

NEW ZEALAND AIRLINE PILOTS Mutual BENEFIT FUND

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CLAIM FORM

Important notes for claimant:

- There are four parts to this Claim Form – Part A: Details of my claim, Part B: Consents for release and disclosure of health and claim-related information, Part C: Documents required and Part D: Consents, authorisations and undertakings.
- You must fully complete all parts of the Claim Form. This includes declaration of private income from other sources – see Part A, My other sources of income, d).
- You must sign at the end of the Claim Form.
- You must provide all the requested documents.
- The trustees will not consider your claim until you have provided all the requested information and documents.
- To be considered for a benefit from the MBF you must have suffered “loss of licence”. This is defined in the rules. “Loss of licence” must be solely or primarily by reason of your disability. “Disability” is also defined in the rules.
- You have the right to access, and correct, information that you give to the MBF in support of your claim.

Part A: Details of my claim

Personal information:

I.....
(FULL NAME)

Date of birth: 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

Address: 0

0 0

Phone: Home 0 0 0 0 0 0 ..0 0 0 .0 Mob 0 0 .0 0 0 ..0 0 0 0 0 0 .0 0 0

Email (for information . including confidential medical and other private information or requests . to be sent to me): 0 .

being a member of the New Zealand Airline Pilots Mutual Benefit Fund (MBF) hereby make a claim on the MBF due to my loss of licence. This claim is made pursuant and subject to the MBF rules.

Loss of licence information:

Date of loss of licence:

Reason for loss of licence: 0

My employer is: 0 ..

My rank is: 0 ..

My sick leave entitlement:

My sick leave entitlement ends on: 0 .

Medical/health practitioner and medical assessor information:

My GP is Dr: 0 0

His/her contact details are: 0
0 0

My AME is: 0
His/her contact details are:

Address 0

Phone Number: 0 0 0 0 0 0 0 0 0 0 0 0 0 . Email address: 0 0 0 0 0 .0 0 0 0 0 0 0 ..

Fax Number: 0

In addition to my GP, I have consulted the following medical practitioners in respect of this disability/health issue:

Name	Phone	Email
.....
.....
.....
.....

I have seen the following other doctors, specialists, and other health professionals (e.g. psychologist, physiotherapist, etc) over the last 10 years:

Name	Phone	Email
.....
.....
.....
.....

My aviation medical examiner is Dr:

My other sources of income:

a) ACC: I am eligible for ACC: (Yes/No)

I get (or, if relevant, expect to get) the following monthly/fortnightly payments from ACC:

Amount: \$0 0 0 0 0 0 0 0 ...

b) GDI: I have a NZALPA GDI policy (Yes/No)

Amount: \$.....0 0 0 .. Stand down (days): 0 0 0 0 0 0 .

c) I have other disability income insurance/income protection insurance: (Yes/No)

Name: Amount: \$.....

Payment frequency: . Stand down: .

d) I have private income from other sources (refer to rule 7(k)): (Yes/No)

Source of Income: .. Amount per month: \$.....

Source of Income: .. Amount per month: \$.....

My bank account:

My bank account details are:

Bank and Branch: Account Name:

Bank and Branch Number: Account Number:

Part B: Consents for release and disclosure of health and claim-related information (including G.D.I./other disability income and employment information)

I (name) D.O.B: ..

of (address): ..

.....

consent to disclosure of my personal and health information as set out below.

Disclosure of medical and health information

I authorise and consent to the following people/organisations providing the trustees of the MBF, their medical advisor/s and/or any case manager/s appointed by the MBF with such medical details and health information as they may require in relation to the disability for which I lost my licence:

- My GP
- My aviation medical examiner
- Any other medical or health practitioners or health providers I have consulted for my health (including those I have named in Part A) or may consult (including but not limited to any I consult at the requirement of the MBF)
- The Medical Officers and other staff of the Civil Aviation Authority (CAA) or the Civil Aviation Safety Authority (CASA)
- My employer.

Disclosure of information on income, sick leave and my employment

I authorise my employer to provide the trustees of the MBF with such employment-related information as they may require in order to assess my entitlement to any benefit. I understand that this may include information about my performance, competency or conduct if the trustees are considering if my claim should be excluded under rule 6(e)viii).

Disclosure of other income

I give permission to the MBF to request the release of information regarding my G.D.I. policy or any other disability income insurance/income protection insurance I have and I correspondingly consent to the release to the MBF of any such information.

Use of my personal and health information

To determine eligibility for benefit and rehabilitation assessment

I acknowledge that the information:

- a) obtained under these consents;
- b) obtained under the authority in my membership application; and
- c) the information I have provided or may provide or consent to others providing to the MBF in relation to my claim

can be disclosed to:

- a) such medical practitioners;
- b) case managers; or
- c) other parties

as the trustees of the MBF and/or their medical advisor/s and/or their case manager/s consider necessary to:

- a) assess my entitlement to any benefit; or
- b) my right to continued membership of the MBF; or
- c) assist towards achieving my vocational rehabilitation; or
- d) ascertain whether my disability has improved sufficiently to enable my licence to be reinstated.

Use by the Fund's medical advisors and case managers

I acknowledge that:

- a) the information obtained as a result of my consents may form part of a report prepared for the MBF by their consultant medical advisor/s or case manager/s appointed by the MBF and may also be disclosed to any health professional from whom the MBF and/or its medical advisor/s and/or a case manager/s appointed by it seeks further advice on my medical condition or my disability or on rehabilitation options;
- b) the MBF's medical advisor/s and/or any case manager/s appointed by the MBF are entitled to disclose information about my medical condition or my disability to the CAA's or CASA's medical personnel, to the medical advisor for my employer, to my aviation medical examiner, or to any other health professional for the purpose of interpreting medical information (for instance, x-rays, laboratory results, or reports);
- c) if the MBF appoints a medical advisor to be my case manager, I authorise him/her to disclose to the trustees of the MBF any information I provide to him/her and any communications between us in relation to my claim;
- d) it will be necessary for the trustees and/or their medical advisor/s and/or any case manager/s appointed by the MBF to disclose the relevant parts of this Claim Form, or a copy of this form, and any other consents I have given (eg. in my membership application), to any medical or health practitioner or health provider who is approached to provide medical details or health information about me or to any other person or organisation covered by the consents.

Use for audit purposes

I also authorise the trustees and their medical advisor/s and case manager/s to disclose medical information held about me to the auditors of the MBF for audit purposes, to its actuary for actuarial purposes, and to other professional advisors who are engaged by the MBF where disclosure of such information is reasonably necessary to enable them to provide advice to the trustees. I understand that, where such disclosures are required, the trustees will use their best efforts to ensure that:

- a) such information will be provided in a form that does not identify me by name; and
- b) such information or copies of it are not removed or transmitted from the MBF's premises

unless either of those precautions is practically unavoidable for the purpose of the advice that is being sought.

Part C: Documents required

I attach the following to this Claim Form:

- Copy of CAA/CASA notice or statement verifying loss of licence and reason for loss of licence **OR** if medical certificate was not renewed, advise date of non-renewal
- If applicable, letter from my doctor or specialist outlining the reason for loss of licence
- Letter from my employer giving the date when all my sick leave entitlements will end
- Evidence of my net earnings during the month immediately before loss of licence (pay slips)
- Letter from my employer giving my gross taxable earnings less PAYE tax during the 12 month period immediately before loss of licence
- If on ACC or have other disability income insurance/income protection please provide proof of monthly/fortnightly payment details

Part D: Consents, authorisations and undertakings

I understand that these consents and authorisations will continue until such time as I advise otherwise in writing, and that even if I do withdraw my consent, such withdrawal will be subject to any applicable mandatory disclosure obligations that may be imposed by legislation.

I understand that:

- any delay in giving the acknowledgments and consents in this form may delay the approval of my claim; and
- if I withdraw my consents or acknowledgments that may put at risk any entitlement I may have established previously to receive benefits from the MBF.

I undertake to advise the MBF as soon as my licence is reinstated and I acknowledge that my entitlement to a benefit will cease as from the date of re-instatement of my licence.

I confirm that the information provided in this Claim Form is complete, true and correct, and I consider that my claim meets the rules of the MBF.

Signature: õ

Name: õ ..

Date: õ