Doctor's Declaration

Latitude Insurance
PO Box 108022
Symonds St, Auckland
Phone: 0800 220 999
Fax: 0800 282 646
gemfinance.co.nz/insurance

How to help us process your claim

Checklist

Before submitting your claim form, make sure you can tick **all** the boxes below:

Illness or injury claims - documents required ✓

Section A: Statement of claimant (you) – all questions answered. ☐

Section B: Doctor's declaration – completed, signed, dated and stamped by your usual treating doctor. ☐

Privacy consent and declaration - read, signed and dated by you. This is on the last page of this claim form. It's important that we have your signature here so we can start processing your claim straight away. ☐

Without the above information we will be unable to process your claim.
This could delay any payment to your account that you may be entitled to.

If you are having any difficulties completing this claim form, please contact our Customer Service Centre on **0800 220 999.**

Latitude
Financial Services

Hallmark Life Insurance Company Ltd. and Hallmark General Insurance Company Ltd. (incorporated in Australia and operating in New Zealand).
LF-4261 (Rev 04/16)

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What needs to be filled out?

Section A – to be completed by claimant (you)

Section B – to be completed by your usual treating doctor

Privacy Consent and Declaration - to be read, signed and dated by you

Section A: Statement of claimant (you)

Who needs to fill this out?
All questions need to be answered by you in this section

Claim number: _____ Account/policy number: _____

First name: _____ Surname: _____ Date of birth: _ _ /_ _ / _ _ _ _

1. Since the last time you contacted us, have you (tick all options that relate to you):

a) Returned to your usual duties? No ☐ Yes ☐ *If yes, please give date*: _ _ /_ _ /_ _ _ _

b) Returned to light duties? No ☐ Yes ☐ *If yes, please give date*: _ _ /_ _ /_ _ _ _

2. Please provide full details of ALL doctors you have consulted over the past five years:

Year	Doctor's Name	Phone Number	Fax Number	Address	Reason
e.g. 2010-2012	e.g. Doctor Smith	e.g. 0800 220 999	e.g. 0800 282 656	e.g. 1-2 Main Street Auckland	e.g. knee injury

Important notice:
This needs to be completed in full by you. If you require any assistance in completing this claim form please contact us toll free on **0800 220 999**.

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Section B: Doctor's Declaration

Who needs to fill this out?
To be completed, signed, dated and stamped by your usual treating doctor

Patient's full name: _____ Date of birth: _ _/_ _/ _ _ _ _

1. Are you the patient's primary medical practitioner?

No ☐ **Please have the claimant's usual treating doctor to complete.**

Yes ☐ Date of the patient's initial Consultation with your medical practice for **any** condition: Date: _ _/_ _/ _ _ _ _

2. Name of primary condition preventing the patient from returning to work? _____

3. Date of first consultation with your medical centre for this condition? Date: _ _/_ _/ _ _ _ _

4. Please tick if the diagnosis is defined as any of the following:

Heart Attack ☐ Major organ transplant ☐ Cancer ☐
Kidney Failure ☐ Coronary artery disease requiring surgery ☐ Stroke ☐

5. Date the patient was first noted to suffer symptoms of, or receive treatment for, the condition: Date: _ _/_ _/ _ _ _ _

6. Has the patient suffered from the same or similar condition, or conditions, previously?

No ☐ **Go to question 8**

Yes ☐

Condition	Initial Consultation Date

7. Does the patient have any other conditions not yet listed above that are preventing them from working?

No ☐ **Go to question 9**

Yes ☐

Condition	Diagnosis Date

8. Is the patient's diagnosis the direct result of an accident?

No ☐ **Go to question 10**

Yes ☐

Please provide details of the accident:

9. If Hospitalised, please provide the following details:

Hospital	From	To

10. If you have referred the patient to a specialist for any of the conditions above, please provide the following:

Specialist Name	Date of Referral	Additional Details

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Section B: Doctor's Declaration (continued)

Who needs to fill this out?
To be completed, signed, dated and stamped by your usual treating doctor

To the best of my knowledge, the patient has been entirely prevented from engaging in all duties of an occupation for which he/she is reasonably suited by education, training or experience.

From: _ _ / _ _ / _ _ _ _ To: _ _ / _ _ / _ _ _ _

I anticipate that he/she will return to work by: _ _ / _ _ / _ _ _ _

In my opinion the patient's prognosis is: _____

Please provide further details if necessary: _____

Name: _____ Provider number: _____

Address: _____ Postcode: _____

Phone: _____ Fax: _____

Signature of medical practitioner: _____ Date: _ _ / _ _ / _ _ _ _

Claimant to complete

Declaration & Privacy Consent (to be signed and dated by you)

1. I declare that the information supplied by me on this form is in every respect true and correct and that I have not withheld any information likely to affect the acceptance of the claim. I understand that the claim may be denied if the information supplied is untrue or I have not revealed all relevant facts.
2. I hereby authorise my employer, their Workers Compensation insurer, my insurers or any hospital or medical practitioners who have treated me to provide Latitude Insurance with any information it may request regarding any illness, injury, medical history, treatment or copies of medical, hospital or employment records. A photocopy of this authorisation shall be considered as effective and valid as the original.
3. I authorise my employer and/or their Workers Compensation insurer to provide Latitude Insurance with information relating to my employment including but not limited to my employment history, payroll information, employment records and termination.
4. I agree to Latitude Insurance collecting my **sensitive information** (particularly health information), for the purpose of considering this claim. I understand that further information regarding how Latitude Insurance collects, uses, discloses and stores my personal information is contained in the important Privacy Notice and the Privacy Policy *(gemfinance.co.nz/privacy).*

Name: _____

Current address: _____

Signed: _____ Date: _ _ /_ _ /_ _ _ _

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