

Accident (DM)

Claim Form

Please print out for signatures and post original to Chartis, Box 1745, Auckland

Employer /Group / Bank group:	<input type="text"/>		
Full policy Number with Prefix :	<input type="text"/>		
Full Name of Member:	<input type="text"/>		
Phone	<input type="text" value="[]"/>	Email:	<input type="text"/>
Full Name of Patient:	<input type="text"/>		
Phone:	<input type="text" value="[]"/>	Date of Birth	<input type="text" value="/ /"/>
Full Residential Address:	<input type="text"/>		
Email:	<input type="text"/>		
Patient's Relationship to member	<input type="text"/>	Patient's Occupation	<input type="text"/>

Settlement Details

Payee name

Option 1: Direct credit to NZ bank account. Please complete bank details and account number below

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Option 2 Overseas Bank Transfer

Bank Branch Country

Account details

OFFICE USE
Bank a/c checked

AHA no longer issues cheques. To confirm transfer of funds, an auto email will be sent to your broker or direct

Email: Broker Payee

Payee Signature

ACCIDENT

When did the accident occur?

Describe the Accident

Describe the Injuries

ILLNESS

When did the first symptoms appear?

What is the medical diagnosis of your condition?

When did you first see a doctor for this condition?

Doctor's Name and Address

Dates hospitalised:

Admitted

Discharged

Name and Address of hospital

Name of your regular family doctor

Phone

Address

Have you ever had this, or a similar condition, in the past?

YES / NO

(attach separate statement if insufficient space)

All Doctors Names and addresses and dates consulted/treated

Date	Name	Address
/ /		
/ /		
/ /		

Your hospital admission / discharge summary must be provided with the five fully completed pages of this claim

Continued over page

Declaration by Insured Person

I/we (print full name/s of insured/s)

declare that the above answers and those contained in any attachments are true, and to the best of my knowledge, those in the Physician's Statement are true and note that the Insurer may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to render Chartis Insurance New Zealand Limited, ('Chartis') every assistance in dealing with the matter and acknowledge that failure to co-operate with Chartis and to provide all information relevant or potentially relevant to the circumstance may result in my/our claim being denied.

Authorisation :

I/we hereby authorise any hospital, physician or other person who has attended me, to furnish Chartis or its representatives with:-

- i. copies of hospital and medical reports/notes;
- ii. information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

I agree that a photocopy of this authorisation shall be considered as effective as the original and authorise its use as such.

Privacy:

I/we consent to Chartis in accordance with the Privacy Act 1993:

1. collecting holding and using personal information including information by audio, photographic or video surveillance, provided for purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
2. disclosing personal information submitted to another Chartis company, its staff members, the insured, other insurers and re-insurers, law enforcement agencies, investigators, lawyers, assessors, advisors and the agent of any of these, insurance broker, insurance agent or intermediary, employer for the purpose of administering my claim or providing a report.

Information is provided voluntarily however if we do not collect this information we may not be able to assess a claim. Insured persons have rights of access and correction to their personal information under the Privacy Act. Further information about this or making a privacy complaint can be obtained by emailing : Privacy.officerNZ@chartisinsurance.com

Name	<input type="text" value="Please Print"/>	Signature of Insured
Date	<input type="text" value=" / /"/>	
If you are signing on behalf of the Insured person please state your authority to do so and relationship. Please print your name and contact phone:		
Name	<input type="text" value="Please Print"/>	Phone <input type="text" value="[]"/>
Position of Authority to sign – Nature of Relationship		<input type="text"/>

Please also have the physician's statement overpage completed and attached

Attending Physician's Statement

This form must be completed without expense to the Insurer

Please print clearly if there is insufficient space for any answers please attach a separate sheet.

Patient's Name	<input type="text"/>	Age	<input type="text"/>
1) What is the condition causing disablement? <input type="text"/>			
Diagnosis: Chief complaint /History /Complications			
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			
2) Has patient ever had the same or a similar condition?			<input type="text" value="YES / NO"/>
If treated by another physician for the condition, please note below			
Date	<input type="text" value="/ /"/>	Condition	<input type="text"/>
Treating Physician	<input type="text"/>	Phone	<input type="text" value="[]"/>
Date	<input type="text" value="/ /"/>	Condition	<input type="text"/>
Treating Physician	<input type="text"/>	Phone	<input type="text" value="[]"/>
3) If injury, when did the accident occur? <input type="text" value="/ /"/>			
4) When did patient first receive medical attention for the above? <input type="text" value="/ /"/>			
By whom? <input type="text"/>			
5) Dates hospitalised: Admitted <input type="text" value="/ /"/>			
Name and location of hospital			
<input type="text" value="Name"/>			
<input type="text" value="Location"/>			
What Operation if any was performed? <input type="text"/>			
6) Were there any other doctors or consultants attending?			<input type="text" value="YES / NO"/>
If insufficient space please attach separate sheet			
Name	<input type="text"/>	Speciality	<input type="text"/>
Address	<input type="text"/>	Email	<input type="text"/>
7) Date discharged from your care <input type="text" value="/ /"/>			
8) Are you the usual family doctor for this Patient?			<input type="text" value="YES / NO"/>
If so, since what date have you been attending? <input type="text" value="/ /"/>			

9) What defects or chronic diseases does the patient have and when did they originate?

10) Degree of temporary disability:

Based upon Patient's occupation of : (specify)

a. Has the patient been able to do ANY work?

b. If so from what date? Full duties Restricted Duties

c. If not, when will he/she be able to work? Restricted Duties

11) Has injury described in 1 above resulted in any residual disability?

If Yes please give full details and provide copies of specialist or other reports

Your name: Qualifications:

Phone Email:

Address

Signed Date

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