dollar INSURANCE®

terminal illness benefit

Need some help completing this form? Call us on **0800 226 223** (9am – 8pm NZST).

At Dollar Insurance, we want to get your claim underway as quickly as possible. To help us do this:

1. Check the latest policy schedule to make sure that the $1 a Day Life Cover for the terminally ill Policy Owner is in place and up to date.
2. Fill out this form in black or blue pen. Make sure all answers are clear and easy to read.
3. **Complete Section 1: Parts A to G**. If you can't find the latest policy schedule, please call us and we can help.
4. Once Section 1 has been fully completed by the Policy Owner (or by someone on their behalf), please pass on this form to the main registered Medical Specialist who's been treating the terminally ill Policy Owner, so they can complete **Section 2: Part H**. Our decision about this claim is based on the details you give us, and the details given by the Policy Owner's Medical Specialist.
5. When sections 1 and 2 are complete, send the whole completed form and any supporting documents back to us. If the claim is approved, the benefit will be paid to the Policy Owner.

Section 1: Policy Owner's details

Part A: Policy Owner's details

Policy number:	
First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	
Phone (H):	Phone (M):
Email:	Date of birth: ☐☐ / ☐☐ / ☐☐☐☐

Please tell us your preferred method of communication with an asterisk (*).

Part B: Policy Owner's payment authority

Once the claim has been approved, the benefit will be paid to the Policy Owner's bank account below.

Name of bank:
Name of account holder:
Account number: ☐☐ – ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐☐

Part C: Policy Owner's terminal illness claim

1.	**What condition are you claiming for? (Please give as much detail as you can.)**
2.	**What treatment(s) have you received for your condition?**
3.	**Date the symptoms first began:** / /
4.	**Doctor's details who has been mainly treating you:**
	Doctor's name:
	Address:
	Suburb: | Town/City:
	Postcode: | Phone:
	Date of first visit: / / | Date of last visit: / /
5.	**Have you ever had similar symptoms before this time?** **Yes** **No**
	If 'yes', please give details and dates of the doctor or hospital that treated you:
	Doctor's name:
	Address:
	Suburb: | Town/City:
	Postcode: | Phone:
	Date of first visit: / / | Date of last visit: / /
6.	**Please advise details of your usual doctor:**
	Doctor's name:
	Address:
	Suburb: | Town/City:
	Postcode: | Phone:

Part C: Policy Owner's terminal illness claim (continued)

7.	If applicable, please give details of all other doctors you've consulted with about your current condition:	
(i)	Doctor's name:	
	Address:	
	Suburb:	Town/City:
	Postcode:	Phone:
	Dates of consultation:	
(ii)	Doctor's name:	
	Address:	
	Suburb:	Town/City:
	Postcode:	Phone:
	Dates of consultation:	
(iii)	Doctor's name:	
	Address:	
	Suburb:	Town/City:
	Postcode:	Phone:
	Dates of consultation:	

Part D: Authority to release information

The details about your claim are private and can't be shared with any other person or organisation other than as mentioned in our Privacy Policy, or unless we have your specific permission.

If you want to choose a person we can share information about your claim with, please fill out their details below.

Their first name:	**Surname:**
Relationship to you:	
Your signature:	**Date:** / /

Part E: Policy Owner's consent to obtain a medical report

I give permission for Momentum Life Limited (the Insurer) to be provided with medical information, including copies of any medical reports, clinical reports or otherwise, from any Medical Practitioner who at any time has taken care of me about anything which affects my physical or mental health. I agree that a copy of this consent is legally acceptable as the original.

Your signature:	**Date:** / /

Part F: Consent

'Them', 'they' and 'their' refers to Momentum Life Limited ("the Insurer") and 'I', 'my', 'you' and 'your' refers to the Policy Owner and the Claimant.

As part of this insurance claim with the Insurer, I give permission and authority for them to collect and use any personal information (including medical or financial information) they might need to manage and make a decision about this claim. This includes their subsidiaries, advisers, reinsurers and any agents they choose to use. They might also use this information for data reports, so long as they don't use my name. I also give permission for my information to be shared with relevant third parties including (but 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 single organisation where the collection and sharing of my information is legally allowed.

I also understand my personal information may be shared with agents, representatives, organisations or contractors working with the Insurer if it's necessary. They might use this information when they provide services to the Insurer, or for customer satisfaction surveys, or simply where it's allowed by law.

I understand that under the Privacy Act 1993 and The Health Information Privacy Code 1994, I have the right of access to, and correction of, any information provided.

Part G: Policy's Owner's declaration

I have carefully read and thought about all the questions in this form. All my answers are truthful and correct. By completing this form, I understand I'm responsible for providing the Insurer with all the facts and information they may need to make a decision about this claim.

I understand that lying about anything may cancel this claim. Also, if I don't provide all the information the Insurer needs, this claim can't be assessed and no benefit will be paid.

I understand the information (including personal and sensitive information) contained in this form may be used or shared in the manner set out in Dollar Insurance's Privacy Policy – dollarinsurance.co.nz/privacy-policy.

Your signature:	Date: __ __ / __ __ / __ __ __ __

Please have the treating Medical Specialist complete Part H on the following pages.

Section 2: Medical details

This section (Part H) is to be fully completed by the main registered treating Medical Specialist.

Part H: Confidential medical report - terminal illness benefit

Please note that the information required in this document is about the Policy Owner (patient).

It's the Policy Owner's (or person acting on their behalf) responsibility to pay any fees needed to complete this document.

To help the Insurer make a final decision about this claim as quickly as possible, please make sure all the questions in this form are fully understood and answered.

If for any reason there's not enough room on this document to provide all the details we've asked for, please write the details on a separate piece of paper. Remember to include the question you're answering and attach it to this form when complete.

1. Patient's details

First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	

2. Medical details

a. **Are you the patient's usual Medical Specialist?** Yes ☐ No ☐

If 'no', please provide details of their usual doctor:

Doctor's name:

Address:

Suburb:	Town/City:
Postcode:	Phone:

b. **What is the diagnosis of the condition? Please fully describe the patient's terminal illness and expected quality and time of remaining life. (Please attach copies of any test results confirming the diagnosis and severity.)**

c. **On what date did the condition start?** __ __ / __ __ / __ __ __ __

d. **On what date did the condition become terminal? (Life expectancy of 12 months or less)** __ __ / __ __ / __ __ __ __

e. **Date of the first consultation in connection with the current condition:** __ __ / __ __ / __ __ __ __

f. **Provide the dates and results of any X-rays, ECG, blood pressure or other tests performed. Alternatively, please supply a complete copy of your patient's clinical notes, test results and reports.**

Date	Test	Results
__ __ / __ __ / __ __ __ __		
__ __ / __ __ / __ __ __ __		
__ __ / __ __ / __ __ __ __		
__ __ / __ __ / __ __ __ __		

Part H: Confidential medical report - terminal illness benefit (continued)

g. What treatment is currently being given, including surgery and medication, if any:

h. Please provide the names and addresses of other consulting specialist(s) or medical services the patient has been referred to.

Name:	Specialty or medical service:

i. If the patient has been hospitalised, provide the following details.

Admission date:	Discharge date:	Name of hospital:
/ /	/ /	
/ /	/ /	
/ /	/ /	
/ /	/ /	

j. Have you ever treated the patient before for any condition? Yes ☐ No ☐

If 'yes' please supply details. Alternatively, please supply a complete copy of your patient's clinical notes.

Date consulted:	Nature of the condition:
/ /	
/ /	
/ /	
/ /	

k. 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. Include dates and which doctor(s) attended for each previous episode. Alternatively, please supply a complete copy of your patient's clinical notes.

Please return the completed form to Dollar Insurance. You can either:

Scan & email to claims@dollarinsurance.co.nz (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); **OR**

Mail to The Claims Manager, Dollar Insurance, PO Box 99892, Newmarket, 1149 (mark the envelope as CONFIDENTIAL).

Policies and claims are managed and paid by Momentum Life Limited NZBN 9429041981658 (trading as Dollar Insurance) and are subject to the terms, conditions, limitations and exclusions as set out in the Policy Wording which was current at the acceptance date.