Health Insurance Claim Form

TOWER

→ Please tick one of the boxes below indicating what type of health claim you are making.

☐ I wish to request pre-approval or payment for surgery, non-surgical hospitalisation and/or a diagnostic investigation that exceeds $200. ***(Please complete sections 1, 2a, 2b and 2c)(PAF)***

☐ I wish to request payment of a claim that has been pre- approved. ***(Please complete sections 1 and 2b)(HCFD)***

☐ I wish to claim for GP, dental, optical, diagnostic or other medical expenses costing less than $200, or specialist consultation costs. ***(Please complete sections 1 and 4)(OHCF)***

☐ I wish to nominate a person who can help administer the claim on my behalf. ***(Please complete section 3)***

Important reminders

- Please check your details are correct and use the space provided below to make any changes.
- Make sure you ***sign and date*** the important information and declaration in section 6.
- Please note that mere completion and submission of this form is not an acceptance of your claim.
- Please complete section 5 for refund payment requirements.

Please answer the applicable sections fully before you date and sign this form.
If you need assistance in completing this form please phone us on 0800 754 754.

1. About your policy

Policy Number				
Name of Policy owner 1				
Name of Policy owner 2				
Address	Street no./name			
	Suburb	Town/City	Postcode	
Telephone	Home ( )	Mobile ( )	Email	
If your details listed here are incorrect or incomplete, please update them in the space provided below				
Address	Street no./name			
	Suburb	Town/City	Postcode	
Telephone	Home ( )	Mobile ( )	Email	

2a. About your claim (to be completed by the patient)

→ NB: You ***must*** supply a copy of the specialist letter and the quotation for the treatment /operation / diagnostic investigation.

Name of Patient (Insured person)		Date of birth	/ /
Proposed treatment /operation / diagnostic investigation		Proposed date	/ /
Reason for treatment /operation / diagnostic investigation			
Is this condition ACC related?	☐ Yes ☐ No *(If yes, please provide a copy of the ACC pre-approval letter)*		
Proposed length of hospital stay	(number of days) Day stay? (please tick) ☐ Yes ☐ No		

2b. About the cost (treatment /operation /diagnostic investigation costs as quoted by your specialist – to be completed by the patient)

→ NB: Please attach ***original*** paid invoices, proof of payment (receipts) or quotes obtained

			Claim payable to	
Provider/service	Cost	Name of provider	Provider	Claimant
Surgeon	$			
Anaesthetist	$			
Radiology (i.e. MRI scan, CT scan)	$			
Prosthesis	$			
Hospital accommodation	$			
Theatre time (in minutes)				
Theatre fee	$			
Other	$			
Total procedure cost	$			

2c. Medical report (to be completed by your usual family doctor, dentist or optometrist)

Important notes:

- To help us process this application quickly, please have this section completed and signed by your family doctor, dentist or optometrist
- Please also ensure they attach any supporting documentation stating when symptoms or signs of this health condition first became ***apparent*** to you.
- A copy of the first letter sent to your doctor after your first consultation with the specialist regarding the health condition.

Family doctor, dentist or optometrist name			
Address	Street no./name		
	Suburb	Town/City	Postcode
Telephone	Home ( )	Fax	( )
How long has the patient been under your care? Number of years?			
If less than 3 years, please detail the previous doctor consulted *(if known)*			
Name of previous doctor			
Address	Street no./name		
	Suburb	Town/City	Postcode
What is the underlying health condition that made the surgery/treatment/diagnostic necessary?			
What was the date the patient first noted the symptoms?			
What was the date the patient first sought investigation or medical advice?			
Please provide details of any subsequent consultations /investigation /treatment /surgery including dates.			
If the patient has required surgery/treatment/investigations for this or a similar condition before, please provide details including dates.			
Please attach a histology report, if applicable, regarding the above health condition.			
Family doctor, dentist or optometrist signature		Date	

3. About your representative (if applicable - to be completed by the patient)

I give my authority for any details of this claim to be provided to:

Name and relationship to patient			
Address	Street no./name		
	Suburb	Town/City	Postcode
Telephone	Home ( )	Mobile ( )	Email

Or

My adviser	☐ Yes ☐ No *(If yes, please provide your adviser's name below)*
Adviser's name	

4. Non-surgical claims (such as GP, dental and optical costs - to be completed by the patient)

Important notes:

- Claims must be supported by the ***original itemised accounts and receipts*** (not copies) showing the name of the patient, date of consultation, description of services; name, qualification and GST number of the provider of the service; plus pharmacist receipts must show the name of the patient, prescription number and name of the medication prescribed and the cost of each item
- Please ensure that all accounts and receipts are submitted to TOWER Health & Life Limited, ***within 12 months*** of incurring the cost, or when bills reach ***$100***. Claims must be submitted within 30 days after the termination of the policy.
- If you require more space to provide the details below, please complete the details on a separate sheet, attach it to this claim form and ensure you include your policy number on the separate sheet.
- If you are making a claim for specialist consultation costs or diagnostic investigations please include a copy of the initial referral letter from your family doctor or specialist

First name of patient	Date of treatment	Name of provider	Reason for service/ item provided	Amount
			Total Claim	$

5. About your refund (to be completed by the policy owner or patient if also the policy owner)

Please enter your bank account number below to have your refund directly credited to your bank account. Please note that resulting claim refunds cannot be paid when a policy premium is in arrears.

Bank		Branch number				Account number							Suffix	

If your bank account details above are incorrect, please update them below

Bank		Branch number				Account number							Suffix	

6. Important information and declaration (to be completed by the policy owner(s) and the patient)

Duty of Disclosure
You and anyone else named in this claim form must tell us everything you know (or ought to know) which would influence the decision of a prudent insurer whether to accept this claim, and if so, on what terms. (For example, you must disclose any health conditions you have currently or have had in the past.) You must tell us immediately about any changes to the information you have currently or have had in the past. If you fail to do so, we can avoid or cancel the policy from the commencement/reinstatement date and not pay any claim. We may retain all the premiums paid and any claims paid by us may be recovered from you. When in doubt, disclose. We treat all information confidentially.

Privacy Act 1993
We are collecting information about you and anyone named in this claim form to evaluate, administer and assess this claim.
You must provide this information as part of your legal duty to disclose all relevant facts to us. If you fail to do so we may decline your claim or avoid or cancel your policy from the commencement/reinstatement date and not pay any claim. We may release information from this form or received from others relating to this claim to your adviser, ACC, your previous insurers, anyone who assisted you or us in arranging this insurance, any/all of your medical/health providers, and anyone reasonably necessary to assist us in relation to this claim.

You have certain rights of access to and correction of the information under the Privacy Act 1993 and the Health Information Privacy Code 1994.

DECLARATION
We, the people named in this claim, declare that:
- If we are signing this claim form on behalf of children under the age of 16, we are authorised to do so.
- Anyone assisting us to complete this claim form is acting as our agent.
- All the information given in support of this claim (whether in this claim form or separately from it) is correct and complete.
- All relevant facts have been disclosed.
- We understand that we must tell you immediately about any changes to the information we have already given to you.
- We understand any premium paid on this policy does not bind TOWER Health & Life Limited to accept the claim.
- Where premiums are in arrears, we authorise you to deduct this from the claim payable to speed up claim processing.

Sign Here

→ Policy owner signature 1

→ Date

→ Policy owner signature 2

→ Date

AUTHORISATION
(On whom the claim is being made. If the patient is 16 years or younger, the patient's parent or legal guardian must sign this declaration)
We authorise TOWER Health & Life Limited to:
- Obtain any personal and health information about me and authorise anyone else to disclose this information to TOWER Health & Life Limited, but only to the extent this is reasonably necessary to consider, process and manage this claim. This specifically includes any medical and lifestyle information held by any health or medical practitioner, dentist, medical laboratory, hospital, ACC,a previous insurer, or other relevant entity or organisation.
- Disclose the information above to any other person, body or agency but only to the extent this is reasonably necessary for the purposes mentioned above. We understand this may include disclosure to the parties and for the purposes named above in the Privacy Act 1993 section.
- Disclose this information and other information about my claim to the adviser who helped arrange the insurance.
- Use a photocopy of this signed declaration as confirmation of these authorities.

→ Policy owner signature 1

→ Date

Check list for Pre-Approval application

Have you:
- ☐ Ticked appropriate box at the start of the form
- ☐ Included GP referral letter
- ☐ Included first Specialist letter to your GP
- ☐ Included procedure cost estimate
- ☐ Section 2c Medical Report completed by your GP
- ☐ Your bank account details in section 5

Once completed please send this form to:
TOWER Health & Life Limited, PO Box 6547, Wellesley Street, Auckland 1141
Tel 0800 754 754 Fax 0800 345 134 healthandlife@tower.co.nz www.tower.co.nz