

PLEASE ONLY PRINT THOSE PAGES RELEVANT TO YOUR CLAIM

NZRU VOLUNTARY PERSONAL ACCIDENT INSURANCE CLAIM FORM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. All receipted invoices for self paid expenses
2. For any accounts submitted which have not yet been paid please ensure this is noted clearly on the account and the reason why payment has not yet been made.
3. Attach all available documents, receipts / invoices, which support circumstances relating to your claim.
4. If your claim is as a result of a medical condition you will need to provide medical evidence. The supplemental Medical Certificate attached can be used for further information. Please have your treating physician provide a full report detailing your diagnosis, treatment provided, prognosis and the like.

★ Failure to provide these items may result in delays in processing your claim.

MEDICAL EXPENSES

When did the injury first occur?

| | |
|-------------|-----------------|
| Date / / | Time am / pm |
|-------------|-----------------|

How did the injury occur?

| |
|--|
| |
|--|

Describe the injuries sustained

| |
|--|
| |
|--|

What date did you stop work

| | |
|----------|--|
| Date / / | |
|----------|--|

Have you ever suffered from this injury before?

| | | |
|------------------------------|-----------------------------|---------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | If so give details. |
|------------------------------|-----------------------------|---------------------|

Have you lodged a claim under ACC ?

| | | |
|---|-----------------------------|--------------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | If so provide ACC Ref #: |
| Please provide a copy of the ACC claim form with this claim. | | |

Please provide the name; address, contact phone number & email address for the patients usual GP and any other treating physicians

| Name, | Address | Phone |
|-------|---------|-------|
| | | |
| | | |

Are these expenses recoverable from any other source, society, organisation and/or insurer?

If so, please provide full contact details & policy reference:

| |
|--|
| |
|--|

Please itemise the expenses incurred

| Name, address and phone of medical attendant / provider | Nature of illness / injury and treatment | Amount |
|---|--|--------|
| | | |
| | | |
| | | |
| | | |
| | Total | |

Employer Details

To be completed for claims Under Section 2 of the policy – Temporary Total disablement, causing loss of income

Employers/Company name

I, an authorised officer of the above employer/company, declare that was disabled by a rugby injury and did not attend work for the period from/...../..... to/...../.....

I declare that was/was not paid their usual wage/salary during the period from/...../..... to/...../.....

Signature of Employer :

Date: / /

MEDICAL CERTIFICATE

| | | | |
|---|------------------------------|-----------------------------|---|
| This is to verify that (Name of Patient) | | | |
| Consulted me on the | Date : / / | | |
| Please state the full nature of the Injuries sustained. | | | |
| Is this injury due to, resulting from, or connected with an existing medical or degenerative condition? | | | |
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| If "Yes" what is the history of this condition | | | |
| Has the injury resulted, or is it likely to result, in permanent injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If so what will be the nature of this Injury: |
| | | | |
| Any further remarks and the prognosis: | | | |
| | | | |
| Signature: | | | Date: / / |

Please forward claim form and any relevant documents to:

Jardine Lloyd Thompson Limited
Level 9, Forsyth Barr House
45 Johnston Street
PO Box 11145
Wellington

PRIVACY CONSENT

ACE Insurance Limited ("ACE") collects, uses and retains your personal information only in accordance with the principles in the Privacy Act 1993. A copy of our Privacy Statement, which expands upon our privacy obligations and provides further information on your rights to access your personal information held by us is available on our website or by contacting our Privacy Officer on +64 (9) 377 1459.

Your personal information will be used by ACE, or any third party that ACE provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information includes:

- (a) any information provided in relation to your claim;
- (b) any information that is health information or sensitive information;
- (c) any other personal information that you may provide to ACE or its third party contractors;
- (d) any information relating to the insurance policy on your life, including terms and conditions and claims history;
- (e) details of your employment including position, period of employment, remuneration, hours worked and duties performed; and
- (f) any other information relating to your income and solvency.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the "Parties"). You agree that the Parties may disclose your personal information to ACE.

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ACE group, other insurers, our reinsurers, and government agencies (where we are compelled to by law). These third parties may be located outside New Zealand. ACE may also disclose your personal information to witnesses in respect to your claim.

You agree to us using and disclosing your personal information pursuant to ACE's Privacy Statement and this Claim Privacy Consent. In the event of any conflict between the documents, this Claims Privacy Consent shall be determinative. This consent remains valid unless you alter or revoke it by giving written notice to our privacy officer.

If you do not consent to the terms of this Claims Privacy Consent or revoke your consent, ACE may not be able to process or assess your claim.

DECLARATION

I declare that to the best of my knowledge the particulars are true and correct, and that I have not withheld any information that is relevant to this claim. I will notify ACE immediately if any of the lost or stolen property mentioned in this claim is subsequently recovered and surrender the property or refund the money received in compensation to ACE.

I accept that wilful or reckless exaggeration or inflation of the amount(s) claimed will result in automatic forfeiture of the claim and the policy shall be void.

I request and authorise any hospital, doctor, or other person who has attended or examined me to furnish to ACE or its representative all information concerning any illness or injury suffered, medical history, consultations, prescriptions, or treatments including X-ray plates and copies of all hospital or medical records, so that they may be included as a part of the proofs of the claim submitted. A photocopy of this authorisation will be considered as effective and valid as the original.

I authorise the disclosure to ACE of personal information held by any person or organisation regarding or affecting this claim and authorise ACE to release to any other relevant person or organisation information regarding or affecting this claim.

| | | | |
|------------------------|-------|-----------------------------|-------|
| Signature of Claimant: | _____ | Signature of Club Official: | _____ |
| Name of Claimant: | _____ | Name of Club Official: | _____ |
| Date: | _____ | Position in Club: | _____ |
| | _____ | Date: | _____ |

THE PERSONAL INFORMATION COLLECTED ON THIS CLAIM FORM WILL BE HELD BY ACE INSURANCE LIMITED
YOU HAVE RIGHTS OF ACCESS TO AND CORRECTIONS OF INFORMATION UNDER THE PRIVACY ACT 1993