SOVEREIGN

Health insurance claim form and/or prior approval request

This form can only be used for Health Insurance claims and/or prior approval requests. Page 1 - 3 is to be completed for claims and/or prior approval requests. Pages 4 and page 5 are to be completed only when payment is required.

1 Details

Please tick one of the boxes to explain what you are applying for:

- ☐ Prior approval (application for a future surgery or procedure - please also attach estimate of costs)
- ☐ Payment for a claim already prior approved # _____ Claim number
- ☐ Payment for a new claim not prior approved

Is your treatment within the next 5 days? ☐ Yes ☐ No

2 Policy owner details

Policy number _____

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname _____ **First name** _____

Addresses

Mailing address

Street _____

Suburb _____

City _____

Postcode _____

Best contact telephone number ( )

Email address _____

Date of birth / /

3 Who is this claim for?

☐ Policy owner (go straight to step 4) ☐ Other member insured on the policy - please complete below

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname _____ **First name** _____

Date of birth / / **Best contact phone number** ( )

Email address _____

4 Claim details

Please provide a referral letter from your GP or Dentist containing the first consultation date for this condition by any medical practitioner and the history of condition or treatment. If you do not have this, please have a GP or Dentist complete Appendix A.

Have you claimed for this condition before? ☐ No ☐ Yes Claim number (if known)

Symptoms started / / Sought medical advice / /

Treatment recommended

Name of provider/facility

Date of admission / / Date of discharge / /

Do you have a health policy with another provider you could claim on for this condition? ☐ Yes ☐ No

Is this condition ACC related? ☐ Yes, please attach decision letter from ACC regarding this condition. ☐ No

5 Duty of disclosure

As part of an insurance claim with Sovereign, I consent and give authority to Sovereign and any of its related companies and agents to collect, use and disclose, any medical, financial or other personal information about the life assured for the purposes of assessing and managing the insurance claim.

This information may be collected from/disclosed to external agencies and service providers ('agencies') for the above purpose including:

- Registered medical practitioners and Specialists (which may, where required, include an entire copy of my/our medical file)
- Medical laboratories and testing facilities
- Accident Compensation Corporation, governmental departments or bodies
- Advisers
- Insurers or reinsurers (whether public or private)
- Any other person or organisation which holds information which is relevant to my insurance or the assessment of my claim.

6 Acknowledgement

I acknowledge, understand and agree that:

- In the collection, disclosure, use and storage of information, Sovereign will at times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.
- The supply of the information gathered from the above sources is voluntary and that Sovereign may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on the insurance. I understand that the personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.
- That in collecting information relevant to assessing and managing the insurance claim, Sovereign may receive/collect information that is not relevant to that purpose (for example where the life assured's entire file is provided) and that Sovereign will only use/disclose the relevant information and not any other.
- The personal information will be stored at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether New Zealand or elsewhere). I understand that Sovereign will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).
- Access to and correction of the personal information may be requested by me.
- Sovereign may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities.
- Medical information can be included in the emails sent to the email address detailed on this claim form or subsequent addresses I provide to Sovereign claims.
- Financial information, along with any subsequent payment details can be sent to the email address detailed on this claim form or subsequent addresses I provide to Sovereign claims.

7 Declaration - important, please read carefully

I declare that all medical information pertaining to me and relevant to my insurance claim has been provided and disclosed to Sovereign, and understand that making any false or fraudulent claim could result in cancellation of my policy and/or oblige me to repay any claims.

I further understand that the medical information provided is the basis on which Sovereign will assess and manage 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 declare that all the answers to questions in this form are true and complete. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I further agree that a digital copy of this authority will be valid as an original.

Please print full name of person claiming

If a claim is being made by a child under 16 years of age, a parent or guardian must sign on the child's behalf. Please insert parent or guardian's full name and sign below.

Signature of person claiming

Date / /

Please print full name of policy owner

Signature of policy owner

Date / /

Complete to here for prior approval. Continue on to page 4 for payment details.

Sovereign House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag Sovereign,
Victoria Street West,
Auckland 1142

Freephone 0800 500 108
Freefax 0800 329 768
Email enquire@sovereign.co.nz
Web www.sovereign.co.nz

SOVEREIGN

Health insurance payment form and/or claim

This form can only be used for Health Insurance claims. Page 4 is to be completed once treatment/procedure is complete and payment is required.

Policy number

Claim number

8 Refund for claims

Please provide a copy of accounts or invoices (and receipt, if paid).
Payment will be made directly to the bank account you provide in section 9 below unless you elect have payment directly to provider by ticking the right-hand column of this section.

Provider	Amount	Pay to provider (tick)
	$	Yes
	$	Yes
	$	Yes
	$	Yes
	$	Yes
	$	Yes
	$	Yes
	$	Yes
	$	Yes
	$	Yes

9 Account details

(Please note: Reimbursement can only be made to a bank account, not a credit card).

If we haven't paid into this account before please provide evidence of bank details such as a printed bank statement.

Please provide bank account details for reimbursement.

Name of account

Bank | Branch | Account number | Suffix

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HEALTH INSURANCE MEDICAL INFORMATION FORM

SOVEREIGN

Complete by GP or Dentist in absence of referral letter

This form can only be used for Health Insurance claims. Page 5 is only to be completed if a complete referral letter is not provided. This information is required for Sovereign to complete assessment of your claim, this must be completed by your GP or Dentist.

A Appendix A - Medical Certificate

To be completed by a GP or Dentist (at client's expense) if a complete referral letter is not provided.

Name of client

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname _____ First name _____

Name and address of GP/Dentist

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Surname _____ First name _____

Mailing address

Street _____

Suburb _____

City _____

Postcode _____

I confirm that I am the Patient's GP/Dentist and that I referred the Patient to the Specialist for tests, e.g. x-rays ☐ Yes ☐ No / / Date of referral

How long have you been the patient's medical attendant? ☐ years ☐ months

Medical condition requiring treatment _____

Date of first medical examination by any GP/Dentist for this condition and any subsequent consultations for this condition / /

Details of the recommended treatment/test _____

Is this accident related? ☐ Yes ☐ No

If yes, has an application been made to ACC? ☐ No ☐ Yes _____ Please provide details including ACC number

Signature and stamp of GP/Dentist _____ Date / /

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