Southern Cross
Health Society

Critical Illness claim

This form must be completed when making a claim for a Critical Illness Event under your Critical Illness policy.
After completing this form, please sign and return to: Private Bag 3216, Waikato Mail Centre, Hamilton 3240.
For assistance in completing this form, visit www.southerncross.co.nz/society/forms
If you have any questions call toll free on **0800 800 181**. Calls to this number may be recorded.

Critical Illness policy number

MEMBER DETAILS Policyholder name and mailing address

Title ________ First name ____________________ Surname ____________________ Date of birth ____________

Postal address ____

Street number | Street | Suburb | Town/city

Home phone | Work phone | Extn

Mobile phone | E-mail ____________________

REFUND OPTIONS (Tick one option only) If neither option is indicated, we will refund by cheque

☐ **Option 1** Direct credit to bank account **OR** ☐ **Option 2** By cheque

For direct credit refunds, please ensure that the correct bank account details are listed and that you have ticked Option 1.

BANK/BRANCH NUMBER | ACCOUNT NUMBER | SUFFIX

PRIVACY ACT/DECLARATION

This claim form collects personal and health information about each member named on this form for the purposes set out in the Southern Cross Medical Care Society Privacy Statement, including evaluating your claim, preventing, detecting and investigating fraud, and contacting you from time to time (using any of the above contact details) with information about Southern Cross products and services. The intended recipient of this information is Southern Cross Medical Care Society. The information is being collected and held by Southern Cross Medical Care Society, Private Bag 3216, Waikato Mail Centre, Hamilton 3240, Freepost Authority 158217. If you fail to provide the information requested your claim may be declined. Each member named on this claim form has the right to access and request correction of their information in accordance with the Privacy Act 1993. The full Southern Cross Medical Care Society Privacy Statement is available at ww.southerncross.co.nz/privacy.

This declaration must be signed in order for your claim to be paid

I declare that:

- All of the information supplied on this claim form is complete, true and accurate.
- I am authorised by each member named on this claim form to complete and sign on their behalf.
- This claim is made in accordance with my policy document and the Rules of Southern Cross Medical Care Society.
- I authorise Southern Cross Medical Care Society to obtain from any person or organisation (including health care providers) any further information reasonably required to evaluate and investigate this claim (including after payment), and I authorise that person or organisation (or health care provider) to disclose such information to Southern Cross Medical Care Society.
- I authorise any change of bank account details noted on this claim form.

Policyholder signature ______________________________ **Date signed** ______/______/______

1. YOUR CRITICAL ILLNESS EVENT

Name of member claiming ______________________________

Please indicate the Critical Illness Event you wish to claim for

☐ Cancer
☐ Cardiac
☐ Organ failure requiring major organ transplant
☐ Loss of independent living
☐ Functional loss
☐ Stroke

Medical practitioner details

Please provide the name and contact details of the Medical Practitioner the member has consulted with in relation to the Critical Illness Event that this claim is for

____

Please provide the name and contact details of any other health services provider(s) that the member has seen (is seeing) in relation to this Critical Illness Event

____

To enable assessment of this claim please ensure that you have

☐ Checked that the policyholder has signed the declaration above.

☐ Checked that the attending Medical Practitioner has completed, signed and dated Section 2 of this form and attached all necessary supporting documentation to this claim form.

☐ Checked that the claim relates to a Critical Illness Event which occurred within 12 months of today's date.

2. CLINICAL DETAILS OF CRITICAL ILLNESS (to be completed by your attending Medical Practitioner)

Please provide answers to the following questions to assist us in assessing a claim for your patient. Be as comprehensive as possible in answering the questions to avoid time delays that may occur if we need more information to clarify any answers.

On what date did this patient first seek medical advice in relation to the Critical Illness or any health condition which relates to a sign or symptom of the Critical Illness ?	______/_______/______
When was your patient first aware of these Critical Illness signs and or symptoms ?	______/_______/______
On what date was the Critical Illness first diagnosed?	______/_______/______

Please provide clinical details of the conditions, signs or symptoms that have resulted in the diagnosis of this Critical Illness

Has this patient suffered the condition, sign or symptom previously? ☐ Yes ☐ No

If yes, please provide details.

Attending Medical Practitioner contact details

Name ______________________ Phone ☐☐ ☐☐☐☐☐☐☐ Extn ☐☐☐☐

Fax ☐☐ ☐☐☐☐☐☐☐ E-mail ______________________

I declare that the information I have disclosed is true and complete

Signature ______________________ **Date signed** ______/_______/_______

Supporting documentation to be supplied by the attending Medical Practitioner

To assist us in assessing a Critical Illness claim, please ensure that you have attached the relevant supporting documentation.

Cancer

- A copy of all relevant pathology reports; and
- Medical Report outlining details of the Cancer; and
- Operation notes or other details regarding treatment provided or recommended.

Cardiac

Open Chest Surgery

- A pre-surgery angiogram report ; and
- Cardiothoracic surgeon's operation notes.

Myocardial Infarction

- A Cardiologist must certify that a Myocardial Infarction has occurred (including all the supporting evidence for the diagnosis).

Organ Transplant

- Specialist Report outlining the reasons for the transplant; and
- A copy of the operation notes.

Loss of independent living

- Medical Report outlining the diagnosis and the daily living assessment.

Functional Loss

- Medical Report detailing diagnosis and functional loss.

Stroke

- Medical Report (including copies of results of relevant diagnostic imaging, assessment of degree of neurological deficits and likely progress).