

Critical Condition Claim Form



Pursuant to the Privacy Act 1993 the following is brought to your attention:

- This claim form collects personal information about you
- The information is collected to evaluate your claim
- The collection of this information is required pursuant to the terms of your insurance policy
- The failure to provide this information may result in your claim being declined
- The information is being collected and held by Southsure Assurance Limited, PO Box 1404, Invercargill
- The intended recipient of the information is Southsure Assurance Limited, PO Box 1404, Invercargill
- You have the right of access to and correction of this information in accordance with the Privacy Act 1993

Your Personal Details

Title	Given Name(s)		Surname		
Address					
Date of Birth	/	/	Phone – Home()	Phone – Work()	Phone – Mobile()
Occupation at time of Disablement			Your Usual Occupation		
Current Employer or Previous Employer if not currently employed:					
Employer Address				Employer's phone no. ()	
Dates of employment: from / / to / /				Average hours worked per week?	
On what basis are you currently employed? (please circle as appropriate)					
Full Time		Part Time		Casual Contractor Seasonal Temporary	
If claiming under ACC, what is your ACC Claim Number?					
And, what is the address of the ACC office?					

About Your Critical Condition

Date on which the injury or illness first occurred / /	What was your last working day? / /
Describe the circumstances leading to your current disability	
Who is your usual doctor?	For how long? Months Years
Your doctor's address	Phone number ()
Please give the names and addresses of ALL doctors, specialists and hospitals consulted by you for this current disability:	
Name	Address
Name	Address
Name	Address
Was the injury caused by a motor vehicle accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did the Police attend? Yes <input type="checkbox"/> No <input type="checkbox"/>
I resumed my work duties on / /	or I expect to be fit for some work duties / /

Your Medical History

Have you previously suffered from this illness, or any similar or related illness?

Yes ☐

No ☐

If Yes, Please provide the following details:

Name of Doctor

Address

Phone number ()

Date(s) of consultation (1) / / (2) / / (3) / / (4) / /

Nature of the complaint

Period(s) of disability (1) from / / to / /
(2) from / / to / /

Have you previously suffered from any **other** major illness or injury **unrelated** to this disability?

Yes ☐

No ☐

If Yes, Please provide the following details:

Nature of the complaint

Date(s) of occurrence (1) / / (2) / / (3) / / (4) / /

Period(s) of disability (1) from / / to / /
(2) from / / to / /

Do you take regular medication for **any** illness or injury?

No ☐

Yes ☐

If Yes, please provide details of all medications, prescribed dosage and related medical condition

(1)

(2)

Please ensure ALL questions have been answered fully, you have read and signed the declaration below and your doctor has completed the Medical Certificate overleaf. Please attach a letter from your employer confirming your incapacity to work to this claim form

MEDICAL DECLARATION (must be completed by the Insured)

I declare that the information given above is true and complete, and that I was in no way under the influence of intoxicating liquor or drugs when the disability occurred, and that the disability being claimed for in this claim is the sole cause of my Disablement and my inability to attend work.

I hereby authorise any doctor, medical practitioner, hospital, clinic, A.C.C., insurance company, employer, Department of Social Welfare, WINZ, or any other authority to disclose to Southsure Assurance Limited all information concerning my medical and employment history. I agree to meet any costs including medical expenses associated with obtaining this information. A photocopy of this authorisation shall be as valid as the original.

I understand that all claim payments will be made to my financiers.

I authorise the disclosure of personal information held by other parties which relate to this claim and agree to Southsure Assurance Limited disclosing to other parties personal information regarding this claim.

I authorise any licensed Private Investigator instructed by you to make enquiries into my claim to take such audio transcription, photographic or video surveillance as might be necessary for the assessment of my claim, such audio transcriptions, photographic or video surveillance may be carried out without my prior knowledge or any other consent.

Name _____ Signature _____ Date _____

MEDICAL CERTIFICATE (must be completed by your doctor)

Name of Attending Doctor

Phone number ()

Insured's Name

Insured's Occupation

Are you the Insured's usual Doctor? Yes ☐ No ☐ For how long have you been his/her doctor? years
months

State the nature and cause of the disablement:

When did you first treat the Insured for this illness/injury? / /

Please provide details of the treatment:

Please provide details of any prescribed medication:

Please give details of any medical conditions which have a bearing on this current disablement:

Has the insured ever received any previous medical diagnosis, treatment, operation or attention for this or any similar disablement or related cause? Yes ☐ No ☐ If Yes, Please supply details of dates and nature of disability:

What is your prognosis of the present disablement?

Have you any reason to: (please tick as appropriate)

- | | | |
|--|------------------------------|-----------------------------|
| 1. Suspect that the disablement has resulted from in any way the use of intoxicating liquor or drugs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Test for Human Immunodeficiency Virus (if Yes, please provide a copy of the results) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Suspect that the disablement has resulted from or been contributed to by any intentionally self-inflicted injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Has the insured been hospitalised? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

I hereby declare that the person named above:

1. Is totally unable to work solely due to the disablement giving rise to this claim: Yes ☐ No ☐

Period from / / to / /

OR

2. Is capable of performing light, limited or restricted duties whether available or not: Yes ☐ No ☐

Period from / / to / /

For _____ hours per day and _____ days per week

If the insured has been cleared to return to work, please give the period of disablement, from / / to
/ /

If total disablement still exists, on what date is it likely to cease? / /

Signature of Medical Practitioner:
the Medical Practice

Address/Office Stamp

Date / /