

## Form Instructions

### What is the purpose of this form?

This document provides medical information to help us assess your claim within the terms and conditions. During assessment, we may request further information to clarify your claim.

### How to fill the form:

**Step 1:** This report must be completed by the **Registered General Practitioner (GP)** or **Specialist** who:

- Has made recommendation against travelling or;
- Provided medical treatment to you

All sections of the form must be completed with supporting documentation.

The form must be signed by the **Registered General Practitioner (GP)** or **Specialist**.

**Step 2:** Once completed, please upload to your online claim submission or return to the below addresses.



**Upload to your online claim**

[AGA online portal](#)



**Email your form to us**

travelclaims@allianz-assistance.co.nz



**Mail your form to us**

P O Box 112316, Penrose, Auckland  
16424066

## Your details *(to be completed by the claimant)*

Claim reference / policy number

Full name

Date of birth

Email

Telephone

Full address

## Privacy notice

We collect, use and disclose any personal information in accordance with our Privacy Policy referred to in the Product Disclosure Statement and available on our Allianz Worldwide Partners webpage under the Privacy & Security link so we can:

- Identify you and your policy details
- Assess and manage your claim in respect of your medical condition(s)

### What happens if you don't give us your personal information?

If the form is not completed by your treating doctor or is incomplete, we may not be able to assess your claim. Please note that completing this form is mandatory to proceed to the claim assessment.

### Contact us

If you have any question regarding this form, please contact us by email or phone

## Patient details

Patient Name Date of Birth How long have you treated the patient? Relationship to the claimant 

## Medical details

What is the medical condition the patient is claiming for?

Cancer ☐ Respiratory ☐ Cardiac ☐ Renal or urological ☐ Pregnancy ☐Back pain/ spinal condition or other musculoskeletal ☐ Other ☐Date of onset of symptoms Date of diagnosis 

What were the patient's initial symptoms?

Please give precise diagnosis of the medical condition which gave rise to this claim:

Did you make any recommendation about the travel arrangements and on what date? *(If applicable to the claimant)*

Has your patient ever been investigated or treated for this medical condition other related condition or related complication?

☐ Yes/ Other related condition (please explain) ☐ No

Has your patient ever been referred to any specialists for this medical condition, related condition or related complication?

☐ Yes ☐ NoHas the patient been hospitalised within the past 2 years in relation to the condition? ☐ Yes ☐ No

### How can we help?

Allianz Global Assistance  
Level 3, 1 Byron Avenue  
Takapuna, Auckland 0622  
[www.allianz-assistance.co.nz](http://www.allianz-assistance.co.nz)

Travel Claims Department  
P O Box 112316, Penrose, Auckland 1642  
Tel 0800 630 117 or +64 9 487 0813  
Fax +64 9 489 8167

Email Claim Documents: [travelclaims@allianz-assistance.co.nz](mailto:travelclaims@allianz-assistance.co.nz)  
Claim Questions: [claims@allianz-assistance.co.nz](mailto:claims@allianz-assistance.co.nz)

## If this condition is in relation to cancer:

Has your patient ever previously been investigated or treated for any oncology conditions or other related conditions or complications? ☐ Yes ☐ No

**If this is related to or under investigation or involves a recurrence or metastases, please attach a copy of the histopathology reports.**

## If this condition is in relation to respiratory:

Has your patient ever previously been investigated or treated for respiratory conditions or other related conditions or complications? ☐ Yes (**please provide all related reports and notes**) ☐ No

## If this condition is in relation to cardiac:

Has your patient ever previously been investigated or treated for cardiovascular or cerebrovascular conditions or other related conditions or complications? ☐ Yes (**please provide all related reports and notes**) ☐ No

## If this condition is in relation to renal or urological:

Has your patient ever previously been investigated or treated for renal or urological conditions or other related conditions or complications? ☐ Yes (**please provide all related reports and notes**) ☐ No

## If this condition is in relation to back pain or spinal condition or other musculoskeletal:

Has your patient ever previously been investigated or treated for back pain/spinal conditions or other musculoskeletal related conditions or complications? ☐ Yes (**please provide all related reports and notes**) ☐ No

If yes, has your patient ever required prescription medication for the condition/s? ☐ Yes ☐ No

## If this condition is in relation to pregnancy:

What is the expected delivery date?

Date of first symptoms of complication?

Date complication was diagnosed

Is it a single or multiple pregnancies?

Was the pregnancy as a result of artificial or assisted reproductive techniques, including drug/hormone therapy, artificial insemination or in vitro fertilization? ☐ Yes (*If yes, please explain*) ☐ No

Has your patient ever been investigated or treated for any of the following complications of pregnancy: Cervical problems (eg. incompetent cervix), vaginal bleeding, high blood pressure, pre-eclampsia, abnormalities of the placenta or other. (*Please specify and comment on the applicable conditions*)

☐ Yes ☐ No

**Please provide copies of all specialist reports related to the pregnancy complication.**

## Registered Medical Practitioner details

Print name

Signed

Date

Stamp/  
Provider number