

# Accidental Serious Injury Benefit

## Privacy Statement

### Notice under the Privacy Act 1993 and The Health Information Privacy Code 1994

'We', 'us' and 'our' refers to WeProtect Limited (WeProtect) and Fidelity Life Assurance Company Limited (Fidelity Life) and 'you' and 'your' refers to the Policy Owner and the Life Insured.

We collect personal information about you. The personal information and any additional information obtained, (including medical information or financial information if required) will be used by us and our officers to assess and administer the claim. The information may also be used for statistical purposes provided you are not identified.

WeProtect and Fidelity Life, their subsidiaries, advisers, reinsurers and any agents appointed by us collect from, use, and disclose to any third party, your information that is reasonably necessary to assess, administer and manage the claim. Those third parties include (but are not limited to): advisers, agents, health service providers including recognised private and public hospitals, registered medical practitioners and specialists, medical authorities, Accident Compensation Corporation, therapists, insurers and reinsurers, and any other individual organisation where the collection/disclosure is required or permitted by law.

The information may also be disclosed between us, outside of WeProtect or Fidelity Life where the disclosure is necessary for one or more purposes for which the personal information was collected, to agents, representatives, organisations, or contractors who provide services to us in connection with the administration of products or services, for the purpose of customer satisfaction surveys, or where permitted by law.

We will take all reasonable steps to keep the information secure and ensure it is accurate, complete and up to date.

Under the Privacy Act 1993 you have the right of access to and correction of the information that we hold about you. We will rely on you to keep us informed of any changes to your information.

The NZ Cover Direct Privacy Policy is available at [www.nzcoverdirect.co.nz](http://www.nzcoverdirect.co.nz). If you have any query in relation to your privacy please contact NZ Cover Direct:

**Phone:** 0800 894 504 (Mon to Fri, 9am - 8pm NZST)

**Email:** [customerservice@nzcoverdirect.co.nz](mailto:customerservice@nzcoverdirect.co.nz)

**Mail:** Claims Manager, NZ Cover Direct, PO Box 99892, Newmarket, 1149

## Completion instructions

**Step 1:** As Policy Owner, you should first check your most recent policy schedule to make sure that the Accidental Serious Injury cover is in place and current for the injured Life Insured. Then complete **Section 1: Parts A to E**. Note that once the claim is approved, the claim payment will be made to you.

**Step 2:** The Life Insured who has suffered the injury must complete **Section 2: Parts F to I**. If you are both the Policy Owner and Life Insured, then you must complete all **Parts A to I**. If you are unable to complete the form your legal representative may complete the form on your behalf. Our assessment is based on the details provided here and the details provided by the Life Insured's medical practitioners.

**Step 3:** Once Sections 1 and 2 have been **fully completed**, please forward this form to the Medical Practitioner who has predominantly attended to the injured Life Insured, to complete **Section 3: Parts J and K**. Once he/she has completed their Parts, the Medical Practitioner is to send the whole completed form back to NZ Cover Direct.

# Section 1: Policy Owner's details

## Part A: Policy Owner's details

Policy Owner:	Policy number:	
Address:		
Suburb:	City:	Postcode:
Phone (H):	Phone (W):	Phone (M):
Email:		

## Part B: Policy Owner's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party (including parents or children) other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below:

First name:	Surname:
Relationship to you:	
Policy Owner's signature:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>

## Part C: Policy Owner's payment authority

Once the claim has been accepted the benefit will be credited to the account below.

Name of bank:	Name of account holder:
Account number: <input type="text"/> - <input type="text"/> - <input type="text"/>	

## Part D: Policy Owner's declaration

I have read and carefully considered the questions on this document and declare that all the responses are true and correct in relation to the claim. By completing this form I understand I have a duty to provide WeProtect and Fidelity Life with all the facts material to my claim and all information they may reasonably require in relation to my claim.

I acknowledge that the making of a false statement may invalidate this claim, and that if I fail to provide all or part of the information Fidelity Life requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement on page 1.

Policy Owner's signature:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
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## Section 2: Life Insured's details

### Part E: Life Insured's details

Title:	First name:	Surname:
Date of birth:	<input type="text"/> / <input type="text"/> / <input type="text"/>	Weight: <input type="text"/> kg Height: <input type="text"/> cm
Occupation:		
Address:		
Suburb:	City:	Postcode:
Phone (H):	Phone (W):	Phone (M):
Email:		

### Part F: Life Insured's Accidental Serious Injury claim

#### Medical details of the Life Insured

1.	Which of the following conditions has the injury resulted in? (Please tick one)
	<input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Coma <input type="checkbox"/> Major Burns <input type="checkbox"/> Loss of Use of Limbs
	<input type="checkbox"/> Loss of Speech <input type="checkbox"/> Paralysis <input type="checkbox"/> Major Head Trauma <input type="checkbox"/> Blindness
	These conditions are defined in your Policy Wording.
2.	On what date did the injury occur? <input type="text"/> / <input type="text"/> / <input type="text"/>
3.	Name of doctor you have predominantly consulted with about the claimed condition:
	Address:
	Suburb:      City:      Postcode:
	Phone:
	Date of first consultation? <input type="text"/> / <input type="text"/> / <input type="text"/> Date of last consultation? <input type="text"/> / <input type="text"/> / <input type="text"/>
4.	Is the doctor named in (3) above your usual doctor? Yes No If 'no', please provide details of usual doctor:
	Doctor's name:
	Address:
	Suburb:      City:      Postcode:
	Phone:

### Part G: Life Insured's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party (including parents, spouse or children) other than as set out in our Privacy Policy or unless we have your express consent

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below:

First name:	Surname:
Relationship to you:	
Life Insured's signature:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>

## Part H: Life Insured's consent to obtain a medical report

I hereby consent to Fidelity Life and WeProtect being provided with medical information, including copies of any medical reports, clinical reports or otherwise, from any Medical Practitioner who I have attended at any time concerning anything which affects my physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

First name:

Surname:

Date of birth:

 /  / 

Life Insured's signature:

Date:

 /  / 

## Part I: Life Insured's declaration

I have read and carefully considered the questions on this document and declare that all the responses are true and correct in relation to the claim.

By completing this form I understand I have a duty to provide WeProtect and Fidelity Life with all the facts material to my claim and all information they may reasonably require in relation to my claim.

I acknowledge that the making of a false statement may invalidate this claim, and that if I fail to provide all or part of the information Fidelity Life requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement on page 1.

Life Insured's signature:

Date:

 /  / 

Please have the treating Medical Practitioner complete parts J & K on the following pages.

# Section 3: Medical details

This section (Parts J and K) is to be fully completed by the registered treating Medical Practitioner.

## Part J: Confidential Medical Report - Accidental Serious Injury benefit

Please note that the information required is in relation to the injured Life Insured (patient).

To ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this section are fully addressed and answered. Responses such as "refer to doctor", "see above", etc, are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.

Please attach copies of letters/reports or accident documents regarding the injury. If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date any attachments.

<b>1. Patient's details</b>		
First name:	Surname:	
Address:		
Suburb:	City:	Postcode:
<b>2. Medical details</b>		
a.	Are you the patient's usual Medical Practitioner?	Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please provide details of usual doctor:
	Doctor's name:	
	Address:	
	Suburb:	City: Postcode:
	Phone:	
b.	Which of the following conditions has been suffered by your patient? (Please tick one)	
	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Coma <input type="checkbox"/> Major Burns <input type="checkbox"/> Loss of Use of Limbs
	<input type="checkbox"/> Loss of Speech	<input type="checkbox"/> Paralysis <input type="checkbox"/> Major Head Trauma <input type="checkbox"/> Blindness
c.	What was the date of injury?	<input type="text"/> / <input type="text"/> / <input type="text"/>
d.	What was the date of the first consultation in connection with the current condition?	<input type="text"/> / <input type="text"/> / <input type="text"/>
e.	Please fully describe the patient's current condition and prognosis for recovery, relapse or whether the condition is permanent:	
f.	Provide the dates and results of any X-rays or other tests performed:	
	Date:	Test: Results:
	<input type="text"/> / <input type="text"/> / <input type="text"/>	  
	<input type="text"/> / <input type="text"/> / <input type="text"/>	  
	<input type="text"/> / <input type="text"/> / <input type="text"/>	  
g.	What treatment is currently being given, including surgery and medication, if any:	

## Part J: Confidential Medical Report - Accidental Serious Injury benefit (continued)

h.	Please provide the names and addresses of any consulting specialist(s) or medical services the patient has been referred to:		
	Name:	Speciality or medical service:	
i.	If the patient has been hospitalised, provide the following details:		
	Admission date:	Discharge date:	Name of hospital:
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
j.	Please provide details if the patient has a previous history of the current condition, or any impairment likely to be connected with the current condition:		

## Part K: Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended the above named patient and that all the information supplied by me in this Report is true.

First name:	Surname:		
Qualifications:			
Address:			
Suburb:	State:	Postcode:	
Phone:	Fax:		
Medical Practitioner's signature:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>		

### Please return the completed form to NZ Cover Direct. You can either:

1. Scan and email to [customerservice@nzcoverdirect.co.nz](mailto:customerservice@nzcoverdirect.co.nz) (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); or
2. Mail to Claims, NZ Cover Direct, PO Box 99892, Newmarket, 1149 (please mark the envelope as CONFIDENTIAL).