HealthCare
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Date Received:

Bereavement Grant Claim Form

Membership Number: _____

Name of Claimant: _____

Name of Deceased Member: _____ Date of Birth: ____/____/____

Postal Address: _____

_____

Postcode: _____ Work Phone: ( ) _____

Home Phone: ( ) _____ Mobile Phone: ( ) _____

Email Address: _____

MY BANK DETAILS:

Account Number: ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

BANK BRANCH ACCOUNT NUMBER SUFFIX

PLEASE NOTE: All claims will be paid directly into the bank account provided by you above (Cheques are no longer issued)

Claimant's relationship with the deceased: _____

Where the Member dies, the benefit is payable to the surviving partner or to the person who is the accredited next of kin. In the event that the deceased has no accredited next of kin a discretionary application may be made by the person responsible for the funeral expenses and arrangements (a supporting letter is required from the solicitor).

It should be noted that the benefit is not payable to an estate.

Please attach copies of the following documents to this claim form as indicated

(a) In all cases – the Death Certificate, or an original newspaper announcement clearly stating the full date of the bereavement

(b) If you are the next of kin but not registered under the policy – a letter from the solicitor, or a copy of the deceased's will confirming you as the next of kin

(c) If there is no accredited next of kin and you are the person responsible for the funeral expenses and arrangements – a letter from the solicitor, or a copy of the deceased's will confirming you as such

DECLARATION THIS MUST BE COMPLETED IN ALL CASES

1. I am the Claimant detailed above
2. I understand that this claim will be treated in confidence and in accordance with the terms and conditions current at the time the events under claim occurred.
3. I consent to UniMed communicating with me via the preferred email address specified on this application form.
4. I confirm that I am authorised by each person named on this claim form to complete and sign on their behalf.
5. I declare that that the information provided on this form is true and correct and I hereby authorise the Society to make further investigation if required.

SIGNATURE OF CLAIMANT: _____ **DATE:** ____/____/____

PRIVACY ACT Pursuant to the Privacy Act 1993 the following is brought to your attention:

(a) This claim form and any supporting documents collect personal information about you and the deceased and is collected to effect the claim you make.

(b) The intended recipient of the information is UniMed, who collect information reasonably required to evaluate this claim. It is held by UniMed, whose office is at 165 Gloucester Street, Christchurch.

(c) The collection of this information is required pursuant to the common law duty to disclose all material facts relevant to the claim and is mandatory.

(d) If you fail to provide this information it may result in your claim being declined or rejected.

(e) Each person on this claim form has the right to access and request correction of this information is subject to the provisions of the Privacy Act 1993.

(f) While for the most part we are able to treat this information as confidential between you and us, there are circumstances in which the practices of the insurance industry may require us to disclose this information for statistical purposes (however you are not identifiable).

(g) Each person on this claim form authorises UniMed to obtain from any party or organisation (including health care providers) any information reasonably required to evaluate and investigate this claim, and each person named on this claim form authorises that party or organisation to disclose such information to UniMed.