Franchise Loss of Income and/or Franchise Fees
claim form

Section marked "Policyholder" must be completed and signed by a principal of the Insured Person if not the policyholder.

Section marked "Attending Physicians Statement" to be completed by the patient's Doctor.

ALL QUESTIONS MUST BE FULLY ANSWERED - DASHES ARE INSUFFICIENT

Please attach a separate sheet if insufficient space

1 SETTLEMENT DETAILS

Payee name

Email address

Direct credit to bank account

BANK BRANCH ACCOUNT NUMBER SUFFIX

Payee signature

SECTION ONE – SCHEME

Full name of scheme

Scheme claims contact

Policy expiry date

Benefit payable to

Policy holder name

2 INSURED PERSON TO COMPLETE

Full name of insured person

Street address

Email address

Policy holder name

Business phone

Home phone

Date of birth

Weight

Height

Gender

Occupation prior to disablement

Describe your usual duties

Describe the injury or sickness for which you are claiming

On what date did your sickness commence, or your injury occur?

If **injured**, what were you doing at the time?

Have you ever suffered a similar sickness or injury in the past? Y N

If yes, give full details: nature of incapacity / severity

Period of time off work: from to

When did you first consult a doctor for the condition for which you are claiming?

When did you become totally disabled for work?

If still **totally** disabled, when do you expect to return to work?

Please turn over.

INSURED PERSON TO COMPLETE (CONTINUED)

If you have returned to work, when were you able to again perform:

Part of your occupation duties?

Date

Time (AM/PM)

All of your occupational duties?

Date

Time (AM/PM)

3 GIVE DETAILS BELOW OF ALL ATTENDING PHYSICIANS AND HOSPITALS ATTENDED

Date of consultation/treatment	Name of hospital	Name of Doctor	Address/email

Name of your usual Doctor

Address / email

Have you ever lodged a personal accident or sickness claim before? Y N

If yes, on what date?

What injury or illness did you suffer?

Give details of incapacity

Insurer details: address / claim number / policy number

Are you making any other insurance/compensation claim in respect of this disability? Y N

If yes, please provide full details

(Please specify whether government benefits / superannuation / life insurance or other)

Please note: All injury claims must first be notified to ACC.

ACC record number

4 INSURED PERSON (IF SELF-EMPLOYED)

Do you operate as a limited liability company? Y N

Do you or your company pay an ACC levy? Y N

What is your business trading name?

Business address

Business phone number

What date did you commence trading?

What is your accountant's name?

Accountant's address

Accountant's phone number

5 SPORTS INJURY CLAIM (TO BE COMPLETED BY THE CLUB SECRETARY)

Name of club

Secretary / treasurer: Name

Phone number

Email address or address

I certify that (name)

was injured on (date)

whilst playing (sport)

at Grade

with the club

Signature

Date

Name and position

6 ## ATTENDING PHYSICIAN'S STATEMENT
– THIS FORM MUST BE COMPLETED WITHOUT EXPENSE TO THE INSURER

Patient's name

Age

What is the condition causing disablement?

Diagnosis: chief complaint/ history / complications

Has the patient ever had the same or a similar condition? Y N

If treated by another physician for the condition, please note below

Date

Condition

Treating physician

Phone

If injury, when did the accident occur?

When did the patient first receive medical attention for the above?

By whom?

Dates hospitalised: admitted

Name and location of hospital

What operation, if any, was performed?

Were there any other doctors or consultants attending? Y N

If yes: Name

Specialty

Address

Email

Date discharged from your care

Were there any other doctors or consultants attending? Y N

If yes: Name

Specialty

Address

Email

Are you the usual family doctor for this patient? Y N

Is yes, since what date have you been attending?

What defects or chronic diseases does the patient have and when did they originate?

Degree of temporary disability

Based on patient's occupation of

Has the patient been able to do ANY work? Y N

If yes, from what date:

Full duties

Restricted duties

If no, when will he/she be able to work:

Full duties

Restricted duties

Has injury described above resulted in any residual disability? Y N

If yes, please give full details and provide copies of specialist or other reports

ATTENDING PHYSICIAN'S STATEMENT (CONTINUED) – THIS FORM MUST BE COMPLETED WITHOUT EXPENSE TO THE INSURER

Your name

Qualifications

Phone

Email

Address

Signature

Date

7 DECLARATION – AUTHORITY & PRIVACY CONSENT

INSURED PERSON MUST SIGN BELOW

I/we (print names)

declare that the above answers and those contained in any attachments are true and note that the Insurer may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to provide Berkshire Hathaway Specialty Insurance Company ("BHSI") with assistance in dealing with this matter and understand that failure to co-operate with BHSI and to provide all information relevant to the circumstance may result in my/our claim being denied.

AUTHORITY:

I/we authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish BHSI or its representatives with:

i. copies of hospital and medical reports/notes;

ii. copies of employment records and income tax returns; to the extent that they are relevant to the claim and

iii. information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

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

PRIVACY:

I/we consent to BHSI in accordance with the Privacy Act 1993:

1. collecting holding and using personal information including information by audio, photographic or video surveillance, provided for purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
2. disclosing personal information submitted to a related BHSI company either in New Zealand or overseas, their staff members located outside New Zealand, the insured, other insurers and re-insurers, law enforcement agencies, investigators, lawyers, assessors, advisors and the agent of any of these, insurance broker, insurance agent or intermediary, employer for the purpose of administering my claim or providing a report.

Information is provided voluntarily however if we do not collect this information we may not be able to assess a claim. Insured persons have rights of access and correction to their personal information under the Privacy Act. Further information about this or making a privacy complaint can be obtained by emailing Rothbury.

NOTE: BHSI will only seek information which in its opinion it believes to be relevant to investigation of the claim.

Signature/s of insured person/s

SIGN HERE

Date

IF YOU ARE SIGNING ON BEHALF OF THE INSURED PERSON, PLEASE STATE YOUR AUTHORITY TO DO SO AND THE NATURE OF YOUR RELATIONSHIP. PLEASE COMPLETE:

Name

Phone

Position of authority to sign – nature of relationship

I/We

1. Declare that to the best of my/our knowledge the information provided in support of the claim is correct and complete in all ways and there is no further information relevant to the claim.

Please Note: The collection of this information is required under the terms of your policy in order for the claim to be evaluated. Failure to provide complete and correct information may result in the claim being declined.

2. Agree to provide any further information that may be required;
3. Authorise the disclosure and obtaining, of my/our personal information in respect of this claim, to and from parties including Insurers, intermediaries and other members of the Insurance Industry, the insurance Claims Register PO Box 474, Wellington, where information is retained and made available to other insurers and other parties relevant to your claim including those with a financial or commercial interest in, and/or involved in the repairing or replacing of, the subject matter of the claim.
4. Understand I/we have certain rights of access to and correction of my/our personal information pursuant to the Privacy Act 1993; and
5. All information collected will be held by Target Insurance, 188 Quay Street, Auckland and/or the Insurer.

Signature of Policyholder/Insured

SIGN HERE

Full name

Position

Date