MARAC
MARAC INSURANCE LIMITED

Policy / Claim number:
(Office use only)

Lifestyle Protection
Accident and Illness Claim Form

How to complete this claim form
We always endeavour to process your claim in a timely manner, please ensure that you complete all the relevant sections and attach all the required information. Feel free to call us on 0800 45 10 10 if you have queries about the form.

YOUR PERSONAL DETAILS – INSURED

Mr/Mrs/Miss/Ms/Dr (please circle)	First Names	Surname
Address		
Suburb	City	Postcode
Home Phone No.	Work Phone No.	Mobile Phone No.
Email Address	Date of Birth	
Current occupation		

DETAILS OF YOUR ILLNESS

Date first contracted	Date your first sought medical advice
Description of your illness	
Date your illness was diagnosed	By whom

DETAILS OF YOUR INJURY

Place where you suffered your injury		
Time am /. pm (please circle)	Date	Date you first sought medical advice
Place where you suffered your injury		
What were you doing at the time?		
How was it caused?		
What injuries were suffered?		
Name and address of any witness		

MARAC
MARAC INSURANCE LIMITED

Policy / Claim number:
(Office use only)

GENERAL DETAILS

Have you been able to do limited work duties? ☐ Yes ☐ No ☐If Yes, please provide details

Have you been engaged in any other occupation? ☐ Yes ☐ No ☐If Yes, please provide details

Have you ever had a similar injury or illness? ☐ Yes ☐ No ☐If Yes, please provide details

If you are still disabled or not deemed fit to work, how much longer the disability is likely to continue?

Name of your Doctor Address of your Doctor

If you have you known this Doctor for less than three years, who was your previous Doctor?

PROCEEDS OF CLAIM

Please confirm (tick a box) where you would like the claim proceeds to be paid (if accepted):

☐ Credit the monthly benefit payable onto my MARAC loan

☐ Credit the monthly benefit payable into the following bank account ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐

YOUR SIGNATURE – INSURED

Consent and Declaration: I hereby declare that the statements contained in this claim are true and correct to the best of my knowledge, and I have not suppressed or misstated any facts that are relevant to this claim.

Medical and Information Authority: I authorise any person or entity (including any hospital, physician or other person who has attended me, my employer, my accountant and other professional advisers and financial institutions) to provide MARAC Insurance Limited or its representatives with:

a) Copies of hospital and medical reports/notes considered relevant to my claim;
b) Information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment) considered relevant to my claim; and
c) Copies of any other documents or records considered relevant to your claim and which may include copies of employment records, income tax returns and bank statements.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original and authorise its use as such.

Signed

Date

Your checklist for processing your claim:

MARAC
MARAC INSURANCE LIMITED

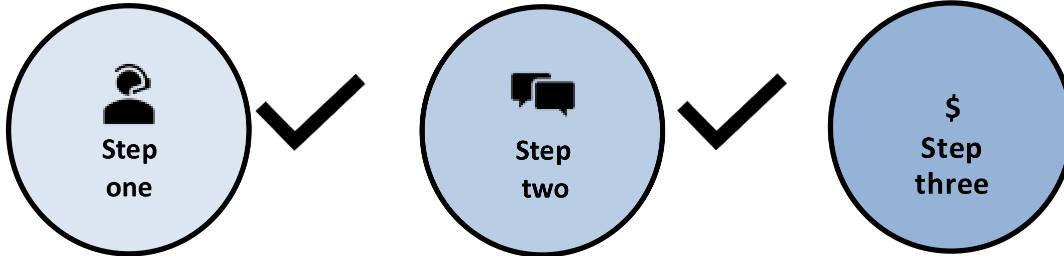
Policy / Claim number:
(Office use only)

Please tick to ensure all relevant information is attached.

☐ Your claim form signed and completed

☐ The Medical Report completed by your Medical Practitioner

☐ Any other relevant documents



- You can call us for a claim form on 0800 45 10 10 or
- Email us at insurance@marac.co.nz or
- Visit our website www.marac.co.nz

- Fill out your claim form and return to us at insurance@marac.co.nz or post the claim
- Don't forget to include your supporting documents to help us process your claim.

- We will process and settle your claim as soon as we can.

Please send your claim form and all supporting documents to: insurance@marac.co.nz or post to MARAC Insurance, PO Box 9919, Newmarket, Auckland 1149.

Your privacy matters

This Policy collects information about you to evaluate the insurance you seek. The recipient and holder of the information is MARAC Insurance Limited, 35 Teed Street, Newmarket, Auckland. The collection of this information is required pursuant to the common law duty to disclose all material facts relevant to the insurance sought and is mandatory. The failure to provide this information may result in your Policy being declined. You have right of access to, and correction of this information subject to the provisions of the Privacy Act 2020. The Information will be held at the office of MARAC Insurance Limited, 35 Teed Street, Newmarket, Auckland. The information may be used for the purposes of marketing by MARAC.

This policy is under New Zealand law

New Zealand has jurisdiction and the laws of New Zealand apply to this policy. All claims will be paid in New Zealand currency.

MEDICAL REPORT

To be completed by your Medical Practitioner

MARAC
MARAC INSURANCE LIMITED

Policy / Claim number:
(Office use only)

Name of your Patient/Insured

Surname

First Names

1. Your Full Name (Medical Practitioner)

2. Patient's Home Phone No. Patient's Work Phone No.

Patient's Address

Suburb City Postcode

3. What is your patient's occupation, business or profession?

4. Are you the patient's usual Medical Practitioner? ☐ Yes ☐ No If Yes, how long has s/he ben a patient?

5. Please state the nature and extent of the injuries or illness

6. What do you believe is the cause of the injuries or illness?

7. Please give details of any treatment given

8. Is the patient (to your knowledge) following / complying your treatment plan instructions? ☐ Yes ☐ No

9. On what date did you first attend the patient in connection with this condition or any related symptoms?

10. To your knowledge, has the patient previously suffered from this condition? ☐ Yes ☐ No
    If Yes, please provide full details including when the condition was first diagnosed

11. Do you consider this injury or illness is terminal or will result in permanent disablement? ☐ Yes ☐ No
    If Yes, please give details

12. Has the patient been referred to a specialist or do you intend to refer? ☐ Yes ☐ No
    If Yes, please provide name and address of the specialist

13. To your knowledge, was the injury self-inflicted? (if applicable) ☐ Yes ☐ No

14. Is this condition directly or indirectly related to infectious diseases, such as HIV, AIDS, SARS or related condition, alcohol, drugs or poison? ☐ Yes ☐ No

    If Yes, please give details

15. Is the patient suffering from any other conditions (additional to that described in question 6 above)? ☐ Yes ☐ No
    If Yes, please state the nature of the condition and to what extent recovery may be affected

16. Please confirm the patient has been unable to attend work, or has not been deemed fit to work, from

17. When do you expect the patient will resume work, or will be deemed fit to work? ☐ Part of their work ☐ Full time duties

18. General remarks

SIGNATURE OF YOUR MEDICAL PRACTITIONER

Consent and Declaration: I agree that I have personally examined the patient at the time of completing this report, and that all the information I have given in this report are true and correct.

Signed

Date