in full to the extent relevant. Your Medical Practitioner must also sign and date the Claim Form in the appropriate place.

4. We normally pay benefits up to the date that your Medical Practitioner has signed the Claim Form. If your disability is ongoing after that date, we will send you a Continuing Claim Form or Progress Form which your Medical Practitioner should sign and complete on your next visit.

   Once we have received this completed form, we can make a further payment up to the date your Medical Practitioner has signed the form. The reason we do not pay benefits in advance of when your Medical Practitioner signs a Claim Form, is that the future disability has not yet occurred, and insurance only pays for losses that have already occurred. We follow this procedure even if your Medical Practitioner states an 'approximate date' for your disability to end. Of course, all payments depend on your claim falling within the terms and conditions of your Policy.

5. We may ask you or your Medical Practitioner for more information concerning your claim, or we may arrange a further independent assessment by a Specialist of our choosing.

6. Please send this Claim Form together with all supporting documents within 30 days of the commencement of your disability via post to Combined Insurance, Private Bag COMBINED, Remuera, Auckland 1541, via fax to 09-520-9009, or email the form to claims@combined.com. If you do not report your claim within 30 days and we consider the delay has prejudiced our ability to assess your claim, this may affect and/or delay payment of your claim.

7. **Our Claims Process**

   On receipt of this completed claim form we will take the following steps:

   - Acknowledge receipt of your claim within 5 business days.
   - Identify your insurance policy, register your matter against it and assign a claim number for reference. Determine whether or not to accept your claim within 10 business days of the date we have all the information we need to determine your claim.
   - If we are unable to determine whether or not to accept your claim within 10 business days, such as when we request that you provide further information from your doctor or employer, we will advise you of the additional information we require. You must cooperate with us by providing the information we seek to settle your claim.
   - If we require information from an independent specialist, or a doctor or other third party which we request directly, then we will advise you of the information required and will provide you with an estimate of how long we expect it will take to determine your claim, once we have this information.
   - We will update you once every 20 business days, or another such interval as we may agree with you, until your claim is resolved.

8. With the exception of some circumstances, you have a right to access the information we have relied on in evaluating your claim and you can ask us to correct any mistakes or inaccuracies in that information.

9. If we decline your claim in whole or in part, we will clearly explain the reason or reasons. You have a right to access our Complaints and Disputes Resolution process which is summarised on the back page of this claim form.

10. Should you require any assistance in completing this Claim Form, or have any queries about claiming, or how we assess a claim, please contact us on **0800 COMBINED (266 246)** and we will be happy to assist you.

Important Notes for Particular Benefits

11. If your Policy covers you for benefits while you are **hospitalised**, please attach a copy of your hospital statement showing the dates of admission and discharge. If you were in intensive care during your period of hospitalisation, the Statement should indicate this.

12. If you are claiming for a **Fracture** Benefit, please attach a copy of the medical report verifying a fracture.

13. If you are claiming for **Covered Cancer** please attach a copy of a Pathology, Histology, or Histopathology Report, that medically verifies the diagnosis and a copy of your hospital statement showing any out-patient treatments if you are claiming an **Out-patient Treatment** benefit.

14. If you are claiming a benefit for **Skin Cancer**, please attach a medical statement verifying this.

15. If you are claiming a **Transportation** benefit please attach a receipt for your travel expenses.

16. If you are claiming a **Family Lodging** benefit please attach a copy of your hotel/motel bill.

17. If you are claiming a **Facial Disfigurement** benefit, please send a photograph of the relevant scar with your claim form. Please note that we may require you to submit a further photograph of your scar if your injury had not fully healed at the time you first lodged your claim.

18. If you are claiming an **Emergency Ambulance** benefit, please attach a copy of your ambulance statement or account.

Fair Insurance Code

Chubb is a member of the Insurance Council of New Zealand (**ICNZ**) and a signatory to ICNZ's Fair Insurance Code (**the Code**). The Code and information about the Code is available at http://www.icnz.org.nz/ and on request.

Privacy Statement

Combined Insurance is a division of Chubb Insurance New Zealand Limited. Chubb collects, uses and retains your personal information in accordance with Chubb's Privacy Policy, which also applies to Combined Insurance.

This statement is a summary of Our privacy policy and provides an overview of how We collect, disclose and handle Your personal information. Our privacy policy may change from time to time and where this occurs, the updated privacy policy will be posted on Our website.

Chubb is committed to protecting Your privacy. Chubb collects, uses and retains Your personal information in accordance with the requirements of New Zealand's Privacy Act, as amended or replaced from time to time.

Personal Information Handling Practices

When do We collect Your personal information?
Chubb collects Your personal information (which may include health information) from You when You interact with Us, including when You are applying for, changing or renewing an insurance policy with Us or when We are processing a claim, complaint or dispute. Chubb may also (and You authorise Chubb to) collect Your personal information from other parties such as brokers or service providers, as detailed in Our privacy policy.

Purpose of Collection
We collect and hold the information to offer products and services to You, including to assess applications for insurance, to provide and administer insurance products and services, and to handle any claim, complaint or dispute that may be made under a policy.

If You do not provide Us with this information, We may not be able to provide You or Your organisation with insurance or to respond to any claim, complaint or dispute, or offer other products and services to You or Your organisation.

Sometimes, We may also use Your personal information for Our marketing campaigns and research, to improve Our services or in relation to new products, services or information that may be of interest to You.

Recipients of the Information and Disclosure
We may disclose the information We collect to third parties, including:

- contractors and contracted service providers engaged by Us to deliver Our services or carry out certain business activities on Our behalf (such as actuaries, loss adjusters, claims investigators, claims handlers, professional advisers including lawyers, doctors and other medical service providers, credit reference bureaus and call centres);
- intermediaries and service providers engaged by You (such as current or previous brokers, travel agencies and airlines);
- other companies in the Chubb group;
- the policyholder (where the insured person is not the policyholder);
- insurance and reinsurance intermediaries, other insurers, Our reinsurers, marketing agencies; and
- government agencies or organisations (where We are required to by law or otherwise).

These third parties may be located outside New Zealand. In such circumstances We also take steps to ensure Your personal information remains adequately protected.

From time to time, We may use Your personal information to send You offers or information regarding Our products that may be of interest to You. If You do not wish to receive such information, please contact Our Privacy Officer using the contact details provided below.

Rights of Access to, and Correction of, Information
If You would like to access a copy of Your personal information, or to correct or update Your personal information, want to withdraw Your consent to receiving offers of products or services from Us or persons We have an association with, please contact the Privacy Officer by posting correspondence to Chubb Insurance New Zealand Limited, PO Box 734, Auckland; telephoning: +64 (9) 3771459; or emailing Privacy.NZ@chubb.com.

How to Make a Complaint
If You have a complaint or would like more information about how We manage Your Personal Information, please review Our Privacy Policy for more details, or contact Our Privacy Officer at the details above.

You also have a right to address Your complaint directly to the Privacy Commissioner by telephoning 0800 803 909, emailing enquiries@privacy.org.nz or using the online form available on the Privacy Commissioner's website at www.privacy.org.nz.

Complaints and Dispute Resolution

We take the concerns of its customers very seriously and has detailed complaint handling and dispute resolution procedures that you may access, at no cost to you. To assist us with your enquiries, please provide us with your claim or policy number (if applicable) and as much information as you can about the reason for your complaint or dispute.

Our complaints and dispute procedures are as follows:

Stage 1 – Complaint Handling Procedure

If you are dissatisfied with any of our products or services and you wish to lodge a complaint, please contact us via:

Email: Complaints.NZ@chubb.com
Phone: COMBINED (266 246)
(call free within NZ)
+ 64 9 520 9000 (if calling from overseas)
Fax: +64 9 520 9009
Post: The Complaints Officer
Combined Insurance
Private Bag COMBINED
Remuera Auckland 1541

Stage 2 –Dispute Resolution Procedure

If you are dissatisfied with our response to your complaint, you can advise that you wish to take your complaint to Stage 2 and referred to our dispute resolution team. Our internal dispute resolution team can be contacted via:

Email: DisputeResolution.NZ@chubb.com
Phone: +64 9 377 1459
Fax +64 9 303 1909
Post: Internal Dispute Resolution Service
Chubb Insurance New Zealand Limited
PO Box 734
Shortland Street
Auckland 1140

Stage 3 – External Dispute Resolution

We are a member of an independent external dispute resolution scheme operated by Financial Services Complaints Limited (FSCL) and approved by the Ministry of Commerce & Consumer Affairs. Subject to FSCL's Terms of Reference, if you are dissatisfied with our dispute determination or we are unable to resolve your complaint or dispute to your satisfaction within two months you may contact FSCL via:

Post: PO Box 5967, Lambton Quay, Wellington 6145
Phone: 0800 347 257 (call free for consumers) or
+64 4 472 FSCL (472 3725)
Fax: +64 4 472 3728
Email: info@fscl.org.nz
Website: www.fscl.org.nz

Please note if you would like to refer your complaint or dispute to FSCL you must do so within 2 months of the date of our dispute determination.

Further details regarding our complaint handling and dispute resolution procedures are available from our website and on request.

SECTION 1

Claimant to complete this page
(Please print using BLOCK LETTERS)

IMPORTANT. Write your Account Number here _____ *Office Use Only* ☐☐☐☐☐☐☐

Claimant's Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: Claimant's Full Name:

Date of Birth: / / Height: Weight:

Residential Address: Postcode:

Postal Address *(If different from above)*: Postcode:

Claimant's Telephone Number: Daytime: ( ) Mobile: ( )

Claimant's Email Address : Occupation:

Employer's Name: Employer's Address:

Employer's Contact Person:

Employer's Contact Telephone Number: ( )

Are you claiming under a Family Policy? ☐ Yes ☐ No ***If Yes, please provide Family Policy Account Number:***

It is our preference to make claims payments by Electronic Funds Transfer (EFT).

A Do you want us to make payments on this claim by EFT into your account?
☐ Yes ☐ No

B ***If Yes to 'A',*** is the account that you pay your premium from the Account you want us to pay your claim payments to?
☐ Yes ☐ No

C ***If No to 'A' and/or 'B',*** please provide name of preferred Financial Institution:

Account Name:

Bank Branch Number Account Number Suffix

Complete for Accident only

1. When did the accident occur? Date: / / at am / pm
2. Where did the accident occur? Street Number: Street Name:
   Suburb: City/Town:
3. Nature of Injuries: *(Please be specific)*
4. How did the accident occur? *(Please be specific)*

5. If it was a motor vehicle accident, please provide a description of the vehicle(s) involved.
   ***(Note:** if more than 2 vehicles involved attached details of other vehicles separately)*
   Your vehicle Registration No.: Make: Model:
   The other person's vehicle Registration No.: Make: Model:
6. Was the accident reported to the Police? ☐ Yes ☐ No Date: / / Police Station:
   Was anyone charged by the Police? ☐ Yes ☐ No ***If Yes, who was charged?***
   What was the charge? ***(Note:** You must provide us with a copy of the Police Report if we request you to)*
7. During the 24 hours before the accident, did you drink any alcohol or take any drugs? ☐ Yes ☐ No
   ***(If Yes,** please provide details - state types and quantities)*
   Did you have a Blood Alcohol Test or Drug Test by the Police? ☐ Yes ☐ No ***If Yes, what was the result?***
8. Were you transported to Hospital by Ambulance after the accident? ☐ Yes ☐ No
   Name of Hospital you attended: ***(Note:** You must provide us with a copy of the Ambulance Report if we request you to)*
9. Eye witness details. Please provide details of any eye witness.
   Witness 1 - Full Name: Address:
   Email Address: Telephone Number: ( ) *Daytime*
   Witness 2 - Full Name: Address:
   Email Address: Telephone Number: ( ) *Daytime*
   Witness 3 - Full Name: Address:
   Email Address: Telephone Number: ( ) *Daytime*

Complete for Sickness only

10. Nature of sickness: *(Please be specific)*

11. When were the symptoms first noticed? Date: / /

12. Who was the first Medical Practitioner you consulted for this condition?

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

When did you first see the Medical Practitioner for this condition? Date: / /

13. Have you consulted any other Medical Practitioner for this condition? ☐ Yes ☐ No ***(If Yes,** please provide details)*

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

Dates of Consultations:

14. Did you go to Hospital in respect of this sickness? ☐ Yes ☐ No ***(If Yes,** please provide details)*

Hospital Name:

Address:

Date of Admission: / / Date of Discharge: / / Number of Days in Hospital:

15. Have you previously had the same sickness? ☐ Yes ☐ No ***(If Yes,** please provide details)*

Date(s):

Treatment Received:

Name of treating Medical Practitioner/Specialist:

Address of Medical Practitioner/Specialist who treated you:

Complete for Accident and Sickness

16. Which Medical Practitioner is currently treating you for your injury/illness? *(If the same as '**Q12**' write 'As above')*

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

When did you first see the Medical Practitioner for this condition? Date: / /

Other Dates of Treatment? ☐ Yes ☐ No ***(If Yes,** please provide details)*

17. Who is your usual family Medical Practitioner? *(If the same as '**Q16**' write 'As above')*

Medical Practitioner's Name:

Medical Practitioner's Address:

Medical Practitioner's Telephone Number: ( )

18. What other significant medical or surgical treatments have you received in the past 5 years? *(Please provide details)*

Date(s):

Nature of the condition(s) treated:

Name of treating Medical Practitioner/Specialist:

Address of Medical Practitioner/Specialist who treated you:

19. Are you affected by any other long term or chronic disability? ☐ Yes ☐ No ***(If Yes,** please provide details)*

20. Were you hospitalised? ☐ Yes ☐ No ***(If Yes,** please state date of hospitalisation)* From: / / To: / /
(Please also attach a copy of any hospital statements if you are hospitalised and claiming a confinement benefit)

21. Are you claiming for Transportation and Family Lodging Benefits?
☐ Yes ☐ No ***(Please attach receipts supporting your claim if you are claiming for these)***

22. If you are claiming a benefit as the result of the diagnosis of any covered Skin Cancer, please attach proof of diagnosis. ☐ Yes ☐ No

23. **'Total Disability'.** Between what dates were you unable to perform any duties? *(Refer to the **'Definitions'** at the top of **'Section 2'**)*
From: / / To: / /

24. **'Partial Disability'.** Between what dates were you able to perform only partial duties? *(Refer to the **'Definitions'** at the top of **'Section 2'**)*
From: / / To: / /

25. Date you returned to your normal duties. Date: / /

Claim Privacy Consent

I/ we:

i. understand that Chubb Insurance New Zealand Limited CU1-3, Shed 24, Princes Wharf, Auckland (Chubb) requires personal information (which may include Health information) so that Chubb can evaluate this claim and administer the insurance policy and that failure to consent to the collection, use and disclosure of personal information may result in the claim being refused in part or in full;

ii. authorise Chubb to obtain from other parties personal information (which may include Health information) about me/us that Chubb views as relevant to the claim;

iii. agree to Chubb disclosing to other parties, including but not limited to, service providers engaged by Chubb, the insurance broker, the policy holder (if this differs from the claimant) or reinsurers personal information (including Health information) collected in relation to this claim or the insurance policy;

iv. I authorise any person or entity, including but not limited to Medical Practitioners and the Parties referred to in the Privacy Consent, to provide to Chubb such personal information (including health information) as Chubb in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefit;

v. understand that I/we have rights of access to, and correction of, personal information held by Chubb; and

vi. understand that further information about how Chubb collects, uses, discloses and processes my/our information is set out in Chubb's Privacy Policy, available at www.chubb.com/nz-en/footer/privacy.html.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact Chubb's Privacy Officer on +64 (9) 377 1459 or email Privacy.NZ@chubb.com.

Authority and Declaration

I/ we:

- understand that in evaluating my/our claim or by accepting documents in support of my/our claim, Chubb has made no acceptance of liability, nor waived any of its rights;
- confirm that any information that I/we supply will be true, correct and complete and that I/we will not withhold any information likely to affect the acceptance or handling of my/our claim and understand that if I/we provide untrue information or do not disclose relevant information that it might result in my/our claim being declined in part or in full;
- will give all reasonable assistance to Chubb and co-operate in the assessment of my/our claim; and
- appoint Chubb to do everything necessary to give effect to the consents and authorisations in this document and to execute, on my/our behalf, any documents or to do such acts required to give effect to this Privacy Consent and Authority.

Name of claimant:

Signature of claimant: X

Date: / /

Name of Witness:

Signature of Witness: X

Date: / /

SECTION 2

Medical Practitioner only to complete this section

This section must be fully completed by a Legally Qualified Medical Practitioner, at the Claimant's expense.

Please read carefully before completing this section.

Definitions

Total Disability
The inability to perform each of the substantial duties of your business or occupation (usual activities if not employed).

Partial Disability
The inability to perform one or more, but not all of the substantial duties of your business or occupation (usual activities if not employed).

Medical Practitioner
Means a licenced medical practitioner operating within the scope of his or her New Zealand licence and who is not a member of your immediate family.

Patient's Full Name: _____ Date of Birth: / /

1. Please tick whether claim is for: ☐ Sickness ☐ Injury

   Diagnosis:

   Cause:

2. If the patient is suffering from an injury, how did the patient advise you that the injury occurred?

3. **Please Complete for Fractures only.** Was the Fracture confirmed by an X-Ray? ☐ Yes ☐ No *(Please attach a copy of the X-Ray report)*

   Describe the type of Fracture:

4. When did the symptoms first appear, or the accident happen? Date: / /

5. When did the patient first consult you for this condition? Date: / /

   Did Total Disability begin this day? ☐ Yes ☐ No ***If No, please state date total disability began*** Date: / /

6. Has the patient ever had this condition before? ☐ Yes ☐ No
   If Yes, please state if the present condition is an aggravation or recurrence of a previous injury or sickness.

   Recovery Date: / /

7. Has the patient ever had any other disease or infirmity that may be affecting the present condition? ☐ Yes ☐ No
   If Yes, what was the disease or infirmity?

   To what degree did this contribute to current disability?

8. Is the patient still under your care for this condition? ☐ Yes ☐ No
   If Yes, and the patient has not recovered, what is the expected recovery date? / /

   Please provide details of the Treatment Plan to assist the patient's recovery:

   If No, and the patient has recovered, please write the recovery date. Recovery Date: / /

9. Has the patient had surgery or is surgery anticipated? ☐ Yes ☐ No Date: / /

   Details of surgery:

10. Has the patient been referred to any other Medical Practitioner or Specialist? ☐ Yes ☐ No *(**If Yes,** please provide details)*

    Medical Practitioner's Name:

    Medical Practitioner's Address:

    Medical Practitioner's Telephone Number: ( ) Date Referred: / /

11. Are you the patient's usual Treating Medical Practitioner? ☐ Yes ☐ No ***If Yes, for how many years?***

    If No, please advise the details of the patient's usual Treating Medical Practitioner/Medical Practice.

    Medical Practitioner/Medical Practice's Name:

    Medical Practitioner/Medical Practice's Address:

    Medical Practitioner/Medical Practice's Telephone Number: ( )

12. Disability Periods. *(Refer to **'Definitions'** at top of the opposite page)*

a) Totally Disabled:

From: / / To: / / *(Inclusive)*

b) Partially Disabled

From: / / To: / / *(Inclusive)*

c) Hospitalised as an overnight In-patient

From: / / To: / / *(Inclusive)*

At: *(Hospital Name)*

d) Hospitalised as an overnight In-patient in Intensive Care

From: / / To: / / *(Inclusive)*

At: *(Hospital Name)*

e) Do you expect the patient to remain totally disabled for the next 12 months? ☐ Yes ☐ No

13. Is there any further medical information relevant to this claim?

Medical Attendant Authority and Declaration

Chubb Insurance New Zealand Limited Privacy Consent and Declaration

Privacy Consent

I/ we:

i. understand that Chubb Insurance New Zealand Limited CU1-3, Shed 24 Princes Wharf, Auckland requires personal information (which may include my/our personal information and the patient's health information) so that Chubb can evaluate the patient's claim and administer their insurance policy;

ii. agree to Chubb disclosing to other parties, including but not limited to, service providers engaged by Chubb, the insurance broker, the policy holder or reinsurers personal information collected in relation to this claim or the insurance policy;

iii. understand that I/we have rights of access to, and correction of, personal information held by Chubb; and

iv. understand that further information about how Chubb collects, uses, discloses and processes my/our information is set out in Chubb's Privacy Policy, available at www.chubb.com/nz-en/footer/privacy.html.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact Chubb's Privacy Officer on +64 (9) 377 1459 or email Privacy.NZ@chubb.com.

Declaration

I/we confirm that to the extent I/we am/are aware, the information supplied in this form is true and correct.

Medical Practitioner's Declaration

WE RECOMMEND THAT A COPY OF THIS FORM IS TAKEN FOR YOUR FILES.

MEDICAL PRACTITIONER'S STAMP REQUIRED

Date: / / Provider Number:

Qualifications:

Address: *(If not on stamp)*

Telephone Number: *(If not on stamp)* ( )

Email Address: *(If not on stamp)*

Full Name of the Medical Practitioner's:

Signature of the Medical Practitioner's: X