Bereavement grant claim.

UniMed

If your policy starts with a number (not letters) this is your form.

This form is for Members on Hospital Select Plus Modules, UniCare Advantage and other Health Plans or group insurance schemes issued by UniMed.

Where a Member is covered under a Health Plan that includes the bereavement grant benefit, and the Member dies, the bereavement grant is payable to the surviving partner or to the person who is the verified next of kin. If the deceased has no verified 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).

Complete and return to us at claims@unimed.co.nz.

Any field marked by an asterisk (*) is mandatory and must be completed in all cases.

1. Claimant details

Please provide this information for the person we are paying the claim to:

Full name*

First name(s)

Last name

Address*

Street

Town/ city

Postcode

Email*

Contact phone number*

Relationship to the deceased*

Tick one to confirm status*

- ( ) I am a Member on the policy
- ( ) I am next of kin
- ( ) I am not next of kin but am responsible for funeral expenses/ arrangements

2. Details of the deceased

Name of deceased Member*

First name(s)

Last name

Membership number*

Date of birth (dd/mm/yy)*

Date of death (dd/mm/yy)*

3. Payment details

Name of account (e.g. John Smith)*

Account number*

4. Supporting documents

Copies of the following documents must be provided:

☐ Evidence of death* – copy of Death Certificate, coroner's report or certification from Funeral Director

☐ Evidence of claimant status* – a letter from the solicitor or copy of the deceased's Will

5. Declaration and authorisation

The personal information about you and the deceased is collected for the purpose of evaluating your claim.

Please refer to our Privacy Statement for more information about how your information will be used, our privacy practices, and your associated rights – unimed.co.nz/privacy.

Failure to provide the information requested may result in the claim being declined.

☐ **I declare all information provided in this form is true, correct and complete and that I have not omitted or misrepresented any information.**

☐ **I authorise UniMed to obtain from any party or organisation (including healthcare providers) any information reasonably required to evaluate and investigate this claim.**

Claimant full name | **Signature** | **Date signed** (dd/mm/yy)