Insurance Claim Form

Claim form covers:

Lifestyle Security Plan Foundation Package, Borrowers Protection Plan and Personal Loan Insurance.

INSTRUCTIONS:

1. Disability A, B, C, D, E 2. Redundancy, Bankruptcy (BPP only) A, B, F, G, H 3. Hospital Benefit (BPP only) A, B, I 4. Critical Illness (PLI only) A, B, C

Who completes the following sections?

Section A	to be completed in all cases by the claimant or his/her legal representative.
Section B	to be completed by ASB Bank Limited ("ASB") staff.
Section C	to be completed by the claimant in the event of Disability or Critical Illness.
Section D	to be completed by the claimant in the event of Disability.
Section E	to be completed by the Attending Doctor or GP in the event of Disability.
Section F	to be completed by the claimant in the event of Redundancy/Bankruptcy.
Sections G & H	to be completed by the employer in the event of Redundancy or the assignee in the event of Bankruptcy.
Sections I	to be completed by the claimant if hospitalised more than 3 nights (BPP only).

When complete, please return this form to the ASB Bank Limited, Insurance Services, PO Box 35, Shortland Street, Auckland 1140.

A. Claimant's statement: (Personal details to be completed in every instance)

Surname (please print)

First names

Title: Mr | Mrs | Miss | Ms | Mx | Dr Other

Home address

Date of birth: D D M M Y Y Y Y

Were you an income earner? ◯ Yes ◯ No

If yes, please state number of regular hours worked per week.

What is your gross monthly income? $

Telephone number – Home

Business

Email Address

Name and address of current and last two employers

Duties

Period covered

to

to

to

Consent

As part of an insurance claim with AIA New Zealand Limited ("AIA"), underwriter of policies issued by AIA or related company Sovereign Assurance Company Limited ("Sovereign"), I, the life assured consent and give authority to AIA and any of its related entities and agents to request any of my medical or other personal information affecting my insurance or the assessment of my claim from any third party which AIA reasonably considers may hold that information.

I also authorise those third parties to disclose that information to AIA and/or any of its related entities, their officers, their advisers, their agents and reinsurers, and to any legal tribunal before which any question concerning my insurance may arise. Those third parties may include:

- Registered medical practitioners and Specialists (which may include an entire copy of my/our medical file)
- Medical laboratories and testing facilities
- Accident Compensation Corporation, government departments or bodies
- Advisers or ASB Bank Limited ('ASB') employees handling insurance-related information
- Insurers or reinsurers (whether public or private)
- Counsellors, psychologists and therapists, and
- Any other person or organisation which holds information which is relevant to my insurance or the assessment of my claim.

I understand that the supply of the information gathered from the above sources is voluntary and that AIA and/or any of its related entities may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my Insurance. I understand that the personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.

I consent to the disclosure of my claims information to ASB for the purposes of notifying ASB of any issues or disputes arising in respect of my claim.

I understand that my personal information will be stored at:

- ASB North Wharf, 12 Jellicoe Street, Auckland and by ASB's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere).
- AIA's head office, 74 Taharoto Road, Takapuna and by AIA's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere).

I understand that ASB and AIA will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).

I understand that ASB and AIA may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of the personal information may be requested by me.

I understand that AIA may share my claims details with related insurers to enable co-ordination of claims resolution.

Continued over the page

A. Claimant's statement: (Personal details to be completed in every instance) - Continued

Declaration - important, please read carefully

I declare that all occupational, medical and financial information pertaining to me and relevant to my insurance claim has been provided and disclosed to AIA.

I understand that failure to provide full disclosure of all occupational, medical and financial information that AIA considers as relevant in the assessment of my claim would be considered to be material misrepresentation and/or material non-disclosure and as such AIA is entitled to use legal remedy, should this occur.

I further understand that the occupational, medical and financial information provided is the basis on which AIA will assess and manage my claim and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed.

I declare that all the answers to questions in this form are true and complete. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I further agree that a digital copy of this authority will be valid as an original.

Signed by claimant

Date D D M M Y Y Y Y

B. Policy statement: To be completed by ASB Staff

Policy numbers relating to claim

Verified by ASB staff member (Name)

Branch number

Date D D M M Y Y Y Y

Have you attached the policy schedule(s)?

◯ Yes ◯ No

C. Medical Information: To be completed by the Claimant

Please describe your current diagnosis/condition (if injury related, please also describe how the injury occurred)

When did your symptoms first become apparent and what were they?

Date you first sought medical assistance for your claim/condition

D D M M Y Y Y Y

Have you ever previously suffered from the same, similar or related condition? ◯ Yes ◯ No

If Yes, please give full details including what the condition was, who you saw, and when was it

C. Medical Information: To be completed by the Claimant - Continued

Name of Usual Doctor (please print)

Address of Usual Doctor

Have you consulted any other Doctor, or Specialist during the last 12 months?

◯ Yes ◯ No

If Yes, please provide details below:

Name of Doctor/Specialist

Address of Doctor/Specialist

Name of Doctor/Specialist

Address of Doctor/Specialist

D. Additional disability claim information: To be completed by the Claimant

Date the disability commenced D D M M Y Y Y Y

Date you ceased to work D D M M Y Y Y Y

Please provide names and addresses of Doctor(s) attended in relation to your disability

Doctor's name (please print)

Doctor's address

Doctor's name (please print)

Doctor's address

Since you have become disabled have you been able to engage in any duties or tasks of your usual occupation/any occupation? ◯ Yes ◯ No

If yes, please provide details of the duties or tasks you have engaged in including hours worked

Are you receiving or have your received any other income from any other source, including ACC, private registered insurer, sickness benefit or another Insurance Policy? ◯ Yes ◯ No

If yes, please give details

If applicable:

ACC or private registered case manager

ACC or private registered case number

ACC or private registered case branch

E. Medical report for disability: To be completed by the attending doctor

The costs of the Doctor completing this claim form are to be paid by the claimant.

Should the space allowed for answering any of the questions be insufficient, please attach a separate sheet.

Name of patient (please print)

Age

Sex

Occupation

Please describe your understanding of the duties of the patient's occupation(s)

E. Medical report for disability: To be completed by the attending doctor - Continued

Please provide a complete description of the disability from which your patient is currently suffering (include any reports)

When did your patient first cease work due to this disability?

D D M M Y Y Y Y

When did you originally examine the patient concerning the current disability?

D D M M Y Y Y Y

Has the patient been seen by any other Doctor, hospital or clinic for this condition? ◯ Yes ◯ No

If yes, please provide details and copies of all reports

Do you have any reason to believe this disability was intentionally self-inflicted? ◯ Yes ◯ No

If yes, please provide details

Has the patient a history of this disability or condition? ◯ Yes ◯ No

If yes, please provide details of all consultations relating to this current disability.

Date	Condition	Treatment

When do you expect your patient to resume his/her regular duties?

Part-time

D D M M Y Y Y Y

Full-time

D D M M Y Y Y Y

Are you the patient's usual doctor?

◯ Yes ◯ No - please provide the usual doctor's name and address below:

Name of usual doctor (please print)

Address of usual doctor

Is your patient confined to hospital or bedrest at home?

◯ Yes ◯ No

I am providing this information based on, and for the purposes stated in, the claimant's declaration and authority.
I confirm this information can be given to the claimant (if required under the provisions of the Privacy Act 1993).

Attending doctor's name (please print)

Attending doctor's address

Signature of doctor completing the report

Date

D D M M Y Y Y Y

F. Redundancy/bankruptcy claim form: To be completed by the claimant

Please include copy of letter from employer advising of redundancy. (Bankruptcy claim applicable for Borrowers Protection Plan only.)

Prior to completing this claim form were you ◯ an employee or ◯ self-employed?

If employee, state name and address of your last employer

Name of last employer (please print)

Address of last employer

Date you ceased employment D D M M Y Y Y Y

Are you still unemployed? ◯ Yes ◯ No

If no, on what date did you begin your new job? D D M M Y Y Y Y

Reason for termination of employment?

Are you registered with Work and Income New Zealand or any other agency?

◯ Yes ◯ No

How many hours have you worked on average over the last six month period prior to redundancy?

If this claim is due to bankruptcy, please have this section witnessed by the Official Assignee.

Signature of claimant

Signature of official assignee (if applicable)

G. Redundancy/bankruptcy: Please ask the Employer to complete this section

If claiming for bankruptcy, this section is to be completed by the Official Assignee.

(This statement is strictly confidential and only for the information of the Insurer.
No information will be disclosed without the permission of the employer/assignee concerned.)

Name of employer (please print)

Full name of employer

Employer address

Employed by you: From D D M M Y Y Y Y To D D M M Y Y Y Y

Have you employed anyone else to fill this claimant's position? ◯ Yes ◯ No

Did the claimant receive redundancy pay? ◯ Yes ◯ No

If yes, please state the gross figure received and attach a detailed break down of this amount. $

Average weekly gross income in the six weeks prior to redundancy? $

Did the claimant accept voluntary redundancy? ◯ Yes ◯ No

Was he/she in full-time permanent employment with your company at the date of Redundancy/Bankruptcy? ◯ Yes ◯ No

If no, please provide details of the basis of their employment or hours worked on a regular basis (e.g. contract worker, seasonal worker, casual employee, etc.)

Prior to redundancy was the claimant employed by your company outside New Zealand or Australia? ◯ Yes ◯ No

If this person was not made redundant, what is the reason for his/her unemployment?

Does the claimant or a member of his/her family have effective financial control over the company from which the claimant has been made redundant? ◯ Yes ◯ No

Please give the date that the claimant was notified that he/she would or might be made redundant D D M M Y Y Y Y

What date was it generally known that redundancies were being considered by your company? D D M M Y Y Y Y

How many other personnel were made redundant at the same time?

H. Declaration: To be signed by employer/official assignee

I hereby declare the information given is true, correct and complete and that no material information has been withheld.

Signature

Name of employer/official assignee (please print)

Date

D D M M Y Y Y Y

Name

Company stamp

Title

Company name

I. Hospital benefit: (only applicable to Borrowers Protection Plan (Scheme 1) issued before 2 August 1998)

Have you been hospitalised in a public or private hospital for more than 3 nights?

◯ Yes ◯ No

If yes, how many nights were you in hospital?
Please attach a copy of your admission/discharge form.

Insurance claims information

ASB and the Insurer have worked closely together to develop a comprehensive service level agreement to ensure our customers receive quality claims service. The Insurer will manage all claims and you can expect regular contact from their dedicated professional claims specialists.

In assessing claims, the Insurer recognises they have an obligation to all our customers to pay genuine claims on time once they receive the required information. To help the Insurer process your claim as quickly as possible, please ensure that the information you provide is correct and complete to the best of your knowledge. If you are unsure of the relevance of information to be disclosed, please call the Helpline and speak with one of the claim specialists.

How the claims process works

Notification

Complete the attached Claim Form to make a formal application for a claim and to authorise the Insurer to obtain information from any doctor, medical specialist, ACC, your accountant or past or current employer pertaining to your claim. If you are unsure of the relevance of any information you may have, please phone the Insurer on the Helpline.

Assessment

During this process, the Insurer will assess your claim from the information they receive from you or your doctor, medical specialist, employer, etc.

You may also be making a claim with an ACC Insurer. The amount you claim from the Insurer may be affected by this claim.

Your status as an earner including the number of hours you worked each week prior to your claim will affect any benefit payment that may be made - please refer to your Policy Document for further details.

Acceptance

Once the claim has been assessed and accepted, the Insurer will pay the benefit, monthly in arrears after the waiting period of 30 days has been completed.

For example, if you have an accident on 1 June, you must get this date certified by a doctor and inform us by completing a claim form. After a 30 day waiting period, you will be eligible to claim on 1 July. During this time the Insurer will assess your condition. If you are still unable to work on 1 July and your claim has been accepted, the Insurer will pay from this date. Benefit payments are made in arrears.

In case of a redundancy claim the wait period may be extended if a redundancy settlement is received from your employer, please refer to your Policy Document for full details.

Management

In managing your claim the Insurer will focus on keeping in touch, and ensuring you receive any relevant information.

Once complete, please post this form to:

ASB Bank Limited
Insurance Services
PO Box 35
Shortland Street
Auckland 1140

Or for further information, please contact:

AIA New Zealand Limited
0800 272 543