

**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 you 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  
circle)

am / . pm (please

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

**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 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

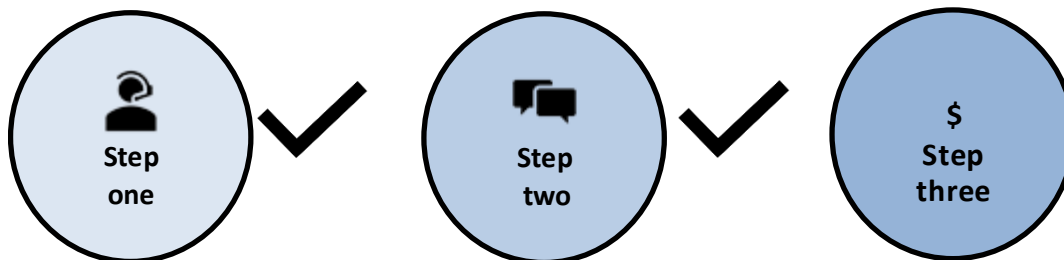
Date

**Your checklist for processing your claim:**

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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](mailto:insurance@marac.co.nz) or
- Visit our website [www.marac.co.nz](http://www.marac.co.nz)
- Fill out your claim form and return to us at [insurance@marac.co.nz](mailto: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](mailto: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 1993. 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

**Name of your Patient/Insured**

First Names

Surname

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1. Your Full Name (Medical Practitioner)

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2. Patient's Home Phone No.

Patient's Work Phone No.

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Patient's Address

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Suburb

City

Postcode

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

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

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

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

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7. Please give details of any treatment given

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

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

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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

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11. Do you consider this injury or illness is terminal or will result in permanent disablement?  Yes  No

If Yes, please give details

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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

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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

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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

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

.../...../20....

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17. When do you expect the patient will resume work, or will be deemed fit to work?

Part of their  Full time duties  
work

.../...../20....

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18. General remarks

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### 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