Hospitalisation benefit claim form.

Please complete this form for Hospitalisation benefit only claims, where no Income protection claim is required.

Your details.

Insured person name

Date of birth (DD/MM/YYYY)

Policy number

Residential address

Postal address (if different from residential address)

Email address

Preferred contact method
◯ Post ◯ Email

Contact numbers: Home ◯ Preferred phone number

Mobile ◯ Preferred phone number

Occupation

Medical event details.

Medical condition

Have you suffered a similar medical condition before?
◯ Yes ◯ No If yes, please give details of the date, injury, treatment and time off work

Hospitalisation.

Hospital

Admission date and time (DD/MM/YYYY)

: ◯ am ◯ pm

Discharge date and time (DD/MM/YYYY)

: ◯ am ◯ pm

Hospital

Admission date and time (DD/MM/YYYY)

: ◯ am ◯ pm

Discharge date and time (DD/MM/YYYY)

: ◯ am ◯ pm

Hospital

Admission date and time (DD/MM/YYYY)

: ◯ am ◯ pm

Discharge date and time (DD/MM/YYYY)

: ◯ am ◯ pm

Hospitalisation benefit claim form.

Please enclose.

Please enclose copies of all Discharge Summaries for Fidelity Life to consider for each period of hospitalisation that you wish to claim for.

Please also include:

- Your Proof of ID (as detailed in the requirements letter)
- Pre-printed Bank Deposit Slip (if you wish Fidelity Life to pay to an account that differs from your Direct Debit account)

Consent to provide information to adviser.

Adviser name

Company

☐ I consent to the release of all information relating to my claim including, but not limited to, medical and financial information to my adviser and their company.

☐ I provide restricted consent. Please do not provide any medical information to my adviser and their company.

☐ Please do not provide any information to my adviser or their company.

Payment details (to be completed by the policy owner/s).

If your claim is accepted, please note payment will be made by direct credit into the nominated New Zealand bank account. Please advise us if your bank account details change.

Please pay direct credit into the nominated bank account:

Bank - Branch - Account number - Suffix

Please also attach a pre-coded deposit slip, or bank account name and account number on bank letterhead/correspondence

Or:

Please pay into the bank account which my premiums are deducted from ◯ Yes ◯ No

Policy owner 1 name (please print) | Signature | Date (DD/MM/YYYY)

Policy owner 2 name (please print) | Signature | Date (DD/MM/YYYY)

Please return your completed form and any accompanying documents to:

@ claims@fidelitylife.co.nz 09 303 5732 ✉ Freepost 1893, PO Box 37275, Parnell, Auckland 1151.

If you have any questions please contact us on 0800 88 22 88, option 2.

See overleaf for Disclosure of information and Declaration and Consent.

Hospitalisation benefit claim form.

Disclosure of information.

You are required to provide Fidelity Life with all the information relevant to your claim. Where you have an on-going claim you will need to provide relevant information on an on-going basis. This information must be true, complete and accurate. If you fail to disclose information or provide false information this may result in your claim being declined and/or your policy being cancelled.

If you refuse to provide information, Fidelity Life may not be able to assess your claim.

Privacy Consent - Privacy Act 2020 and the Health Information Privacy Code 2020.

'Fidelity Life' refers to Fidelity Life Assurance Company Limited and 'you' and 'your' refers to the insured person filling out this form.

This claim form collects personal information about you. The personal information (including medical information or financial information if required) will be used by Fidelity Life to investigate and determine the validity of your claim and to confirm the information in your application for insurance. The information may also be used for statistical purposes provided you are not identified.

This privacy consent authorises Fidelity Life, its subsidiaries, its advisers, reinsurers and any agents appointed by Fidelity Life to collect from, use, and disclose to any third party, your information that is reasonably necessary to assess, administer and manage the claim. This privacy consent authorises those third parties to disclose that information to Fidelity Life, its subsidiaries, its advisers, reinsurers and any agents appointed by Fidelity Life.

Those third parties include (but are not limited to): advisers, agents, health service providers including recognised private and public hospitals, registered medical practitioners and specialists, medical authorities, health insurers, Accident Compensation Corporation (ACC), banks and financial institutions, accountants, counsellors, psychologists and therapists, insurers and reinsurers, and any other individual organisation where the collection/disclosure is required by law.

The information collected is held securely at Fidelity Life's Auckland Office or by one of Fidelity Life's storage providers and through cloud-based services in New Zealand or Australia who store information on our behalf.

Under the Privacy Act 2020 you have the right of access to request and correction of the information that Fidelity Life holds about you. Fidelity Life will rely on you to keep them informed of any changes to your information.

Declaration and consent.

By completing this form you

1. declare that you have provided Fidelity Life with all the information relating to this claim, that the information is true and correct and that no material information has been withheld.
2. agree to the Privacy Consent.

If you are providing information on behalf of the insured person, you must confirm in writing that you are authorised to do so and provide proof of authorisation.

Insured person name (please print)	Signature	Date (DD/MM/YYYY)

Policy owner name (please print)	Signature	Date (DD/MM/YYYY)

Policy owner name (please print)	Signature	Date (DD/MM/YYYY)

If this form has been completed by someone other than the insured person, please complete the following:

Name (please print)	Signature	Date (DD/MM/YYYY)

Relationship to the insured person	Phone number

Reason you have completed the form on behalf of the insured person