Medical report

accuro HEALTH INSURANCE

Note to the patient's GP/dentist

The below patient is claiming a benefit from Accuro Health Insurance, and we require the information from you, as the registered medical practitioner for the patient, in order to assess this claim as quickly as possible. Thank you for your assistance.

Accuro Health Insurance is not liable for any costs associated with the completion of this form. This form is to be completed by the patient's usual GP/dentist. If the space allowed for answering any of the questions is insufficient, please attach a separate sheet.

Policy number	
Patient's name	
Patient's date of birth	DAY / MONTH / YEAR

1 GP/dentist's details

GP/dentist's name	
GP/dentist's address	
Are you the patient's usual GP/dentist?	◯ Yes ◯ No **Please provide the usual GP/dentist's name and address**
Please indicate whether you hold the patient's full medical/dental history	◯ Yes ◯ No **Please indicate what years the history spans** From _____ to _____

2 Medical history

Please provide a complete description of the condition	
What is the proposed treatment?	
In your opinion, when were signs and/or symptoms first present?	

Please continue on to the next page

2 Medical history continued

What date was medical advice first sought?	
Does the patient have a history of, or predisposition to, this condition?	
Has the patient been seen by any other doctor/hospital/clinic in relation to this condition?	

3 ACC (if applicable)

Is this an ACC-related condition?	◯ Yes ◯ No
If yes, has a claim for this condition been lodged with ACC?	◯ Yes ◯ No
If yes, has ACC accepted cover for this condition?	◯ Yes ◯ No

Please attach any ACC acceptance or decline documents

Please be aware that Accuro's terms and conditions require that you seek cover through ACC before seeking cover through Accuro. If ACC declines cover, we welcome you to apply for cover under your policy.

4 Declaration

Accuro is a brand owned, operated and underwritten by Union Medical Benefits Society Limited (UniMed).

Has this form been completed in full with no answer omitted?	◯ Yes ◯ No

» I declare that the above information, and other information supplied by me in relation to this form, is true and correct and that no information relevant to the patient has been omitted from this form.

» I declare that I am registered as a medical practitioner with the Medical Council of New Zealand or Dental Council of New Zealand and am not the patient, the policy owner or either of their respective partners or relatives.

» I consent and authorise UniMed to disclose to its associated companies, adviser or any other party authorised by the patient, any information provided by me in connection with this form for any of the purposes authorised by the patient.

GP/dentist's signature	Date signed: DD / MM / YY