AMP

Customer Claims Team Contact
Phone 0800 267 425
Email claimsmailbox@amp.co.nz
Website amp.co.nz
Post PO Box 1692, Wellington 6140, New Zealand

AMP Essentials - Temporary Disablement

Your checklist to making a Claim

What are you covered for?

The Essentials Temporary Disablement Benefit is a monthly payment which is paid if you suffer sickness that prevents you from working or performing key daily living activities, and meet the other requirements of the Cover Terms.

Cover Terms are available at **www.amp.co.nz/essentials**.

Our commitment to you

We understand that making a claim often comes at a challenging time for you and your family. Our team of dedicated and experienced Case Managers are here to support you and keep you updated throughout the process. If you are uncertain or need assistance please contact us. We are here to help.

In order for AMP to assess your claim, we require the following to be returned to the Customer Claims Team

Immediate requirements (to start claim process)

- Statement of Claim Form – To be completed by customer
- Medical Certificate – To be completed by current treating doctor/specialist, you need to take the form to your current doctor/specialist for them to complete, and arrange payment of their fee for doing so.
- Any supporting medical information you may have e.g. medical/laboratory tests, x-rays/scans, histology and hospital discharge forms (if applicable)

Additional information (as available or if requested)

- Full Job Description
- If you are self-employed
  - Monthly profit/loss statement
  - Financial information will be required (this will be discussed during the initial assessment)
- If you are a wage or salary earner
  - Monthly payslips (most recent)
  - Copy of employment contract
- Bank account proof such as deposit slip or bank statement

Once we have received the above requested information, we will send you a confirmation within 3 working days, at which point a dedicated Case Manager will guide you through the following process.

We will consider the claim, which may include assessing medical details against the forms completed when the cover was first applied for. We may also seek further information from you or your doctor before making a final decision. The Case Manager will be in contact again within 5 working days with an outcome or if further information is required.

AMP Essentials - Temporary Disablement

Claims Process

The following diagram provides an indication of the steps that AMP will follow when processing your Temporary Disablement claim

Customer action required

Notification of Claim

Claim form sent

Completed claim form/ documents returned

Additional information required?

Yes

Further information returned

No

Claim accepted?

No

Explanation provided

Yes

Declaration sent

Declaration signed and returned

Claim payment made

Claim closed

AMP Essentials is arranged by AMP Wealth Management New Zealand Limited. The insurer of AMP Essentials is AMP Life Limited ABN 84 079 300379 (Incorporated in Australia), AMP Centre, 29 Customs Street West, Auckland 1010.

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AMP Essentials - Temporary Disablement
Statement of Claim Form

Your Guide to Making a Claim

We understand that making a claim often comes at a challenging time for you and your family.

The details you provide in this form will assist in managing your claim. The more accurate your information is, the better placed our team of dedicated and experienced Case Managers will be to support you and keep you updated throughout the process.

AMP can guide you through this form over the phone, please contact us if you need assistance.

*These fields must be completed

Personal details – *(Person Insured to complete)*

AMP KiwiSaver Scheme member number

K

*Title

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

*First name(s) (please print)

*Surname

*Residential address

*Please provide at least one contact number

Contact phone number ( )

Mobile number ( )

*Date of birth D D M M Y Y Y Y

Personal email

What is the best method for us to contact you?

Illness details – *(Person Insured to complete)*

1. Please describe the nature of your illness

2. When was the illness first diagnosed?

D D M M Y Y Y Y

By whom?

Name and address of your treating doctor

Name

Address

Postcode

Date last consulted

D D M M Y Y Y Y

Date of next appointment

D D M M Y Y Y Y

Phone number

( )

Email

Please indicate specific dates on which you have consulted your doctor(s) regarding this illness

Name and address of your specialist ☐ *not applicable*

Name

Address

Postcode

Date last consulted

D D M M Y Y Y Y

Date of next appointment

D D M M Y Y Y Y

Phone number

( )

Email

Please indicate specific dates on which you have consulted your specialist regarding this illness

3. Are you entitled, or have you made, or do you intend to make a claim for this illness from any of the following sources?

- [ ] ACC
- [ ] Your Employer
- [ ] Your Business
- [ ] Any other insurance policy e.g. income protection, bill protection, credit card insurance
- [ ] Income support services
- [ ] Any superannuation fund or group scheme
- [ ] Health insurance policy
- [ ] Other source

If yes to any of the above, please provide details in the table below

Name and contact details of the benefit provider	Type of claim	Policy/Claim number	Status (accepted, denied, pending, under appeal)	If accepted, state amount and frequency of payments
				$
				$
				$
				$
				$
				$

AMP wishes to understand more about the nature of your illness, including treatment you have undertaken with other healthcare practitioners, as well as initiatives you may have undertaken on your own. Please complete the information below to assist us in understanding your treatment plan as well as your response to treatment.

4. If you have been hospitalised as a result of your condition, please provide details below

Name and address of hospital	Reason for hospitalisation	Date admitted	Date discharged

5. Please complete the table below with the relevant details of your healthcare practitioners (including doctors, specialists, physiotherapists, psychologist, etc)

Name	Specialty	Contact details	First attended	Last attended

6. Please list all prescribed medications you are taking, including those not associated with this condition

Medication	Date prescribed	Dosage/ Frequency	Prescribed by whom	Effectiveness

7. If you are also taking non-prescription based remedies, please provide details of these below

8. Please provide details of any other treatment you have undertaken to help you recover and return to work (i.e. increasing activity at home, change in diet, quit smoking, online self help tools, etc)

9. Over time or since commencing treatment has your condition improved?

☐ Yes ☐ No

If Yes, please provide details

10. Please outline any pending investigations

Test/Investigation	Date scheduled	Reason for test

11. Please provide details of any other physical, psychological, or medical conditions you have

Nature of condition	Date diagnosed	Treatment for condition	Impact on your activity levels

Daily activities – *(Person Insured to complete)*

12. Has your illness impacted your capacity to perform any of the following activities of daily living?

Activity impacted		Describe how it is impacted	Expected improvement with time/treatment?
The ability to bathe or shower without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to dress and undress without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to use a toilet without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to get in and out of a bed or chair without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to eat and drink without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain

13. Please outline details of your usual hobbies and/or social/community activities? (e.g. volunteer work, community organisations, sport)

14. What activities are you able to continue, or how has your participation in these activities been impacted by your condition?

15. Do you need to drive to perform your normal job?

☐ Yes ☐ No

16. Are you a smoker?

☐ Yes ☐ No

If Yes, how many do you smoke (on average)?

☐ Packets per week

17. Please indicate your average consumption of alcohol

☐ Nil ☐ <5 Drinks/week ☐ 5–10 Drinks/week ☐ 11–20 Drinks/week ☐ >20 Drinks/week

18. Do you use or have you ever used recreational drugs or any drugs not prescribed to you (other than for coughs, colds, flu or similar minor ailments)?

☐ Yes ☐ No

If Yes, please provide details

Employment – *(Person Insured to complete)*

19. Are you engaged in remunerative work?

☐ Yes ☐ No

If you are an employee please provide

Name of employer

Employer contact details

Name

Address

Postcode

Phone number

( )

Mobile number

( )

Email

Employees and self employed

20. What was your main occupation immediately prior to the onset of your illness?

21. If you had another occupation immediately prior to the onset of your illness, please advise what it was?

22. Have you changed your current occupation in the 3 months prior to your illness?

☐ Yes ☐ No

If Yes, can you please explain why?

23. In what capacity were you employed immediately prior to your illness?

☐ Casual ☐ Part-time Permanent ☐ Full-time Permanent ☐ Contractor

24. Date commenced employment with current employer

D D M M Y Y Y Y

25. Monthly Income (Gross before tax)

$

26. Usual hours per week (weekly average over 3 months prior to illness)

27. Your illness may have meant you needed to make changes to the way you work.

Please provide details of how your illness has impacted your ability to perform your normal job

Reduced hours

On which date did this occur? D D M M Y Y Y Y

Alternative duties

On which date did this occur? D D M M Y Y Y Y

Ceased all work

On which date did this occur? D D M M Y Y Y Y

28. What is your current work status?

Are you still employed with your pre-illness employer? Yes No

Are you still employed with your pre-illness employer but not currently performing your normal job? Yes No

Has your employment been terminated? Yes No

Have you resigned? Yes No

Have you been made redundant? Yes No

Other – please specify

29. Do you enjoy your work?

Yes No

Please tell us what you like about your work

Please tell us what you don't like about your work

30. Are you in contact with your employer (if not self-employed)?

Yes No

If Yes, how often and what have you discussed?

Work duties

31. Please provide details of the duties you are required to perform in your normal job. Please also provide a copy of your job description if you have one

32. Please select the following physical requirements of your occupation where applicable

	Never/rare	Occasional	Frequent	Continuous
Lifting, 20kgs and over	☐	☐	☐	☐
Lifting, 7-19kgs	☐	☐	☐	☐
Lifting, under 7kgs	☐	☐	☐	☐
Carrying, 20kgs and over	☐	☐	☐	☐
Carrying, 7-19kgs	☐	☐	☐	☐
Carrying, under 7kgs	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Climbing – ladders, scaffolding, etc	☐	☐	☐	☐
Climbing – ramps, steps, etc	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐
Office duties (admin, phone, clerical, photocopying)	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐

Never/rare (0%–10%)
Occasional (11% – 40%)
Frequent (41% – 70%)
Continuous (71% +)

33. In your occupation, what percentage of time do you spend performing the following types of duties

Sedentary/administrative	%
Supervising work	%
Light manual	%
Heavy manual	%

34. Would you be able to modify any of the manual handling tasks you perform by seeking assistance from others, using a lifting device or modifying the load?

☐ Yes ☐ No

If Yes, please provide details

35. Please indicate if your normal job involves any of the following

Skill	% of the day required	Can you still do this?
Supervising others	%	Yes No
Conflict resolution and mediation	%	Yes No
Planning and organising	%	Yes No
Meeting tight deadlines or production/sales quotas	%	Yes No
Analytical and abstract thinking	%	Yes No

36. Please list any machines, tools or other equipment that you use on the job (e.g. a forklift, pallet jack, drill etc)

Description of equipment/tools	Duration/frequency per day (i.e. hours per day, number of times per day or % of day)

37. Do you hold any specific certifications, licences, or training required to perform your usual duties?

if Yes, please provide details

38. Please describe any other mental or physical demands required to perform your normal job that have not been covered

Self employed

39. Are you self-employed, or do you own a business or a company?

Yes No (go to question 54)

If Yes, what is the type of business undertaken?

40. Are you Sole trader Partnership Company Trust Other - please advise

Business name

Business phone number

( )

Business address

Postcode

When did the business last trade?

D D M M Y Y Y Y

Total number of employees excluding yourself Full-time Part-time

I receive remuneration from the company by way of Shareholder Salary Dividends Directors fees Other—please explain

Provide Gross Income less business expenses in the last 12 months $

41. Provide details of accountant

Name

Work planning and recovery – *(Person Insured to complete)*

AMP understand the value and importance of work to your recovery. The information you provide in this section will assist us to consider options relating to your ongoing employment. Our Case Managers will work with you, your employer and ACC (where appropriate) and your healthcare practitioners to assist you through this process.

If you are an Employee or Self-employed

42. Please describe any factors related to your work duties and/or workplace that may have contributed to

- **the development of your condition and/or**
- **the reason you are no longer able to carry out your normal job**

43. Are you currently performing any work activities?

Yes No

If Yes, please provide details

If Yes, when did you return to work?

D D M M Y Y Y Y

With respect to this return to work, please provide details in relation to employer, occupation, duties and hours

44. Are you aware if your employer can accommodate modified duties and/or hours?

If Yes, please explain

45. If self-employed, are you able to gradually resume work with modified duties and/or hours?

Yes No

If Yes, please provide details of possible return to work options

46. When do you anticipate returning to work in a part-time capacity?

D D M M Y Y Y Y

47. When do you anticipate returning to work in a full-time capacity?

D D M M Y Y Y Y

48. If you are uncertain as to your return to work date, please explain what needs to change for you to be able to initiate a partial or full return to work and if you require any assistance to facilitate this change

Declaration – *(Person Insured to complete)*

PRIVACY ACT 1993 ("the Act")

Any personal information collected in connection with your claim will allow AMP to assess your claim and to administer your claim and your insurance cover. Under the Act, you have the right of access to, and correction of, any personal information about you. The personal information will be held by AMP, and may be held overseas.

AMP follows a strict confidentiality code about all personal information it holds. This means that your personal information is held securely and access is limited to authorised individuals who need to see it.

COLLECTION OF INFORMATION

I authorise AMP or its representatives to contact and obtain all documents it considers necessary from any source to deal with my claim.

I also authorise any doctor, health professional, hospital or medical institution, who has or may be, consulted by me to give AMP any information it may require.

RELEASE OF INFORMATION

I authorise my employer, any government department, other insurer, or other person who holds information relevant to the assessment of this claim including, but not limited to, information about my sickness, my employment history, to provide to AMP any information it may require. I also authorise AMP to release all medical information and any other relevant information pertinent to the claim to any person they require me to consult with in respect of the claim, or any person engaged by AMP in connection with the management of the claim, or otherwise as reasonably required to assess and/or manage the claim. A photocopy of this authority will be sufficient evidence of my consent to such release.

ADVISER INVOLVEMENT

If you would like your Adviser to be involved with the progress of your claim, please advise their name below.

I authorise AMP to release all relevant information pertinent to my claim to my Adviser.

Name of Adviser/company

DECLARATION

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of sickness. I will provide AMP such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

I understand that failure to provide full disclosure of all occupational, medical, financial, and other information that AMP regards as relevant to the assessment of my claim will be considered to be material misrepresentation and/or material non-disclosure. As such, AMP is entitled to use legal remedies, should this occur. I further understand that the occupational, medical, financial, and other information provided is the basis on which AMP will base the assessment of my claim, and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed. I understand that my AMP Essentials cover may be cancelled, and I can be prosecuted if I make any fraudulent statements.

Throughout this form the term "AMP" is used to refer to AMP Life Limited.

Name of Person Insured

Signature

SIGN HERE

Date

D D M M Y Y Y Y

AUTHORITY TO COMPLETE

☐ Please tick the box if the Person Insured is medically unable to sign the Statement of claim form. Please also attach the relevant proof of authority.

First Name

Surname

Phone number

( )

AUTHORITY TO DISCUSS

As the Person Insured, AMP requires you to advise if you would like AMP to discuss your claim with someone other than yourself.

I declare that as the Person Insured of the above policies, I authorise AMP to discuss aspects of the claim (checked below) with the following person.

First Name

Surname

Phone number ( )

Relationship (to Person Insured) e.g. spouse, son, friend

Private address

(Please indicate clearly where permission is given by ticking the appropriate boxes)

- ☐ Details of my personal and business income where they are relevant to the claim(s)
- ☐ Details of my personal health history where it is relevant to my claim(s)
- ☐ Details of my policies, covers and benefits (only relevant if the Person Insured is the Owner of the policy)

This authority is valid

- ☐ for the duration of the assessment and/or payment of my claim(s), or
- ☐ only for the period (from) D D M M Y Y Y Y to D D M M Y Y Y Y

NEW ZEALAND BANK ACCOUNT DETAILS

If the claim is accepted, or AMP is still assessing your claim but decides to make a payment at AMP's discretion, any payment will be directly credited to this account. Write and include evidence of bank account that clearly states name and bank account number, such as a bank deposit slip or bank statement.

Funds can only be transferred to a New Zealand bank account.

Bank Branch Account Suffix

ATTACH EVIDENCE OF BANK ACCOUNT HERE

Identity verification – *(Person Insured to complete)*

To protect the Person Insured and AMP from financial crime, AMP needs to confirm the Person Insured's identity.
Please ensure each selected document (copy) has been sighted and signed by a trusted referee (as defined on the next page).

Please complete Option 1 in the table below and attach copies of the requested document (please tick which document you are providing).
If you **cannot provide a document from Option 1, then complete Option 2 or 3.**

Option 1 ONE document from this section

☐ NZ passport (Identity page)	☐ NZ firearms licence
☐ Overseas passport (Identity page)	☐ NZ certificate of Identity

Option 2 ☐ NZ Driver's Licence **PLUS** (ONE of the of the documents from this section)

☐ Super Gold card	☐ NZ full birth certificate/Birth certificate issued by foreign government
☐ NZ citizenship certificate/Citizenship certificate issued by foreign government	☐ Bank statement or IRD statement issued in your name in the last 6 months

Option 3 ☐ 18+ identity card **PLUS** (ONE of the documents from this section)

☐ NZ full birth certificate/Birth certificate issued by foreign government	☐ NZ citizenship certificate/Citizenship certificate issued by foreign government

IMPORTANT: If you are providing previously certified identity documents, please ensure the documents have been certified not more than 3 months prior.
Please attach only the certified photocopies of the original documents to this form.

Proof of address

As well as providing your identity documents you must also supply proof of your address. Tick one document option from this section.
The document you supply needs to be addressed to you, and show the residential address detailed on page 3 of this form and dated within the last 6 months.

☐ Letter or invoice from utility company

☐ Bank statement

☐ Letter from government agency (e.g. Inland Revenue, rates bill)

Certify or verify your documents – Please ensure all boxes are fully completed to assist processing

Your documents can be certified by a trusted referee (use the first section below for certifying documents in New Zealand or use the second section below for certifying documents overseas), or verified by an Adviser/AMP employee acting as an agent of AMP (use the third section below).

If you are having documents certified outside New Zealand, your trusted referee must be a person who is authorised to take statutory declarations under the laws of the overseas country, state or territory where the documents are being certified. For more guidance on who can act as a trusted referee overseas, please contact your Adviser or AMP.

DECLARATION BY TRUSTED REFEREE (CERTIFYING IN NEW ZEALAND)

I, FULL NAME OF TRUSTED REFEREE confirm that

1. I have sighted today the original of each document identified with a tick on page 14 above verifying the identity and address of the person named on page 3 of this form, and attached to this statement are true copies of those documents **initialled and dated** by me.
2. The documents that have been provided represent the identity of the person named on page 3 of this form.
3. I am a **(tick one of the following)**

- ☐ New Zealand Lawyer
- ☐ Justice of the Peace
- ☐ Notary Public
- ☐ Registered Medical Doctor
- ☐ Chartered Accountant
- ☐ Police Constable
- ☐ Registered Teacher
- ☐ Kaumātua
- ☐ Member of Parliament
- ☐ Minister of Religion
- ☐ Commonwealth Representative
- ☐ NZ Honorary Consul
- ☐ Fellow of the New Zealand Institute of Legal Executives acting in the employment of a lawyer
- ☐ Registrar or Deputy Registrar of the High Court or a District Court

4. I am not related to and do not live at the same address as the person named on page 3 of this form.

Signature of trusted referee

SIGN HERE

Dated

D D M M Y Y Y Y

OR

DECLARATION BY TRUSTED REFEREE (CERTIFYING OUTSIDE NEW ZEALAND)

I, FULL NAME OF TRUSTED REFEREE confirm that

1. I have sighted today the original of each document identified with a tick on page 14 above verifying the identity and address of the person named on page 3 of this form, and attached to this statement are true copies of those documents **initialled and dated** by me.
2. The documents that have been provided represent the identity of the person named on page 3 of this form.
3. I am a ROLE/DESIGNATION
4. In this capacity, I am authorised to take statutory declarations under the laws of RELEVANT OVERSEAS JURISDICTION
5. I am not related to and do not live at the same address as the person named in on page 3 of this form.

Signature of trusted referee

SIGN HERE

Dated

D D M M Y Y Y Y

OR

DECLARATION BY ADVISER/AMP EMPLOYEE (AS AGENT OF AMP)

I, FULL NAME OF ADVISER/AMP EMPLOYEE ADVISER CODE (if applicable) confirm that

1. I have sighted today the original of each document identified with a tick in on page 14 above verifying the identity and address of the person named on page 3 of this form, and attached to this statement, are true copies of those documents **initialled and dated** by me.
2. I have no reason to believe that this person is not who he/she claims to be.
3. AMP has authorised me to be its agent to conduct customer due diligence procedures and obtain any information required for customer due diligence under the Anti-Money Laundering and Countering Financing of Terrorism Act 2009 and I acknowledge that AMP is relying on me to perform those functions for it.
4. I am not related to and do not live at the same address as the person named on page 3 of this form.

Signature of Adviser

SIGN HERE

Dated

D D M M Y Y Y Y

Customer Claims Team Contact

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Website amp.co.nz
Post P O Box 1692, Wellington 6140, New Zealand

AMP Essentials - Temporary Disablement

Medical Certificate Information sheet

AMP seeks input to assist us in managing your patient's claim.

Your patient currently holds Temporary Disablement cover with AMP for illness that impedes their ability to perform their normal work duties or certain activities of daily living. While AMP is not the treatment provider, AMP's approach is holistic and wide in its coverage. We can provide a monthly benefit where they are unable to work providing that the requirements of the Cover Terms are met.

The more detailed your information is, the better placed we are to assist your patient. We at AMP recognise every customer's situation is unique. We work with our customers transparently, fairly and with respect and empathy. We seek to provide the right support and management at the right time.

AMP's claims management approach

During your interactions with us, you will come to appreciate that AMP believes in the health benefits of work and activity. We seek to assist our customers to focus on what they can do, not on what they cannot do. You will sense our commitment to achieving healthy work outcomes for people with illness or disability.

In the ongoing management of your patients claim we wish to work collaboratively with you to ensure we understand your patient's condition and their progress towards recovery at work. If we require additional information or have information that may inform your clinical management, it is our preference to speak directly with you on the phone and we will book and pay for an appointment with you. If you believe this may lead to delays, then please indicate your preferred method of communication.

Our approach is informed by current research and the **Royal Australian College of Physicians' Faculty of Occupational and Environmental Consensus Statement** to which we are a signatory, along with a wide ranging set of New Zealand organisations. (See **www.racp.edu.au/page/afoem-health-benefits-of-work**).

We support the evidence that long-term work absence, work disability and unemployment have a negative impact on health and wellbeing, and that recovering at work is a positive health choice.

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AMP Life Limited ABN 84 079 300379 (Incorporated in Australia), AMP Centre, 29 Customs Street West, Auckland 1010.

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AMP Essentials - Temporary Disablement

Medical Certificate

Patient's details

First name(s) (please print)

Surname

Gender

☐ Male ☐ Female

Date of birth

D D M M Y Y Y Y

Doctor's details

Name

Specialty

Postal address

Postcode

Phone number

( )

Email

Preferred method of communication

☐ Phone ☐ Email ☐ Fax ☐ In person meeting

Doctor/patient relationship

1. How long has this person been your patient?

2. If you are not this patient's regular treatment provider, please provide the name and address of this patient's regular treatment provider.

Name and address

3. Have you provided information to any other insurer/any bank/WINZ or ACC for this patient?

☐ Yes ☐ No

If Yes, please provide details below

Organisation/Person	Date provided	Information provided

Details and history of condition

4. Please outline below the diagnosis associated with your patient's condition

Diagnosis	Date first consulted	Made by whom

5. Has your patient's illness impacted their capacity to perform any of the following activities of daily living?

Activity impacted		Describe how it is impacted	Expected improvement with time/treatment?
The ability to bathe or shower without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to dress and undress without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to use a toilet without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to get in and out of a bed or chair without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain
The ability to eat and drink without assistance from another person	☐ Yes ☐ No		☐ Yes ☐ No ☐ Uncertain, please explain

6. If your patient's condition is a result of illness, when did your patient first become aware of the condition that lead to cessation of work?

D D M M Y Y Y Y

7. When did the patient first consult you for this condition?

D D M M Y Y Y Y

8. What was the initial diagnosis and why?

9. What was your initial medical advice?

10. What treatment has been employed to date? Please give details of referrals to other doctors or specialists or surgeries

11. What treatment is planned for the future and what other treatment or rehabilitation options are available?

12. Has your patient previously suffered with the same or similar condition or symptoms of the condition?

☐ Yes ☐ No

If Yes, please provide details below.

Approximate date(s)

Details of clinical presentation

Did your patient require time off work?

☐ Yes ☐ No

If Yes, please provide details

Treatment

13. Has your patient always been compliant with recommended treatment?

☐ Yes ☐ No

If No, please provide details of the non-compliance, including your understanding of the reasons

14. Is your assessment and treatment complicated by any of the following?

– Atypical or variable presentation	☐ Yes	☐ No
– Subjective reporting of symptoms that are inconsistent with objective clinical findings	☐ Yes	☐ No
– Work related or workplace issues	☐ Yes	☐ No
– Substance abuse	☐ Yes	☐ No
– Family or interpersonal stressors	☐ Yes	☐ No
– Financial stressors	☐ Yes	☐ No
– Other	☐ Yes	☐ No

If Yes, to any of the above, AMP may be able to assist. Please explain and detail any steps taken to address the complication

15. Is there any form of intervention that AMP should consider supporting which might assist your patient's recovery at work?

Medical restrictions

At AMP we believe that work plays an important part in your patient's recovery. Our expert staff will work collaboratively with you, your patient, and the workplace to assist your patient wherever possible to recover at work or achieve an early, safe and sustainable return to work. To assist us in this regard, please complete the following

16. What is your patient's current occupation and their specific duties?

17. Did you advise your patient to cease work?

☐ Yes ☐ No

18. What date did you advise your patient to cease work?

D D M M Y Y Y Y

19. What objective evidence did you base this decision on?

20. Does your patient have any other ongoing health conditions that impact or may impact on their ability to work? If Yes, what and how?

21. Is it reasonable to expect your patient to attend work regularly? If so, how many hours per day and in what capacity could be expected?

22. If your patient is currently unable to attend work, when do you think a return to work part time or gradual return to full-time would be expected? Please explain

23. Describe your patient's motivation to return to work

Declaration

I hereby certify that the above information is correct to the best of my knowledge.

Name

Signature

SIGN HERE

Date

D D M M Y Y Y Y

Please attach the following items with your completed form

- [ ] Copies of all test results (X-rays, CT scans, MRI, Pathology, Blood tests, Urine tests, Ultrasound, etc)
- [ ] Copies of any medical reports related to the medical condition
- [ ] Any other information that will assist us in understanding your patient's medical status and current needs
- [ ] Detail of all medication that is currently taken by your patient

AMP is not responsible for payment of any fee for the completion of this report. Any fees incurred will be at the expense of your patient.

This is an important document. Please complete fully and return to

Customer Claims Team Contact
Phone 0800 267 425
Email claimsmailbox@amp.co.nz
Website amp.co.nz
Post PO Box 1692, Wellington 6140, New Zealand

Privacy Act Declaration
The information you provide will be held by AMP. Under the Privacy Act 1993 you have the right of access to, and to request correction of, any personal information held by AMP. The information will only be disclosed to another party to the extent necessary for one or more of the purposes set out in this document, including (but not limited to) claims assessment.

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