Health Insurance Claim Form / Prior Approval Request

(please print clearly)

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Policy number

1 Policy Owner's name and postal address

	Last Name	First Name(s)
Mr/Mrs/Miss/Ms		
Mailing address		
Telephone	Home ( )	Business ( )
Date of birth	/ /	
Are you applying for Prior Approval?	☐ Yes ☐ No	

2 Life Assured / Claimant details

Or as above (Tick if appropriate) ☐

	Last Name	First Name(s)
Mr/Mrs/Miss/Ms		
Mailing address		
Telephone (home/business)	( )	Date of birth / /

3 Claim details

Details of the condition which has resulted in this claim (please be specific)		
When did you first experience symptoms and seek medical advice?	Symptoms	
	Symptoms started / /	Sought medical advice / /
Treatment performed/to be performed (please delete one if not applicable)		
Name of hospital/clinic		
Date of admission	/ /	Date of discharge / /
Is this accident related?	☐ Yes ☐ No	ACC or other Insurer number

Please attach a GP referral letter to this form or your GP can complete Section 5. Ensure that the following details are included:

Start date of symptoms ☐ **History of condition** ☐ **Treatment received** ☐

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4 Declaration and consent

This application collects personal information about you and any Life Assured for whom you are claiming under your Policy.

The intended recipient of this information is Sovereign Assurance Company Limited ("the Company") and the information collected will be held at the head office of the Company at 33-45 Hurstmere Road, Takapuna, North Shore.

Failure to provide this information may result in your claim being declined or unable to be assessed. You and any Life Assured have the right to request access to, and correction of, your respective personal information at any time.

I, the Policy Owner, hereby claim the benefit amounts payable on the basis of the statements and information provided by the Life Assured in this claim form which I believe to be accurate and complete in every respect. I understand payments approved by the Company will be forwarded to me on receipt of accounts specifying the service provided and the amount payable.

As part of a health insurance claim with the Company, **I, the Life Assured**, consent and give authority to the Company and any of its related companies to seek from, and for all and any of the following, their officers and employees, to disclose to the Company, their advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial, and any related companies or other personal information affecting such insurance which they may hold in respect of me:

- Registered Medical Practitioners and specialists;
- Hospitals (whether public or private);
- Dentists;
- Accident Compensation Corporation;
- Counsellors, psychologists and therapists;
- Insurers (whether public or private);
- Government departments, agencies, organisations and enterprises.

I agree that a photocopy of this authority will be valid as an original.

Please print full name of Life Assured

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's or guardian's full name and sign below.

Signature of Life Assured **Date** / /

Please print full name of Policy Owner(s)

Signature(s) of Policy Owner(s) **Date** / /

5 Medical Certificate (please print clearly)

To be completed by a Registered Medical Practitioner or Dentist (at client's expense) if no referral letter provided.

This form needs to be completed only once for each initial claim. The aforementioned client has notified us of a requirement for treatment and we would request completion of this form to assist with the processing of the claim.

Name of client

Name and address of General Practitioner/Dentist

I confirm that I am the Patient's General Practitioner/Dentist and that I referred the Patient to the Specialist for tests, i.e. x-rays ☐ Date of referral / /

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

Medical condition requiring treatment

Date of first medical examination by any Doctor/Dentist for this condition / /

History of the condition and when symptoms first commenced

Date of consultations
/ /
/ /
/ /
/ /

Details of the recommended treatment/test

Is this claim accident related? ☐ Yes ☐ No If YES, has an application been made to ACC? (please provide details below)

Signature of General Practitioner/Dentist **Date** / /

Please staple original receipts/invoices here

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Request for payment (please print clearly)

When the medical services for which you are claiming are completed, please attach all original itemised accounts and list below:

Please submit this page to Sovereign for payment.

Policy number

Life Assured / Claimant

Return to: **Sovereign Assurance Company Limited**
Private Bag Sovereign
Auckland Mail Centre 1020

Receipts/invoices enclosed

Please note - payment will be made directly to the treatment provider unless receipts attached.

Name of eligible provider	Invoice Amount	Receipt Amount
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
Total value of claim	$	$

Reimbursement details (please tick your preference)

Please provide bank account details for reimbursement. Please attach a pre printed bank deposit slip.

Name of account

Bank | Branch number | Account number | Suffix

Other (please specify)

Signature(s) of policy owner(s)

Date / /

H4-01/05

Sovereign Services Limited, Sovereign House, 33-45 Hurstmere Road, Takapuna, North Shore, Private Bag Sovereign,
Auckland Mail Centre 1020, New Zealand. Freephone 0800 500 108 Freefax 0800 500 196 enquire@sovereign.co.nz www.sovereign.co.nz