Public Hospital Payment Form

Policy number

1.0 Your details

Contact details

Name

Phone ( )

Mobile ( )

Email

All correspondence will be sent to the email address of the policyowner(s). A valid email address must be provided.

2.0 Your bank account details

Enter your bank account number to have a refund directly credited to your account

Name on account

Account number

Name of bank

Name of branch

2.1 Discharge summary

Name of patient

Date of birth

Date of admission

Date of operation / treatment

Date of discharge

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Operation / treatment performed

What was the underlying condition that made the surgery / treatment necessary?

Please attach the discharge summary

Attached

3.0 Privacy Act Requirements

Privacy Act 2020 and Health Information Privacy Code 2020

Collection and use

This form collects personal and health information. nib will use the information it collects to:

- consider claims and provide the benefits and health related services under the policies, and
- administer the policies, and
- promote and/or market our current and future health and related services and health related products of nib's business partners.

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. If any applicant or insured person fails to provide information required by the duty of disclosure, nib may decline the claim or pre-approval request. When in doubt, disclose.

Intended recipients

In providing our health and related services and using personal information, we may collect information from or disclose personal information to:

- nib and its related companies and business partners, and
- all other policyholders and insured persons, and
- the insurance adviser or other individual who a person has granted authority to access information on their behalf, and
- at claim time:
  - all necessary health service providers
  - any of nib's contractors or service providers assisting it with administering and meeting each applicant's and insured person's claim

You and each person named in this claim form authorise the collection of information from and the disclosure of information to the intended recipients named for the purposes set out above.

Access and correction

The accuracy of personal information is important to us. We will take reasonable steps to ensure a person's information is accurate, complete and up-to-date. We rely on the policyholder(s) and/or insured person to advise of any changes to their contact details and any other personal information. Each person has the right to access and correct their personal and health information held by nib. nib nz limited, 48 Shortland Street, Auckland collects and holds the personal and health information.

Signatures

Each person signing below declares that:

- All the information given by them is true, correct and complete
- If you have provided information on behalf of another person, you confirm that you are authorised to do so.

Note: If the insured person is under 16, their parent/legal guardian, or the policyowner, must sign on their behalf.

Sign here

Full name	Date	Signature
Policyowner or insured person's name	d d m m y y y y	