CREDIT CARD INSURANCE CLAIM FORM

SOVEREIGN

Guide to completing this claim form

For each type of claim there are different requirements and different sections of this form that need to be completed. To help us process your claim quickly, please ensure you have completed all the relevant sections and attached all the required information.

Illness or injury

- Complete sections 1, 2, 3 and 8
- For a Temporary or Permanent Disablement claim, attach 4 consecutive payslips from immediately prior to the event you are claiming for
- Attach any relevant medical information given by your attending physician or treating specialist
- Attach a credit card statement that covers the date of the event you are claiming for.

If you are self-employed, please provide details showing evidence of your income, e.g:

- Monthly financial statements
- Copy of your company accounts
- Letter from your accountant.

Death

- Representative of estate to complete sections 1, 4 and 8
- Attach the full death certificate (or certified copy)
- Attach a credit card statement that covers the date of the event being claimed for.

Bankruptcy

- Complete sections 1, 5 and 8
- Attach 4 consecutive payslips from immediately prior to your bankruptcy, or, if not applicable, provide a copy of your most recent financial accounts
- Attach a copy of the court order declaring your bankruptcy, establishing that you have been adjudicated bankrupt on a creditor's petition
- Attach a credit card statement that covers the date of the event you are claiming for.

Redundancy

- Complete sections 1, 6, 7 and 8
- Attach 4 consecutive payslips from immediately prior to your redundancy
- Attach your letter of redundancy
- Attach a credit card statement that covers the date of the event you are claiming for
- Attach any other details of your efforts to find work, e.g. WINZ or employment agency registration, job searches immediately following your redundancy.

Please refer to your policy document if you are unsure what is covered under each benefit

1 Cardholder details (to be completed by the cardholder who suffered the claimable event or the representative of the estate)

Policy number

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Last name

First name(s)

Addresses

	Residential Address	Postal Address (if different from residence)
Street		
Suburb		
City		
Postcode		

Telephone

Home | Business | Mobile

Cardholder details continued...

Email address

Date of birth / /

Your Warehouse Money or Diners account number

OR, please enter the first six and last four numbers of your insured credit card

For a Death, Terminal Illness, or Permanent Disblement claim only

Cash Assistance Benefit

Bank

Bank account name

Bank account number

(Please enter 0 as the first suffix number if your account only has a two-digit suffix)

2 Illness or injury (to be completed by the cardholder who suffered the claimable event)

Details of the condition or symptoms which have resulted in this claim
Please be specific

What date did the symptoms start? / /

Have you ever previously suffered from the same or similar complaints? Yes No **If Yes, please provide details below:**

Approximate date / /

Description

Details of doctor/ hospital attended

Have you ever claimed for this condition before under this policy? Yes No Claim number (if known) or date you claimed

Do you/have you had an ACC claim for this condition? Yes No **If Yes, please provide details below:**

ACC claim number

ACC case manager (if known)

On what date did you first seek medical assistance for this condition? / /

Please provide name and address of your usual doctor

GP name

Address Street

Suburb

City Postcode

Illness or injury continued...

How long have you been a patient of this GP?

If less than 3 years, please advise the name and address of your previous doctor

GP name

Address Street

Suburb

City Postcode

How long were you a patient of this GP?

State the names of all doctors, specialists, physiotherapists, chiropractors etc consulted by you for this condition, including any you were referred to for further opinion or investigations

First seen on / /

Person consulted

Contact details of doctor/hospital

First seen on / /

Person consulted

Contact details of doctor/hospital

First seen on / /

Person consulted

Contact details of doctor/hospital

What was the last day you worked? / /

On what date were you medically certified to totally cease work? / /

OR, I have not totally ceased work

What was your occupation immediately prior to you ceasing work?

Number of hours usually worked? hours

Name of employer

Contact person

Work telephone

Mobile

Contact person's position

Self-employment

Number of partners/ employees/shareholders/ beneficiaries & profit share entitlement if applicable

Sole proprietor

Independent contractor

Shareholder employee

Company(ies)

Partnership(s)

Trust(s)

Other, please specify

3 **Medical certificate** (to be completed by the cardholder's attending physician or for a Critical Illness or Terminal Illness claim the treating specialist, at the expense of the cardholder)

Please note, we cannot proceed with your claim unless this section has been completed

Patient name

Age

Occupation

Are you the cardholder's medical attendant? If so, for how long?

What is the cardholder's diagnosis/problem list? Please give reasons for your answer

It will greatly assist in the fair assessment of this claim if you provide us with relevant reports, laboratory values, cytological and histopathological reports (original documents will be returned promptly)

Date of onset of symptoms / /

Date of diagnosis / /

Date of first consultation / /

Current and future treatment plan details (include investigations, referrals, medications, surgery, counselling, palliative care and exercise programmes)

OR, prognosis of terminal illness, including life expectancy in terms of months, irrespective of any treatment they may receive

Has the patient had this condition, or any associated problems previously, and if so when?

☐ Yes ☐ No If Yes, please provide relevant clinical information:

For a Temporary or Permanent Disablement claim, please answer the questions below relating to time off work, or note if the patient is not employed.

For all claims, please complete the Contact with Sovereign and Declaration boxes at the end of this section.

Has the patient been advised to cease work? ☐ Yes ☐ No

If Yes, on what date did you advise the patient to totally cease work? / /

Is the patient still completely unable to work? ☐ Yes ☐ No

Has the patient been advised to reduce his/her hours of work? ☐ Yes ☐ No

If yes, how many hours per week?

On what date did you advise the patient to reduce his/her hours of work? / /

Current prognosis on return to pre-injury / illness occupation

Current barriers to a successful return to pre-injury / illness occupation whether full time or part time

What are the current activity / work restrictions (if any)

Medical certificate continued...

What is your understanding of the patient's current occupational duties?

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

Part-time date / /

Full-time date / /

Next planned review date / /

Contact with Sovereign

Would you like a Sovereign case manager or medical adviser to phone you to discuss this case? (You are able to invoice Sovereign at a reasonable cost for this discussion)

☐ Yes ☐ No

Best time to call

Phone number

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

Name

Medical specialty

Address

Street

Suburb

City

Postcode

Telephone

Facsimile

Signature

Date / /

Please attach all relevant medical information in relation to the patient's illness or injury

4 Death claim (to be completed by the representative of the estate)

Full name of person claiming on behalf of the estate

Address

Street

Suburb

City

Postcode

Telephone

Home

Business

Mobile

Relationship to deceased

Death claim continued...

Declaration and signature

I, the undersigned, declare that I am the person referred to in the statements above and that all of the information in this form is true and complete in every respect. I understand that if any statement is incorrect the claim may be declined and the policy cancelled. I authorise any person or company including any health professional, agency, insurer or the Accident Rehabilitation and Compensation Insurance Corporation to provide Sovereign Assurance Company Limited (Sovereign) with full disclosure of any information regarding the cardholder's medical history, including copies of any medical or clinical reports. I also authorise Sovereign to confirm the outstanding balance of the cardholder's credit card immediately prior to the cardholder's death, with the issuer of the credit card. I agree that a photocopy of my authorisation will be as valid as if it were the original.

Print full name

Signature

Date / /

5 Bankruptcy (to be completed by the cardholder who suffered the claimable event)

Complete this section if you are claiming for Bankrupty

Name and address of company/ partnership/business

What is your interest in the company? Eg part shareholder or 100% ownership?

Date adjudicated bankrupt / /

6 Redundancy (to be completed by the cardholder who suffered the claimable event)

Complete this section if you are claiming for Redundancy

Were you employed for financial reward in a permanent position for at least 20 hours per week prior to the termination of your employment? ☐ Yes ☐ No

Prior to ceasing employment, were you ☐ An employee ☐ Self-employed

If you were an employee, state the name and address of your last employer

Name

Address Street

Suburb

City Postcode

Date you ceased employment / /

Are you still unemployed? ☐ Yes ☐ No If not, what date did you begin your new job? / /

Redundancy continued...

Reason for termination of employment?

Are you registered with WINZ or an employment agency? ☐ Yes ☐ No **If Yes, please provide:**

Name of agency | Hours usually worked

Were you outside New Zealand when you were made redundant? ☐ Yes ☐ No **If Yes, what country?**

7 Employer details (to be completed by the employer of the cardholder who has suffered the claimable event)

Please note, we cannot proceed with your claim for Redundancy unless this section has been completed

Full name of employer

Employer address

Street

Suburb

City | Postcode

Name of employee

Employed by you From / / To / /

Have you employed anyone else to fill the employee's position? ☐ Yes ☐ No

Did the employee receive redundancy pay? ☐ Yes ☐ No If Yes, please state the gross figure received and attach a detailed breakdown of this amount

What was the employee's average weekly gross income in the six weeks immediately prior to redundancy?

Did the employee accept voluntary redundancy? ☐ Yes ☐ No

Was the employee in permanent employment for at least 20 hours per week at the date of redundancy? ☐ Yes ☐ No If No, please provide details of the basis of their employment (e.g. contract worker, seasonal worker, casual employee etc) and hours worked on a regular basis

If the employee was not made redundant, what is the reason for his/her unemployment? E.g. end of a trial period

Does the employee or a relative of the employee have ownership or control (e.g. a majority shareholding, ownership) of the employer from which the employee has been made redundant? ☐ Yes ☐ No If Yes please provide full details including the employee's relationship to the employer

Please give the date that the employee was notified that he/she would or might be made redundant / /

What date was it generally known that redundancies were being considered by your company? / /

Employer details continued...

Declaration

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

Name			
Title			
Signature		Date	/ /
Company name			
Company stamp			

8 Declaration and consent (to be completed by cardholder who suffered the claimable event)

This claim form collects personal information about you, the cardholder who suffered the claimable event, for the purpose of assessing your insurance claim under the policy.

The intended recipient of this information is Sovereign Assurance Company Limited ("Sovereign") and/or any of its related entities, their officers, their advisers, their agents and reinsurers and the information collected will be held at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). Sovereign will take reasonable steps to keep such information secure. Sovereign may be required to disclose personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand that Sovereign may share my claims details with related insurers to enable co-ordination of claims resolution. You have the right to request access to, and correction of, your personal information at any time.

As part of a monthly payment or lump sum insurance claim with Sovereign, I, the cardholder who suffered the claimable event, consent and give authority to Sovereign and any of its related entities and agents to seek from, and for all and any of the following, their officers and employees, to disclose to Sovereign, their advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical or other personal information affecting such insurance which they may hold in respect of me:

- registered medical practitioners and specialists;
- laboratories;
- dentists;
- hospitals (whether public or private);
- Accident Compensation Corporation;
- insurers (whether public or private);
- government departments, agencies, organisations and enterprises;
- counsellors, psychologists and therapists;
- your adviser/broker/insurance agent;
- accountants and other financial advisers;
- banks and other financial institutions;
- employers (whether current or not);
- any other person or organisation which Sovereign reasonably considers may hold information about me relevant to this claim.

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following :

I consent to the disclosure of my claims information to ASB Bank Limited ('ASB') for the purposes of notifying ASB of issues or disputes arising in respect of my claim ☐ Yes ☐ No

I, the cardholder who suffered the claimable event, declare that all the answers to the questions in this claim form are true and complete and disclosed in the utmost good faith and that the occupational, financial and medical information pertaining to me has been provided and disclosed to Sovereign. I understand that failure to provide the requested information or provision of incorrect information may result in my claim being declined and/or unable to be assessed and/or my policy being cancelled. If any answer is not in my handwriting I declare that this has been written down at my direction.

Declaration and consent continued over...

Declaration and consent continued...

I consent and give authority to ASB Bank Limited and/or Sovereign to request from AIA International Limited (trading as AIA New Zealand `AIA'), or disclose to AIA, any information pertaining to me and relevant to the assessment of my insurance claim.

I consent to Sovereign sharing information regarding my claim with ASB Bank Limited ☐

I, the cardholder who suffered the claimable event, agree that a photocopy of this authority will be valid as an original.

Please print full name of the cardholder who suffered the claimable event

Signature of the cardholder who suffered the claimable event

Date / /

Sovereign House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag Sovereign,
Victoria Street West,
Auckland 1142

Freephone: 0800 500 108
Freefax: 0800 329 768
Email: claims@sovereign.co.nz