Momentum Life®

Trauma Benefit

Privacy Statement

Notice under the Privacy Act 2020 and The Health Information Privacy Code 2020

'We', 'us' and 'our' refers to Momentum Life Limited (Momentum Life) and 'you' and 'your' refers to the Policy Owner, the Life Insured and the claimant.

We collect personal information about you. The personal information and any additional information obtained, (including medical information or financial information if required) will be used by us and our officers to assess and administer the claim. The information may also be used for statistical purposes provided you are not identified.

Momentum Life, their subsidiaries, advisers, reinsurers and any agents appointed by us collect from, use, and disclose to any third party, your information that is reasonably necessary to assess, administer and manage the claim. Those third parties include (but are not limited to): advisers, agents, health service providers including recognised private and public hospitals, registered medical practitioners and specialists, medical authorities, Accident Compensation Corporation, therapists, insurers and reinsurers, and any other individual organisation where the collection/disclosure may be permitted by law.

The information may also be disclosed outside of Momentum Life where the disclosure is necessary for one or more purposes for which the personal information was collected, to agents, representatives, organisations, or contractors who provide services to us in connection with the administration of products or services, or for the purpose of customer satisfaction surveys, or where permitted by law.

We will take all reasonable steps to keep any personal information we collect and hold about you or any other Life Insured secure and ensure your information is accurate, complete and up-to-date.

Under the Privacy Act 2020 you have the right of access to and correction of the information that we hold about you. We will rely on you to keep us informed of any changes to your information.

The Momentum Life Privacy Policy is available at momentumlife.co.nz. If you have any query in relation to your privacy please contact Momentum Life:

Phone: 0800 108 108 (Mon to Fri, 9am - 7pm NZST) **Email:** claims@momentumlife.co.nz
Mail: Claims Manager, Momentum Life, PO Box 99892, Newmarket, Auckland 1149

Completion instructions

Step 1: As the Policy Owner, you should first check your most recent policy schedule to make sure that the trauma cover is in place and current for the affected Life Insured. Then complete **Section 1: Parts A to D**. Note that once the claim is approved, the claim payment will be made to you.

Step 2: The Life Insured who is suffering the trauma must complete **Section 2: Parts E to I**. If you are both the Policy Owner and Life Insured, then you must complete **all Parts A to I**. Our assessment is based on the details provided here and the details provided by the Life Insured's Medical Specialist.

Step 3: Once Sections 1 and 2 have been **fully completed**, please forward this form to the Medical Specialist who is predominantly attending to the Life Insured, to complete **Section 3: Parts J and K**. Once your Medical Practitioner has completed **Section 3: Parts J and K** please send the whole completed form back to Momentum Life.

Section 1: Policy Owner's details

Part A: Policy Owner's details

Policy Owner:	Policy number:	
Address:		
Suburb:	City:	Postcode:
Phone (H):	Phone (W):	Phone (M):
Email:		

Please indicate your preferred method of communication with an asterisk (*)

Part B: Policy Owner's authorisation to share information about this claim

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below:

First name:	Surname:
Relationship to you:	

Policy Owner's signature: **Date:** / /

Part C: Policy Owner's payment authority

Once the claim has been accepted the benefit will be credited to the account below.

Name of bank:	Name of account holder:
Account number:	– – –

Part D: Policy Owner's declaration

I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim. By completing this form I understand I have a duty to provide Momentum Life with all the facts material to my claim and all information they may reasonably require in relation to my claim. I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Momentum Life requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement on page 1.

Policy Owner's signature: **Date:** / /

Section 2: Policy Owner/Life Insured's details

The Life Insured suffering the Trauma condition to complete Parts E to I.

Part E: Policy Owner/Life Insured's details

Title:	First name:	Surname:	
Date of birth: / /		Weight: kg	Height: cm
Occupation:			
Address:			
Suburb:	City:	Postcode:	
Phone (H):	Phone (W):	Phone (M):	
Email:			

Part F: Policy Owner/Life Insured's Trauma claim

Medical details of the Life Insured will require Medical Specialist details

1. Has the injury or illness occurred resulted in any of the following conditions? (Please tick one)

☐ Benign Brain or Spinal Cord Tumor (Specialist Neurologist)		☐ Blindness (Specialist Ophthalmologist)
☐ Cancer	☐ Coma	☐ Coronary Artery Bypass Surgery
☐ Deafness	☐ Heart Valve Surgery	☐ Kidney Failure
☐ Liver Failure	☐ Loss of Independent Living	☐ Loss of Speech (Specialist Physician)
☐ Loss of Use of Limbs	☐ Lung Failure	☐ Major Burns
☐ Major Head Trauma	☐ Major Organ Transplant (Specialist Physician)	
☐ Paralysis	☐ Severe Heart Attack (Specialist Cardiologist)	
☐ Stroke (Specialist Physician)	☐ Triple Vessel Coronary Angioplasty for Coronary Artery Disease	

These Trauma events are defined in your Policy Wording.

2. On what date did the symptoms or injury first occur? / /

3. Have you previously had the same or similar condition or symptoms? Yes ☐ No ☐

If 'yes', please provide full details. Include dates and which doctors attended for each previous episode:

4. Name of doctor you have predominantly consulted with about the claimed condition:

Address:		
Suburb:	City:	Postcode:
Phone:		
Date of first consultation? / /	Date of last consultation? / /	

5. Is the doctor named in (4) above your usual doctor? Yes ☐ No ☐ If 'no', please provide details of usual doctor:

Doctor's name:		
Address:		
Suburb:	City:	Postcode:
Phone:		

Part G: Policy Owner/Life Insured's authorisation to share information about this claim (optional)

The details regarding your claim are considered to be private and cannot be disclosed to any other party other than as set out in our Privacy Policy or unless we have your express consent.

If you wish to nominate a party of your choice that we can share information about your claim with, please complete the information below:

First name:	Surname:
Relationship to you:	

Policy Owner/Life Insured's signature: **Date:** / /

Part H: Policy Owner/Life Insured's consent to obtain a medical report

I hereby consent to Momentum Life being provided with medical information, including copies of any medical reports, clinical reports or otherwise, from any Medical Specialist who at any time has attended me concerning anything which affects my physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

First name:	Surname:
Date of birth: / /	

Policy Owner/Life Insured's signature: **Date:** / /

Part I: Policy Owner/Life Insured's declaration

I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim. By completing this form I understand I have a duty to provide Momentum Life with all the facts material to my claim and all information they may reasonably require in relation to my claim. I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Momentum Life requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement on page 1.

Policy Owner/Life Insured's signature: **Date:** / /

Please have the treating Medical Specialist complete parts J & K on the following pages.

Section 3: Medical details

This section (Parts J and K) is to be fully completed by the registered treating Medical Specialist.

Part J: Confidential Medical Report - Trauma benefit

Please note that the information required to be completed in this document is in relation to the insured person (patient).

Please note that it is the insured person's responsibility for the payment of all fees associated in the completion of this document.

In order to ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this document are fully addressed and answered. Responses such as "refer to doctor", "see above", etc, are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay of benefit payments.

If for any reason there is not enough room on this document to provide the details being requested, please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date any attachments.

1. Patient's details

	First name:	Surname:	
	Address:		
	Suburb:	City:	Postcode:

2. Medical details

a.	Are you the patient's usual Medical Specialist? Yes ☐ No ☐ If no, please provide details of usual doctor below:		
	Doctor's name:		
	Address:		
	Suburb:	City:	Postcode:
	Phone:		
b.	Which of the following conditions has been suffered by your patient? Will require Medical Specialist details.		
	☐ Benign Brain or Spinal Cord Tumor (Specialist Neurologist)	☐ Blindness (Specialist Ophthalmologist)	☐ Cancer
	☐ Coma	☐ Coronary Artery Bypass Surgery	☐ Deafness
	☐ Heart Valve Surgery	☐ Kidney Failure	☐ Liver Failure
	☐ Loss of Independent Living	☐ Loss of Speech	☐ Loss of Use of Limbs
	☐ Lung Failure	☐ Major Burns	☐ Major Head Trauma
	☐ Major Organ Transplant (Specialist physician)	☐ Paralysis	☐ Severe Heart Attack (Specialist Cardiologist)
	☐ Stroke (Specialist Physician)	☐ Triple Vessel Coronary Angioplasty for Coronary Artery Disease	
c.	What was the date of diagnosis? ☐☐ / ☐☐ / ☐☐☐☐		
d.	What was the date of the first consultation in connection with the current condition? ☐☐ / ☐☐ / ☐☐☐☐		
e.	Please fully describe the patient's current condition and prognosis for recovery, relapse or whether the condition is permanent:		

f.	Provide the dates and results of any X-rays, ECG, blood pressure or other tests performed.		
	Date:	Test:	Results:
	☐☐ / ☐☐ / ☐☐☐☐		
	☐☐ / ☐☐ / ☐☐☐☐		
	☐☐ / ☐☐ / ☐☐☐☐		

g.	What treatment is currently being given, including surgery and medication, if any?	

Part J: Confidential Medical Report - Trauma benefit (continued)

h. Please provide the names and addresses of any consulting specialist(s) or medical services the patient has been referred to:

Name:	Speciality or medical service:

i. If the patient has been hospitalised, provide the following details.

Admission date:	Discharge date:	Name of hospital:
/ /	/ /	
/ /	/ /	
/ /	/ /	

j. Have you ever treated the patient before for any condition? Yes No If 'yes', please supply details.

Date consulted:	Nature of the condition:
/ /	
/ /	
/ /	

k. Please provide details if the patient has a previous history of the current condition, or any impairment likely to be connected with the current condition:

Part K: Medical Practitioner's declaration and agreement

I hereby certify that I have personally attended the above named patient and that all the information supplied by me in this Report is true. I agree that Momentum Life may provide copies of this Report to any Medical Specialist from whom Momentum Life seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom the Insurer is obligated under the Privacy Act 2020 to give access to this Report.

First name:	Surname:	
Qualifications:		
Address:		
Suburb:	City:	Postcode:
Phone:	Fax:	

Medical Practitioner's signature: **Date:** / /

Please return the completed form to Momentum Life. You can either:

1. Scan & email to claims@momentumlife.co.nz **(please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); or**
2. **Mail to The Claims Manager, Momentum Life, PO Box 99892, Newmarket, Auckland 1149 (please mark the envelope as CONFIDENTIAL).**