

## IMPORTANT

### Please read before completing this form

1. Please read these important instructions carefully, on how to complete the attached claim form and how we process claims. This may help us assess your claim faster.
2. We refer to the Claimant as "You" or "Your"; and Combined as "Combined", "We", "Our" or "Us", in the following instructions.
3. You must complete Page 1 - Section 1 in full.
4. Your Doctor, **and only your Doctor** should complete Page 2 - Section 2 in full. Your Doctor must also sign and date the Claim Form in the appropriate place.
5. We normally pay benefits up to the date that your Doctor has signed the Claim Form. If your disability is ongoing after that date, we will send you a Progress Form which your Doctor should sign and complete on your next visit.  
  
Once we have received this completed Progress Form, we can make a further payment up to the date your Doctor has signed the form.  
  
The reason we do not pay benefits in advance of when your Doctor signs a Claim or Progress Form, is that future disability has not yet occurred, and insurance only pays for losses that have already occurred.  
  
We follow this procedure even if your Doctor states an "approximate date" for your disability to end. Of course, all payments depend on your claim falling within the terms and conditions of your Policy.
6. We may ask you or your Doctor for more information concerning your claim, or we may arrange a further independent assessment by a Specialist of our choice.
7. **Please forward this Claim Form (not a copy) within 30 days of the commencement of your disability, to Combined Insurance Company of New Zealand, Private Bag COMBINED, Remuera, Auckland 1541.** If you do not do so within 30 days, we may have a problem in paying your claim.
8. Should you require any assistance in completing this Claim Form, or have any queries about claiming, or how we assess a claim, please contact us on **0800 80 40 20** and we will be happy to assist you.

#### Important notes for Particular Benefits

9. If Your Policy covers you for benefits while you are **Hospitalised as an In-patient**, please attach a copy of your Hospital Statement showing the dates of admission and discharge. If you were in **Intensive Care** during your period of hospitalisation, the Statement should indicate this.
10. If you are claiming for **Malignant Cancer** under a Cancer or Critical Illness policy, please attach a copy of a Pathology, Histology, or Histopathology report, that medically verifies the diagnosis of Malignant Cancer.
11. If you are claiming a benefit for the medical removal of a lesion or non-malignant **Skin Cancer** under a Cancer Policy, please attach a medical statement verifying this.
12. If you are claiming an **Out-patient Treatment Benefit** under a Cancer policy, please attach a copy of your Hospital Statement showing the dates of Out-patient Treatment.
13. If you are claiming an **Emergency Ambulance Benefit** under your Accident Hospital Plan, please attach a copy of your ambulance statement or account.

## Your guide to making and resolving a complaint

You have access to Combined's free Dispute Resolution Process that relates to any aspect of our business, including claims handling, or any problems you have experienced in dealing with our staff or Representatives. The steps you can take are outlined below.

### STEP 1 If you are not happy, we want to know!

Please let us know immediately if you have a problem. Making a complaint is the first and often the only step you will need to take in the Dispute Resolution Process.

**Phone, write, fax or email** our Customer Service Centre. It is important that you provide all the necessary details and the reasons why you are unhappy, so that we can attempt to find a solution that suits everyone.

We would prefer that your complaint is put in writing, marked; Att: Complaints Officer

**MAIL The Complaints Officer**  
Combined Insurance Company of New Zealand  
Private Bag COMBINED  
Remuera  
Auckland 1541

**FAX 0-9-520 9009**

**EMAIL [nz.service@nz.combined.com](mailto:nz.service@nz.combined.com)**

**TELEPHONE Toll Free: 0800 80 40 20**  
**Phone: 0-9-520 9000**

### STEP 2 Internal Dispute Resolution

**If you are dissatisfied with our response to your complaint, please let our Disputes Officer know.**

Outline your concerns and explain the reasons why you feel that we should review the original decision.

Our Disputes Officer has the authority to review the original decision, ensuring that the correct procedures were followed, and is obliged to be fair and timely in investigating the dispute.

We would prefer that your dispute is put in writing, marked; Att: Disputes Officer

**MAIL The Disputes Officer**  
Combined Insurance Company of New Zealand  
Private Bag COMBINED  
Remuera  
Auckland 1541

**FAX 0-9-520 9009**

**EMAIL [nz.service@nz.combined.com](mailto:nz.service@nz.combined.com)**

Alternatively please ask our Customer Services Operator to refer your dispute to the Disputes Officer.

**TELEPHONE Toll Free: 0800 80 40 20**  
**Phone: 0-9-520 9000**

### STEP 3 External Dispute Resolution

We will endeavour to come to a reasonable solution, however sometimes disputes cannot be resolved. If this occurs We will advise you in writing that the matter is in "Deadlock"

We will refer you to the Insurance and Savings Ombudsman ("ISO"). The ISO considers complaints against insurance and savings companies who are members of the ISO scheme. The ISO provides an independent, impartial and free service to Policyholders.

If you would like the ISO to consider your complaint, it must be made in writing within 2 months of the deadlock letter.

For further information please contact:

**MAIL The Insurance and Savings Ombudsman**  
PO Box 10 845  
WELLINGTON

**TELEPHONE 0-4-499 7612 or Toll Free: 0800 888 202**

**WEBSITE [www.iombudsman.org.nz](http://www.iombudsman.org.nz)**

**Privacy:** At Combined we are committed to ensuring that we handle your personal information in accordance with the Privacy Act 1993.

## COMBINED INSURANCE COMPANY of NEW ZEALAND

A Division of Combined Insurance Company of America  
A Limited Company Incorporated in the State of Illinois USA

**Claimant to Complete this Page** (Please print using BLOCK LETTERS)

Office Use Only

**Important. Write your Account Number here**

Claimant's Full Name  Mr  Mrs  Ms

Postal Address  Postcode

Residential Address (If different from above)  Postcode

Occupation  Employer's Name

Date of Birth / / Height Weight

Employer's Address

Claimant's Telephone Number (Daytime) ( )

Are you claiming under a Family Policy?  Yes  No Account Number

### Complete for Accident only

1. When did the accident occur? Date / / at am/pm

2. Nature of Injuries (Please be specific)

3. How did the accident occur? (Please be specific)

4. Was emergency ambulance transport required?  Yes  No *If your policy includes this benefit, please attach an ambulance statement or account*

### Complete for Sickness only

5. Nature of Sickness *If you are claiming for malignant cancer under the Cancer or Critical Illness Plan, please attach a copy of your pathology report. (Please be specific)*

6. When were the symptoms first noticed? Date / /

7. Have you previously had the same sickness?  Yes  No Brief Details

### Complete for Accident and Sickness

8. If you were confined overnight as an in-patient within a **Hospital**, please give the Hospital Name, Address and Dates that you were confined.  
From / / to / /

9. If you were confined as an in-patient within an Intensive Care Unit in this Hospital, please give the Dates that you were confined:  
From / / to / /

10. Are you claiming benefits for Out-patient treatment for Cancer?  Yes  No  
(If you answered 'Yes', please attach proof of your out-patient treatment attendance including dates).

11. What is your attending doctor's name and address. Dates of treatment / /  
Name Address

12. "Total Disability": Between what dates were you unable to perform any duties? (Refer to the definition on the reverse of this form)  
From / / to / /

13. "Partial Disability": Between what dates were you able to perform only partial duties? (Refer to the definition on the reverse of this form.)  
From / / to / /

14. When did you return to your normal duties. Date / /

15. **Authorisation to release information** I acknowledge that, for the purpose of the Privacy Act 1993

- a) The information in this form is provided by me to Combined Insurance Company of New Zealand ("Combined"), for the purpose of assessing my insurance claim and for any other related purpose.
- b) Any information concerning a third party provided by me to Combined has been provided with that third party's consent.
- c) I authorise Combined to obtain such information as it may require concerning me or this claim from any third party or agency and I authorise any third party or agency holding any information concerning me, to release such information to Combined.
- d) I authorise Combined to place details of this claim to the database of the Insurance Claim Register ("ICR") Ltd, PO Box 474, Wellington, where it will be retained and be available to other participating insurance companies to inspect.

16. **Declaration**  
I solemnly declare the above answers to be true and correct in every detail, and that I have not withheld any material information in relation to the above claim.

**Claimant's Signature**

(If Minor, Parent's Signature) X

Date / /

## Doctor only to complete this page

Please note that this page must be fully completed by a Legally Qualified Doctor, at no expense to Combined.

**Definitions** *(Please read carefully before completing this section)*

**Total Disability:** The inability to perform each of the substantial duties of your business or occupation (usual activities if you are not currently employed).

**Partial Disability:** The inability to perform one or more, but not all of the substantial duties of your business or occupation (usual activities if you are not currently employed).

**Doctor:** Means a licenced medical practitioner operating within the scope of his or her New Zealand licence and who is not a member of your immediate family.

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

1. Please tick whether claim is for:  Sickness  Injury

Diagnosis *(If there are any complications that have been diagnosed please describe these.)*

\_\_\_\_\_

2. *Please complete for Fractures only.* Was the Fracture confirmed by an X-Ray?  Yes  No

Describe the type of Fracture.

\_\_\_\_\_

3. When did symptoms first appear or the accident happen? Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. When did patient first consult you for this condition? Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

a) Did total disability begin this day?  Yes  No b) If No, please state date disability started. Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5. Has the patient ever had this condition before?  Yes  No

If Yes please state if the present condition is an aggravation or recurrence of a previous injury or sickness.

\_\_\_\_\_

Recovery Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

6. Has the patient ever had any other disease or infirmity that may be affecting the present condition?  Yes  No

If Yes, what was the disease or infirmity?

\_\_\_\_\_

To what degree did this contribute to current disability?

\_\_\_\_\_

7. Is the patient still under your care for this condition?  Yes  No

If No and the patient has recovered, please write the recovery date. Recovery Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

8. Disability Periods.

a) Totally Disabled From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ *(inclusive)*

b) Partially Disabled From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ *(inclusive)*

c) Hospitalised as an overnight patient. From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ *(inclusive)*

d) Hospitalised as an overnight patient in Intensive Care Unit From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ *(inclusive)*

At *(Name of Hospital)*

\_\_\_\_\_

9. *(Total and Permanent Disability only)* Has the Insured, as a result of the injury, been totally or permanently disabled continuously for the past 12 months?  Yes  No Will the Insured remain totally and permanently disabled?  Yes  No

10. Is there any further medical information relevant to this claim?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Doctor's Stamp



Signed **X**

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Degree \_\_\_\_\_

Address *(if not on stamp)*

\_\_\_\_\_

*(We recommend that a copy of this form is taken for your files)*

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A Limited Company Incorporated in the State of Illinois USA