Combined Insurance Claim Form - Section 1

Claimant to Complete this Page *(Please print using BLOCK LETTERS)*

Office Use Only

Important. **Write your Account Number here**

Claimant's Full Name ☐ Mr ☐ Mrs ☐ Ms

Postal Address Postcode

Residential Address *(If different from above)* Postcode

Occupation Employer's Name

Date of Birth / / Height Weight

Employer's Address

Claimant's Telephone Number *(Daytime)* ( )

Are you claiming under a Family Policy? ☐ Yes ☐ No Account Number

Complete for Accident only

1. When did the accident occur? Date / / at am/pm
2. Nature of Injuries *(Please be specific)*
3. How did the accident occur? *(Please be specific)*
4. Was emergency ambulance transport required? ☐ Yes ☐ No *If your policy includes this benefit, please attach an ambulance statement or account*

Complete for Sickness only

5. Nature of Sickness *If you are claiming for malignant cancer under the Cancer or Critical Illness Plan, please attach a copy of your pathology report. (Please be specific)*
6. When were the symptoms first noticed? Date / /
7. Have you previously had the same sickness? ☐ Yes ☐ No Brief Details

Complete for Accident and Sickness

8. If you were confined overnight as an in-patient within a hospital, please give the hospital name, address and dates that you were confined.
   From / / to / /
9. If you were confined as an in-patient within an Intensive Care Unit in this hospital, please give the dates that you were confined.
   From / / to / /
10. Are you claiming benefits for out-patient treatment for Cancer? ☐ Yes ☐ No
    (If you answered 'Yes', please attached proof of your out-patient treatment attendance including dates).
11. What is your attending Medical Practitioner's name and address? Dates of treatment / /
    Name Address
12. "Total Disability". Between what dates were you unable to perform any duties? *(Refer to the definition on the reverse of this form)*
    From / / to / /
13. "Partial Disability". Between what dates were you able to perform only partial duties? *(Refer to the definition on the reverse of this form.)*
    From / / to / /
14. When did you returned to your normal duties? Date / /

15. **Authorisation to release information** I acknowledge that, for the purpose of the Privacy Act 1993
    a) The information in this form is provided by me to Combined Insurance a division of ACE Insurance Limited ("Combined Insurance"), for the purpose of assessing my insurance claim and for any other related purpose.
    b) Any information concerning a third party provided by me to Combined Insurance has been provided with that third party's consent.
    c) I authorise Combined Insurance to obtain such information as it may require concerning me or this claim from any third party or agency and I authorise any third party or agency holding any information concerning me, to release such information to Combined Insurance.
16. **Declaration**

    I solemnly declare the above answers to be true and correct in every detail, and that I have not withheld any material information in relation to the above claim.

Claimant's Signature

(If Minor, Parent's Signature) X Date / /

PLEASE DETACH AND SEND THIS COPY TO COMBINED INSURANCE

ACE Insurance Limited
Company No. 104656
FSP No. 35924

Combined Insurance is a division of ACE Insurance Limited

FINANCIAL STRENGTH RATING

At the time of print, ACE Insurance Limited has an "A" insurer financial strength rating given by Standard & Poor's (Australia) Pty Limited. The rating scale is

AAA	Extremely Strong	BBB	Good	CCC	Very Weak
AA	Very Strong	BB	Marginal	CC	Extremely Weak
A	Strong	B	Weak	C	Regulatory Action

Plus (+) or minus (-): the rating from 'AA' to 'CCC' may be modified by the addition of a plus or minus sign to show relative standings within the major rating categories.

Phone
0800 COMBINED (266 246)

Fax
0-9-520 9009

Email
nz.service@nz.combined.com

Website
www.combinedinsurance.co.nz

Street Address
105 Great South Road
Epsom Auckland 1051

Postal Address
Private Bag COMBINED
Remuera Auckland 1541

The ACE Group of Companies®

COMBINED INSURANCE®

Claim Form

IMPORTANT

Please read before completing this form

1. Please read these important instructions carefully, on how to complete the attached claim form and how we process claims. This may help us assess your claim faster.
2. We refer to the Insured or Covered Person as "You" or "Your"; and Combined Insurance, a division of ACE Insurance Limited, as "Combined Insurance", "We", "Our" or "Us", in the following instructions.
3. You must complete Page 1 - Section 1 in full.
4. Your Medical Practitioner, ***and only your Medical Practitioner*** should complete Page 2 - Section 2 in full. Your Medical Practitioner must also sign and date the Claim Form in the appropriate place.
5. 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 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.
6. We may ask you or your Medical Practitioner for more information concerning your claim, or we may arrange a further independent assessment by a Medical Practitioner/Specialist of our choice. If we do so, it is at our expense.
7. **Please forward this Claim Form (not a copy) within 30 days of the commencement of your disability, to Combined Insurance, Private Bag COMBINED, Remuera, Auckland 1541.**
8. 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

9. If Your Policy covers you for benefits while you are hospitalised as an in-patient, 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.
10. If you are claiming for **Covered Cancer** under a Cancer or Critical Illness policy, please attach a copy of a pathology, histology, or Histopathology report, that medically verifies the diagnosis.
11. If you are claiming a benefit for **Skin Cancer** under a Cancer Policy, please attach a medical statement verifying this.
12. If you are claiming an out-patient treatment benefit under a Cancer policy, please attach a copy of your hospital statement showing the dates of out-patient treatment.
13. If you are claiming an emergency ambulance benefit under your Accident Hospital Plan, please attach a copy of your ambulance statement or account.

Complaints and Privacy

Complaints and Dispute Resolution

We take the concerns of our customers very seriously and have detailed complaint handling and dispute resolution procedures that you may access, at no cost to you, as follows:

Stage 1 – Complaint Handling Procedure

If you are dissatisfied with our products or services and wish to lodge a complaint, contact: nz.service@nz.combined.com

The Complaints Officer
Combined Insurance
Private Bag COMBINED
Remuera Auckland 1541

The members of our complaint handling team have been carefully selected and trained to handle complaints fairly and efficiently.

Please provide us with your claim or account number (if applicable) and as much information as you can about the reason for your complaint.

We will investigate your complaint and keep you informed of the progress of our investigation. We will respond to your complaint within 15 business days provided we have all necessary information and have completed any investigation required. In cases where further information or investigation is required, we will work with you to agree reasonable alternative timeframes.

Stage 2 – Dispute Resolution Procedure

If you are dissatisfied with our response to your complaint, you may ask that your complaint be treated as a dispute and referred to our dispute resolution team.

Please be assured that the members of our dispute resolution team are independent from our complaint handling team and are committed to reviewing disputes objectively, fairly and efficiently.

You may contact our dispute resolution team by email or telephone or by sending details of your dispute by post at: nz.service@nz.combined.com

Internal Dispute Resolution Service
The Disputes Officer
Combined Insurance
Private Bag COMBINED
Remuera Auckland 1541

Please provide us with your claim or account number (if applicable) and as much information as you can about the reason for your dispute.

We will review your dispute and respond with a written dispute determination within 15 business days provided we have all necessary information and have completed any investigation required. In cases where further information or investigation is required, we will work with you to agree reasonable alternative time frames.

Stage 3 – External Dispute Resolution

We are a member of an independent external dispute resolution scheme operated by the Financial Services Complaints Limited (FSCL) and approved by the Ministry of Consumer Affairs. Where a dispute is covered by the FSCL's Terms of Reference, FSCL offers a free and accessible dispute resolution service to consumers.

If you are dissatisfied with our dispute determination or we are unable to resolve your complaint or dispute to your satisfaction within 40 days, you may refer your complaint or dispute to the FSCL. You may contact the FSCL at any time at:

Financial Services Complaints Limited
PO Box 5967
Lambton Quay
Wellington 6145
Tel: 0800 347257 (Call Free for consumers)
(+64 4) 472FSCL (472 3725)
Fax: (+64 4) 472 3728
E-mail: info@fscl.org.nz
Web: www.fscl.org.nz

If you would like to refer your dispute to the FSCL you must do so within 2 months of the date of our dispute determination.

Privacy Consent

ACE Insurance Limited (ACE) collects, uses and retains your personal information only in accordance with the principles in the Privacy Act 1993. A copy of our Privacy Statement, which expands upon our privacy obligations and provides further information on your rights to access your personal information held by us is available on our website or by contacting our Privacy Officer on +64 (9) 3771459.

Your personal information will be used by ACE, or any third party that ACE provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information includes:

(a) any information provided in relation to your claim;

(b) any information that is health information or sensitive information;

(c) any other personal information that you may provide to ACE or its third party contractors;

(d) any information relating to the insurance policy on your life, including terms and conditions and claims history;

(e) details of your employment including position, period of employment, remuneration, hours worked and duties performed; and

(f) any other information relating to your income and solvency.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the Parties). You agree that the Parties may disclose your personal information to ACE.

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies within the ACE Group, other insurers, our reinsurers, and government agencies (where we are compelled to by law). These third parties may be located outside New Zealand. ACE may also disclose your personal information to witnesses in respect to your claim.

In providing your personal information to ACE in this form and in relation to the claim the subject of this form, you agree to us using and disclosing your personal information pursuant to ACE's Privacy Statement and this Privacy Consent. In the event of any conflict between the documents, this Claims Privacy Consent shall be determinative. This consent remains valid unless you alter or revoke it by giving written notice to our privacy officer.

If you do not consent to the terms of this Claims Privacy Consent or revoke your consent, ACE may not be able to process or assess your claim.

PLEASE DETACH AND RETAIN FOR YOUR INFORMATION

Combined Insurance Claim Form - Section 2

Medical Practitioner only to complete this page

Please note that this page must be fully completed by a Medical Practitioner/Specialist, at no expense to Combined Insurance.

Definitions *(Please read carefully before completing this section)*

Total Disability: The inability to perform each of the substantial duties of your business or occupation (usual activities if you are not currently 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 you are not currently 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 Name Age Date of Birth / /

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

   Diagnosis *(If there are any complications that have been diagnosed please describe these.)*

2. **Please Complete for Fractures only.** Was the Fracture confirmed by an X-Ray? ☐ Yes ☐ No

   Describe the type of Fracture.

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

4. When did patient first consult you for this condition? Date / /

   a) Did total disability begin this day? ☐ Yes ☐ No b) If No, please state date disability started. Date / /

5. 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 / /

6. 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?

7. Is the patient still under your care for this condition? ☐ Yes ☐ No

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

8. Disability Periods

   a) Totally Disabled From / / to / / *(inclusive)*

   b) Partially Disabled From / / to / / *(inclusive)*

   c) Hospitalised as an overnight patient. From / / to / /

   d) Hospitalised as an overnight patient in Intensive Care Unit From / / to / /

   At *(Name of Hospital)*

9. *(Total and Permanent Disability only)* Has the patient, as a result of the injury, been totally or permanently disabled continuously for the past 12 months? ☐ Yes ☐ No Will the patient remain totally and permanently disabled? ☐ Yes ☐ No

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

Medical Practitioner's Stamp (Required)

Signed X Print Name

Date / / Degree NZMC#

Address *(if not on stamp)*

(We recommend that a copy of this form is taken for your files)

PLEASE DETACH AND SEND THIS COPY TO COMBINED INSURANCE