

MAJOR MEDICAL CLAIM FORM

POLICY NUMBER

1 POLICY OWNER'S NAME(S) AND POSTAL ADDRESS

Mr/Mrs/Miss/Ms	Last Name(s) <input type="text"/>	First Name(s) <input type="text"/>
Postal Address	<input type="text"/>	
	Town/City <input type="text"/>	
Telephone	Home Ph. No. () <input type="text"/>	Business Ph. No. () <input type="text"/>
	Mob No. <input type="text"/>	Email <input type="text"/>
Has your address changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you applying for Prior Approval? <input type="checkbox"/> Yes <input type="checkbox"/> No
		If yes, date of procedure/surgery/ investigation or expected admission <input type="text"/> / <input type="text"/> / <input type="text"/>

2 CLAIMANT/LIFE ASSURED'S DETAILS OR IF AS ABOVE PLEASE TICK

Mr/Mrs/Miss/Ms	Last Name <input type="text"/>	First Name(s) <input type="text"/>
Home Address	<input type="text"/>	
	Town/City <input type="text"/>	
Telephone	Home Ph. No. () <input type="text"/>	Business Ph. No. () <input type="text"/>
Date of Birth:	<input type="text"/> / <input type="text"/> / <input type="text"/>	Mob No. <input type="text"/>

3 CLAIM DETAILS

Before proceeding please check for claim exclusions that apply to this contract (refer to section 6)

a. Details of the disease/disorder/condition which has resulted in this claim	<input type="text"/>		
b. Please give details of your symptoms	<input type="text"/>		
c. Date Symptoms Started	<input type="text"/> / <input type="text"/> / <input type="text"/>	Date Sought Medical Advice	<input type="text"/> / <input type="text"/> / <input type="text"/>
d. Name and address of the Registered Medical Practitioner who referred you for treatment, procedure or hospitalisation	<input type="text"/>		
e. Details of your usual GP (if different)	<input type="text"/>		
f. Name of Procedure/Surgery/Investigation	<input type="text"/>		
g. Name of Hospital/Clinic	<input type="text"/>		
h. Name of Specialist/Surgeon who has performed or will perform the procedure	<input type="text"/>		
i. Date of Admission/Procedure/Surgery/ Investigation	<input type="text"/> / <input type="text"/> / <input type="text"/>	Date of Discharge	<input type="text"/> / <input type="text"/> / <input type="text"/>
j. Has this claim resulted from an accident/injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of accident/injury	<input type="text"/> / <input type="text"/> / <input type="text"/>

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k. Have you or are you claiming any amounts from ACC or any other Insurer in relation to this procedure/Surgery/Investigation? Yes No

l. If Yes, what are the details of the organisation/insurer and what are the amounts of the claim(s)?
(Please attach copies of the relevant documentation)

m. Are you seeking any treatment alternatives for this condition? Yes No
(If yes, please give details)

n. Estimated cost of Procedure/Surgery/Investigation or Admission?
(Please attach a copy of the estimate if available)

4 IF YOUR CLAIM IS ACCEPTED, PLEASE INDICATE HOW YOU WANT THIS CLAIM PAID:

Please post a cheque to the Policy Owner(s) Make cheque(s) payable and send direct to Eligible Provider(s) as per attached invoices

Cheque to be collected by Policy Owner Please pay direct to my/our bank account (attach a pre-printed deposit slip)

Bank Account Number

Account Name

5 RECEIPTS/INVOICES ENCLOSED (FOR COSTS INCURRED TO DATE)

Name of Eligible Provider	Amount
1.	\$.
2.	\$.
3.	\$.
4.	\$.

6 EXCLUSIONS

- Self-inflicted harm including attempted suicide, alcohol or drug abuse
- War whether declared or not
- Complications of pregnancy lasting less than 90 days after the end of pregnancy
- Participation in a criminal act
- HIV, AIDS and related conditions
- Mental disease or disorder or psychiatric conditions
- Geriatric conditions or senility
- Acute admission to a public or private hospital
- Cosmetic surgery or procedures
- General Practitioner's costs
- Dentist's costs
- Contraceptions
- Prescription costs except where they are covered under the surgical and non-surgical hospitalisation benefits
- Preventative treatment
- Infertility treatment
- Sterilisation costs incurred within 2 years of the commencement date
- Medical costs covered by ACC
- Costs incurred outside of Australia & New Zealand except those covered under the Overseas Treatment Benefit or Overseas Waiting List Benefit
- Laser eye treatment
- Public Hospital treatment (except under the Public Hospital Cash Grant)
- Congenital disorders
- **Any exclusions specific to your policy. Please check your policy documentation**

7 CHECKLIST: BEFORE SENDING TO ING LIFE (NZ) LIMITED, PRIVATE BAG 92131, AMSC, AUCKLAND 1142

- Original/copy of receipts/invoices
- Original/copy of referral letter from GP/Dentist
- Please ensure the declaration and consent on page 3 has been signed by all policy owners and lives assured
- Have you attached the ACC letter of acceptance/decline for any accident/injury related claim?
- Has the medical questionnaire section on page 3 been completed by the GP/Dentist?
- Have you answered all questions as fully as possible?
- Have you attached any other medical information in support of your claim? (such as report from the specialist)
- Have you attached a copy of the estimate?

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8 DECLARATIONS AND CONSENTS

This application collects personal information about you and any Life Assured for whom you are claiming under your Policy.

The intended recipient of this information is ING Life (NZ) Limited ("the Company") and the information collected will be held at the Head Office of the Company at 205 Wairau Road, Glenfield.

Failure to provide this information may result in your claim being declined or unable to be assessed. You and any Life Assured have the right to request access to and correction of your respective personal information at any time.

I am the Policy Owner and hereby claim the benefit amounts payable on the basis of the statements and information provided by the Life Assured in this claim form which I believe to be accurate and complete in every respect. I understand payments approved by the Company will be forwarded to me on receipt of accounts specifying the service provided and the amount payable.

As part of a medical insurance claim with the Company, I, the Life Assured, consent and give authority to the Company to seek from, and for all and any of the following, their officers and employees, to disclose to the Company, its advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me:

- Registered Medical Practitioners and specialists;
- Dentists;
- Counsellors, psychologists and therapists;
- Government departments, agencies, organisations and enterprises.
- Hospitals (whether public or private);
- Accident Compensation Corporation;
- Insurers (whether public or private);
- Credit Rating & Collection Agencies
- Employers (whether current or not)

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

Privacy Act requirements

- This claim form and any supplementary material which may be required in connection with this claim is a collection of personal information.
- This information will be used to; assess and administer this claim, service and administer the policy, maintain relevant statistical records and provide you with information about other products and services offered by ING Life (NZ) Limited.
- You are required to provide the medical information which has been requested so as to comply with your common law duty to disclose all matters material to the insurance.
- The information will be held by ING Life (NZ) Limited at the address on this form.
- Under the Privacy Act 1993 you have the rights of access to, and correction of, any information provided.

Full Name(s) of All Policy Owners

Signature(s) of All Policy Owners

Full Name of Life Assured

If a claim is being made by a child under 16 years of age, a parent or guardian must sign on the child's behalf. Please insert parent's or guardian's full name and sign below.

Signature of Life Assured Date

9 MAJOR MEDICAL DOCTOR'S QUESTIONNAIRE (TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER OR DENTIST AT CLIENT'S EXPENSE)

EXPLANATION: THE ABOVE LIFE ASSURED IS CLAIMING A MAJOR MEDICAL BENEFIT FROM ING LIFE (NZ) LIMITED AND WE REQUIRE THE FOLLOWING INFORMATION FROM YOU IN ORDER TO ASSESS THIS CLAIM AS QUICKLY AS POSSIBLE. THANK YOU FOR YOUR ASSISTANCE.

Doctor/Dentist Name:

Address:

Phone: Facsimile:

a. How long has the patient been under your care?

b. If less than 3 years, do you hold all medical records? Yes No

If No, please provide details of the previous Doctor(s)/Dentist(s) (if known)

c. What is the medical condition or suspected condition requiring investigation or treatment? Please also provide the ICD 10 reference CODE:

d. When did the signs and/or symptoms of this condition become apparent to the life assured for the very first time? Please specify date(s)

e. When did the life assured first consult with a medical professional including you or your practice in regards to this condition?

f. Is this claim accident/injury related? Yes No If Yes, on what date did the accident/injury or symptoms of this condition occur?

g. How often has the life assured consulted a medical practitioner regarding this condition? Please state date(s)

h. Has the Life Assured consulted you, or any other treatment provider for any other symptoms or conditions that may be associated with the condition they are claiming for? If yes please provide details

i. Date of referral to specialist. (Please attach a copy of the referral letter & the specialist report received in response)

j. Please give details of any other treatment options that have been or may be considered.

Doctor/Dentist Signature: Date:



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