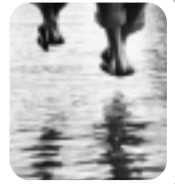


# MAJOR MEDICAL CLAIM FORM



## 1 Policy Owner's Name and Postal Address

Mr/Mrs/Miss/Ms	<i>Surname</i>	<i>First Names</i>
Home Address		
	Town/City	
Has your address changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Business Ph. No. (    )
Policy Number:		Telephone Home (    )
Are you applying for Prior Approval?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## 2 Life Assured Claim Details

Mr/Mrs/Miss/Ms	<i>Surname</i>	<i>First Names</i>
Home Address		
	Town/City	
Date of Birth:	/  /	Business Ph. No. (    )
		Telephone Home (    )

Before proceeding please check for claim exclusions that apply to this contract (refer over page)

a. Name and address of the Registered Medical Practitioner who referred you for treatment, procedure or hospitalisation		
b. Details of the disease, disorder which has resulted in this claim		
c. When did you first seek medical advice and/or treatment for this condition?	/  /	
d. When did you first become aware of any symptoms and what were they?		
e. Are you seeking any treatment alternatives for the attached claim? <i>(If yes, please describe)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Name of Operation/Medical Treatment performed/to be performed <i>(please delete one if not applicable)</i>		
g. Name of Hospital/Clinic		
h. Name of Specialist/Surgeon who has performed or will perform the procedure		
i. Date of admission/expected admission	/  /	Date of Discharge   /  /
j. Is this accident related?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
k. Have you or are you claiming any amounts from ACC or any other Insurer in relation to this procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
l. If Yes, what is the amount of the claim(s)? <i>(Please attach copies of the relevant documentation)</i>		

**3 Payment Details** (please indicate below how you would like your claim paid)

Please post a cheque

Cheque to be collected by Policy Owner

Make cheque(s) payable and send direct to Eligible Provider(s) as per attached invoices

Please pay direct to my/our account      Bank Account Number

Account Name

Other (please specify)

**4 Receipts Enclosed**

Name of Eligible Provider	Amount
1.	\$ .
2.	\$ .
3.	\$ .
4.	\$ .
5.	\$ .

**5 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.
- Perventative 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
- Laser eye treatment
- Public Hospital treatment
- Congenital disorders that were not declared to and accepted by us at the time of application

**6 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 231 Albany Highway, Albany.

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);

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 of Policy Owner(s)

Signature of Policy Owner(s)  Date  /  /

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  /  /

