CONSUMER CREDIT INSURANCE CLAIM FORM

Please complete where applicable and return within seven days – please print

DriveRight

As required by The Privacy Act 1993, the following is brought to your attention.

(a) Parts of the claim form and any further enquiries we make of you in order to consider your claim is the collection of personal information about you;

(b) The information is collected to evaluate your claim;

(c) The intended recipient of the information is IAG Insurance New Zealand Limited, or its subsidiaries and divisions;

(d) The information is collected and held by IAG Insurance New Zealand Limited, Auckland;

(e) The collection of this information is required pursuant to your insurance policy;

(f) The failure to provide this information may result in your claim being declined and your insurance being void from the beginning;

(g) You have certain rights of access to and correction of this information, subject to the provisions of the Privacy Act 1993. But subsequent correction of false information will not affect our right to decline indemnity if you do not provide false information on this form or in support of your claim.

The Making of a false representation with a view of obtaining benefit under an insurance policy constitutes an offence under the Crimes Act 1961.

Insured Surname	(Mr/Mrs/Ms/Miss)
Insureds First Names	
Date of Birth of Insured	Occupation/Hours per week
Telephone	Private
Employers Name/Address	
Insureds Address	

Customer/Account No:	
Does this relate to a loan or a credit card?	
If a loan, what was this for?	

DEATH – If claim is in respect of death

Claimants Surname	
Claimants First Names	
Address	
Telephone	Relationship to Deceased

Please attach a copy of the Full Death Certificate.

Please arrange for the deceased's Doctor to complete the reverse side of the claim form as appropriate.

INJURY – If a claim is in respect of bodily injury resulting from an accident

Date and time of Accident ____ : ____ am/pm

Date you stopped work due to this accident ____

Place of Accident ____

How did the injury occur? ____

Name and address of Doctor(s) in attendance ____

Your Doctor must complete reverse side of this form

ILLNESS – if claim is in respect of an illness

Date on which doctor first examined you ____

Date you stopped work due to this illness ____

Nature of illness ____

Have you suffered previously from the same or similar illness for which you are now claiming: Yes ☐ No ☐ If "Yes". Please give details:

Name and address of Doctor(s) in attendance ____

Your Doctor must complete reverse side of this form:

REDUNDANCY/BANKRUPTCY – If claim is in respect of redundancy

Name and address of Employer ____

Position Held ____ Date you finished your employment:

Was your position a Permanent one? Yes ☐ No ☐

How many hours a week did you work? ____

Was position full time? Yes ☐ No ☐

How long had you been employed? ____

Branch of Work and Income NZ where registered ____

You must include a copy of the Official notice of Redundancy and Client Basic Details Report from Work and Income NZ.

Your employers letter needs to state the reason your employment was terminated.

I, the undersigned or the next of kin, hereby declare that I am the person referred to in the above statements concerning injury, illness or redundancy, which are true in every respect and made without reservation.

Signature Date

1) Please ensure that both sides of this claim form are completed where applicable. You must complete the authority at the bottom of the back page.

2) Mail to DriveRight, PO Box 68200, Newton, Auckland. Telephone 0800 374 448.

Medical Report

If claiming for injury, illness or death, this report must be fully completed by your Doctor

DriveRight

NAME OF PATIENT

1. On what date did the patient first consult you in connection with this accident or illness?
2. Has he/she consulted other doctors prior to you about this condition? Yes ☐ No ☐
   If "Yes", who?
3. Are you the Patient's usual Medical Attendant? Yes ☐ No ☐
   If "Yes", how long have you known him/her?
4. Date of accident, onset of illness, or cause of death.
   (If disability, for an operation, onset date of accident or illness necessitating operation).
5. Please detail the nature of injury, illness or cause of death.
6. If claim is for injury, are the appearances of the injuries consistent with the cause stated? Yes ☐ No ☐
7. Has the Patient previously suffered from this type of injury or illness from which he/she is now suffering or which caused his or her death? Yes ☐ No ☐
   If "Yes", please detail history of condition.

Would the Patient have been aware of this condition? Yes ☐ No ☐

What treatment was the Patient receiving and how long has he/she been receiving this?

8. Is the Patient suffering from any other injury or illness irrespective of that stated above? Yes ☐ No ☐
   If "Yes", please state the nature of this and to what extent recovery may be affected by this.
9. In your opinion is the injury or illness attributable to, or as a result of, any physical defects or illness existing at a prior date? Yes ☐ No ☐
   If "Yes", please give details of defect or illness and the treatments, given for this.
10. Is the Patient totally disabled from attending his/her occupation (unable to work at all)? Yes ☐ No ☐
    If "Yes", anticipated length of **Total Disablement** from working From for wks/mths
11. Date Patient is, or should be released to return to work (if known)
12. Is it likely that the Patient will have to change his/her occupation due to this illness/accident? Yes ☐ No ☐
    If "Yes", why?
13. Is the Patient seeing any specialists about his/her condition? Yes ☐ No ☐
    If "Yes", Who?

OTHER REMARKS

PLEASE PRINT: I certify that to the best of my belief the foregoing statements are correct:

Name: _____ Qualifications _____

Address: _____

Date: _____ Signature: _____ Doctors stamp:

AUTHORITY TO OBTAIN FURTHER INFORMATION – (To be completed by claimant in all cases)

I (full name) _____

of (address) _____

Hereby authorise full disclosure of any information regarding my employement terms and history, my accident or illness, and my medical history, including copies of any medical reports, clinical reports or otherwise to DriveRight New Zealand Limited on their request.

Signed: Date: