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 - Trauma

Your checklist to making a Claim

What are you covered for?

The Essentials Trauma Benefit is a lump sum amount which is paid if you suffer for the first time one of the 40 Traumas described in the AMP Essentials Cover Terms, 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 Customer Claims Consultants 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 Form – To be completed by current treating doctor/specialist**
- ☐ **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)

- ☐ **Bank account proof such as deposit slip or bank statement**

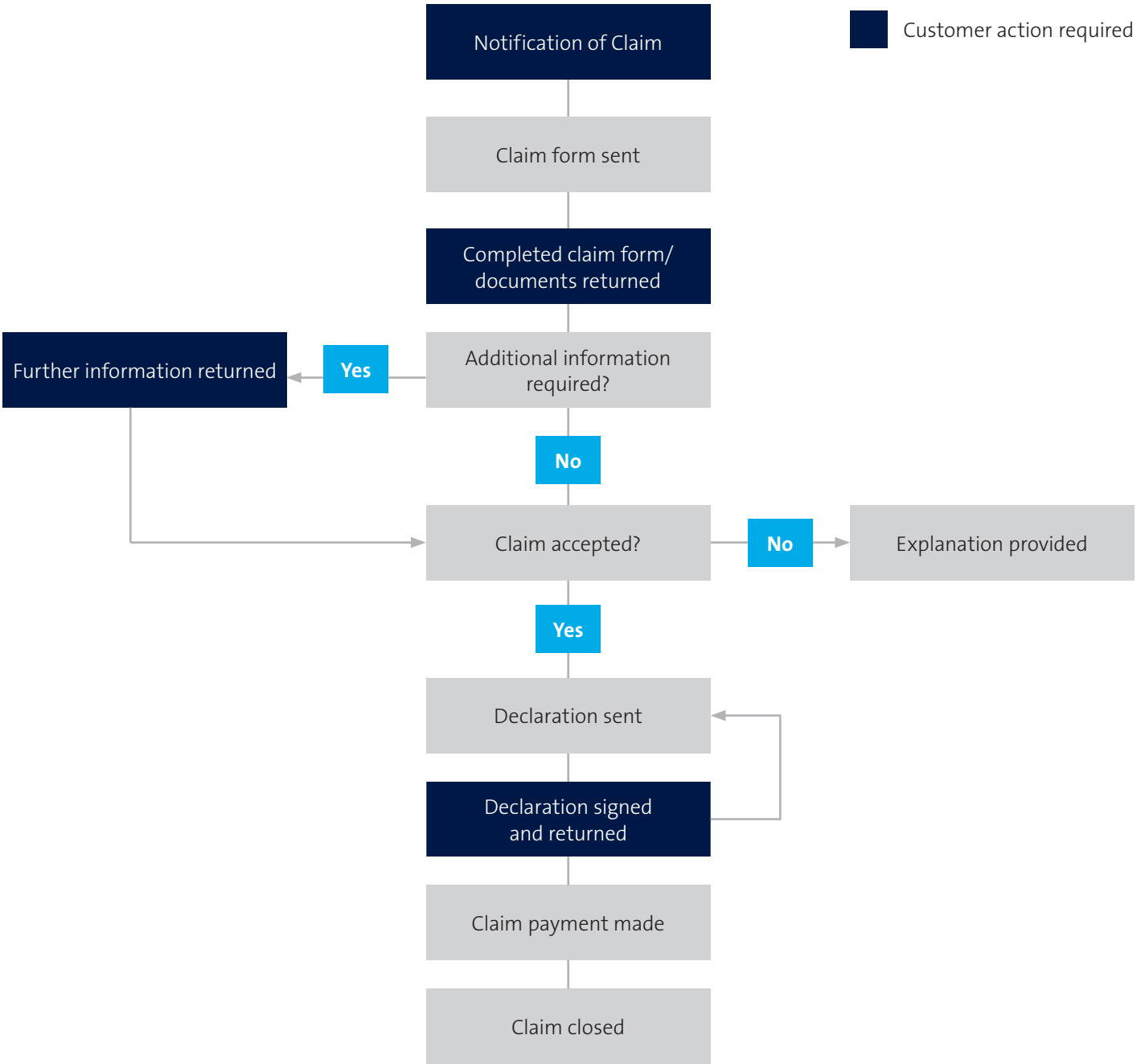
Once we have received the above requested information, we will send you a confirmation within 3 working days, at which point a dedicated Customer Claims Consultant will guide you through the following process.

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 Customer Claims Consultant will be in contact again within 5 working days with an outcome or if further information is required.

AMP Essentials - Trauma

Claims Process

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



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.

RESET

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

AMP Essentials - Trauma

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 Customer Claims Consultants will be to support you and keep you updated throughout the process.

AMP can guide you though 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

*Surname

*First name(s) (please print)

*Postal address

Postcode

*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?

Injury/Illness details – (Person Insured to complete)

1. Please describe the nature of your injury/illness:

2. If you sustained an injury, please explain how the injury occurred:

3. When did your injury occur?

D D M M Y Y Y Y

4. If you are suffering from an illness, when did you first become aware of your illness?

D D M M Y Y Y Y

5. When was the injury/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 injury/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 injury/illness

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

- ☐ Your Employer
- ☐ Any superannuation fund or group scheme
- ☐ Any other 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 or injury, including treatment you have undertaken or 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.

7. 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

8. 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

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

Medication	Date prescribed	Dosage/ Frequency	Prescribed by whom	Effectiveness

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

11. 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)

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

☐ Yes ☐ No

If Yes, please provide details

13. Please outline any pending investigations

Test/Investigation	Date scheduled	Reason for test

14. 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)*

15. Has your injury/illness impacted your capacity to perform your regular activities of daily living such as driving, household chores, errands, personal care, or childcare?

☐ Yes ☐ No

If Yes, please provide details:

Activity impacted	Describe how it is impacted	Expected improvement with time/treatment?
		☐ Yes ☐ No ☐ Uncertain, please explain:
		☐ Yes ☐ No ☐ Uncertain, please explain:
		☐ Yes ☐ No ☐ Uncertain, please explain:

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

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

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

☐ Yes ☐ No

19. Are you a smoker?

☐ Yes ☐ No

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

☐ Packets per week

20. Please indicate your average consumption of alcohol:

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

21. 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

Declaration – *(Person Insured to complete)*

PRIVACY ACT 1993 ("The Act")

Any personal information collected in connection with your claim will allow the insurer to assess your claim and to administer your claim and your insurance cover, and may also be used to provide you with information about other products or services offered by AMP. Under the Act a person has the right of access to, and correction of, any personal information about them. 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/injury, 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 necessary as a result of injury or sickness. I will provide AMP such further evidence of my claim as may be reasonably 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 Life Insured is medically unable to sign the Statement of claim form. Please also attach the relevant proof of authority.

First Name

Surname

Phone number

( )

Declaration – *(Person Insured to complete) - continued*

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

Postcode

(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 Life 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 8 above verifying the identity and address of the person named on page 1 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 1 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 1 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 8 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 1 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 1 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 8 above verifying the identity and address of the person named on page 1 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 1 of this form.

Signature of Adviser SIGN HERE

Dated D D M M Y Y Y Y

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 - Trauma

Medical Certificate

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

Your patient currently holds AMP Essentials trauma cover with AMP for specific illnesses, injuries or medical procedures.

The more detailed your information is, the better placed we are to care for 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.

We wish to work collaboratively with you to ensure we understand your patient's condition. 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.

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

Details and history of condition

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

Diagnosis	Date first consulted	Made by whom

4. If your patient's presenting condition is as a result of an injury

a. When did the incident occur? D D M M Y Y Y Y

b. What was the mechanism of injury?

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

D D M M Y Y Y Y

6. What was the initial diagnosis and why?

7. What was your initial medical advice?

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

9. Is any treatment planned for the future and what if any other treatment options are available?

10. Has you 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

If No, do you consider the injury/illness to be connected in any way with a previous accident or any previous conditions suffered by your patient's lifestyle or recreational activities?

☐ Yes ☐ No

If Yes, please provide details

11. Are you aware of anything in your patient's family history which would have increased the risk of this condition?

☐ Yes ☐ No

If Yes, please provide details

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.