Claim for Disablement Pension

Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Use this form to apply for a new condition or to apply for reassessment of your previously accepted conditions.

Information for claimant (page 1 of 2)

Eligibility for a Disablement Pension

You may be eligible if:

- you served before 1 April 1974 or in Viet Nam and,
- you suffer disablement as a consequence of a service-related medical condition, injury or illness.

Only claim for a medical condition, injury, or illness if you believe it is related to your service.

You may claim for a Disablement Pension whether you live in New Zealand or overseas.

Transferring from a War Disablement Pension to a Disablement Pension

If you are currently receiving a War Disablement Pension and you apply for a new condition or a reassessment of an accepted condition, you will be transferred to a Disablement Pension.

Eligibility for reassessment of your Disablement Pension or War Disablement Pension

You may be eligible for a reassessment of previously accepted conditions if:

- you can provide additional medical information that identifies significant deterioration in your previously accepted condition and,
- your condition was accepted as permanent more than two years ago.

Reassessment of hearing loss and tinnitus:

- Once hearing loss is accepted as a service related condition, we don't reassess unless there are exceptional circumstances. If you think your situation is exceptional, please give us a call to discuss.
- Our policy is based on scientific opinion that noise-induced hearing loss doesn't continue to worsen once a person is removed from the noisy environment.
- If tinnitus is accepted as a service related condition, the maximum rate has already been granted to you. Therefore, we do not reassess tinnitus.

Help completing this form

- A family member, someone from your local RSA, or someone else you trust can help you complete this form.
- If you are unable to complete and sign this form due to physical or mental incapacity, it must be signed by a person with authority to act on your behalf.

Information for claimant (page 2 of 2)

How to claim

1. Book a 45–60 minute appointment with your doctor or health practitioner to discuss your claim. They will complete their sections of **questions 21–29**.
2. You can claim for reimbursement of travel and the cost of this appointment. Attach the appointment receipt to this claim form and complete an **Approved Travel - VA23** form. You can find this form on our website www.va.mil.nz/forms
3. Complete **questions 1–22** of this form, including the **claimant** sections of **questions 21–22**. The more information you give us about your service and your medical condition, the more informed our decision will be.
4. Read and sign **page 3**.
5. Use the **Claimant's checklist** on **page 4** to make sure your application is complete. Attach any medical or scientific evidence you have to support your application. You can find more information at: www.va.mil.nz/how-to-make-a-claim
6. Send us your completed and signed claim form. You can either:
   - scan or take photos of the completed form and attachments, and email it to: veterans@nzdf.mil.nz
   - post the completed form and the attachments to: Veterans' Affairs, PO Box 5146, Wellington 6140.

What happens next

- We may need more information from you or from other people such as a medical specialist. We won't be able to make a decision until we receive this.
- We will pay for these appointments and will reimburse your travel costs if we need you to have additional assessments.
- Once a decision has been made, we will tell you what we've decided and why.

Your obligations

Your obligations are described in section 27 of the Veterans' Support Act 2014. In summary:

- you must give us all the information we need to assess your claim
- you may be required to participate in additional assessments for the purpose of making a decision in relation to your claim
- the information you give us must be true, full and correct to the best of your knowledge. If we find out later that you gave us false or misleading information, your Disablement Pension could be stopped and you may be prosecuted.

Any questions?

Contact us:

- New Zealand freephone 0800 483 8372
- Australia 1800 483 837
- Rest of the world +64 4 495 2070
- or email veterans@nzdf.mil.nz

For more information visit our website www.va.mil.nz

Privacy Statement

You can read our full privacy statement on our website

Your personal information is managed in accordance with the privacy statement on our website:

- www.va.mil.nz/privacy

If you would like a copy of this posted to you please contact us:

- 0800 483 8372 from New Zealand
- +64 4 495 2070 outside New Zealand

Signature

This form must be signed either by the claimant or a person with the authority to act on the behalf of the claimant if they are unable to do so.

If the claimant didn't sign the form, **include one** of the following forms of evidence:

- Power of Attorney or Enduring power of Attorney (in relation to Property)
- Certificate of Administration (from the Public Trustee)

I acknowledge that:

- the information I have given in this claim form is true and correct
- Veterans' Affairs may obtain further information to assess and decide on my claim
- I have read and understood the Privacy Statement for Forms on www.va.mil.nz/privacy
- I authorize the collection and disclosure of health, clinical, or other personal information by or to Veterans' Affairs or by or to named agencies held by any doctor or health practitioner or named agencies, or service providers (such as ACC), or contractors for the purposes set out in the privacy statement; for the purposes of assessment of this claim; administration of any resulting entitlement; and the provision of any services, treatment or rehabilitation under the Veteran's Support Act 2014.
- I have read my obligations in the 'Information for Applicant' section at the start of this form.

Signature | Please sign

Claimant or authorised person

Signature of claimant or authorised person:

Today's date: (DD/MM/YYYY)

/ /

First names:

Surname:

Helper | Complete this section if you've helped the claimant to complete this form.

Helper's relationship to claimant:

First names:

Surname:

Claimant's checklist

If this is your **first application** (tick once completed)

- [ ] Attach **one** of the following forms of identification (ID):
    - full birth certificate—if you supply us with a birth certificate, we will also require another form of ID with your signature
    - current passport
    - driver licence
    - firearms licence
    - SuperGold card.

  If you don't have any of the above forms of ID, please contact us on 0800 483 8372.

- [ ] Attach all information that supports your claim, such as a recent report from a doctor or health practitioner.

- [ ] Ensure the doctor or health practitioner has:
    - completed their sections of question 21–29
    - attached any supporting documentation
    - signed page 3.

- [ ] Attach the receipt for your doctor's appointment and approved travel form if claiming reimbursement.

- [ ] Read the Privacy Statement on page 3.

- [ ] **Sign the completed form on page 3.**

If you already receive a War Disablement Pension or Disablement Pension (tick once completed)

- [ ] Attach additional information in support of your claim, such as a recent report from a doctor or medical practitioner.

- [ ] Ensure the doctor or health practitioner has:
    - completed their sections of question 21–29
    - and attached any supporting documentation
    - signed page 14.

- [ ] Attach the receipt for your doctor's appointment and approved travel form if claiming reimbursement.

- [ ] Read the Privacy Statement on page 3.

- [ ] **Sign the completed form on page 3.**

Your personal details

1 What is your title?

☐ Mr ☐ Mrs ☐ Ms ☐ Miss Other

2 What is your full name?

First name

Middle name/s

Family name

Preferred name

3 When were you born?

☐☐ ☐☐ ☐☐☐☐ D D / M M / Y Y Y Y

4 What is your **Work and Income** number?

This is needed for the purpose outlined in the Privacy Statement on page 3.

You can find this number on your SuperGold Card or Community Services Card if you have one. If you don't know this number please leave it blank.

☐☐☐☐☐☐☐☐☐

5 What ethnic group do you most identify with?

☐ Asian

☐ European

☐ Māori

☐ Pacific Peoples

☐ Other

☐ Prefer not to answer

If this is your **first application**, go to question 7.

If you **already receive** a War Disablement Pension or Disablement Pension and need to update any details, please complete question 6 before moving on to question 17, **Your medical background**.

6 Updated personal details or circumstances

This could include your living or postal address, other contact details, relationship status, next of kin details, dependant children, bank details, employment, or service history.

7 Where do you live?

Street address

Suburb

City

Country

Postcode

8 Is your postal address different from where you live?

☐ No

☐ Yes ➡ **Please enter your postal address below**

Street address

Suburb

City

Country

Postcode

9 Please enter your contact details.

Email

Mobile phone

Work phone

Home phone

We will email you to verify this email address

10 Which bank account do you want payments to be made to?

Account name

Account number

Bank Branch Account number Suffix

Your service history

11 What is your service number?

☐☐☐☐☐☐☐☐

12 When did you serve?

Commenced ☐☐ ☐☐☐☐ M M / Y Y Y Y

Ended ☐☐ ☐☐☐☐ M M / Y Y Y Y

If you had more than one period of service, please provide the dates below

13 Were you deployed overseas?

☐ No

☐ Yes ➡ **Please enter your deployment details below**

Operational deployment	Role on deployment	Approx. start (MM/YYYY)	Approx. end (MM/YYYY)

14 Were you a Prisoner of War?

☐ No

☐ Yes

Your non-military employment

15 Please tell us about your employment immediately **before** your service in the New Zealand Armed Forces.

☐ Not employed

☐ Employed ➡ **Please enter your employment details below**

Employer:

Nature of work:

Approximate start (year) Approximate end (year)

16 Please tell us about your employment immediately **after** your service in the New Zealand Armed Forces.

☐ Not employed

☐ Employed ➡ **Please enter your employment details below**

Employer:

Nature of work:

Approximate start (year) Approximate end (year)

Your medical background

The development of some conditions can be linked to smoking and alcohol use. If you tick **Yes** to whether you smoked or drank alcohol during your service, we may seek further information from you.

17 Did you ever smoke during your service?

- ☐ No
- ☐ Yes

18 Did you ever consume alcohol during your service?

- ☐ No
- ☐ Yes

19 What medical practice do you normally go to?

Do you normally see the same doctor there?

- ☐ No
- ☐ Yes ➡ **Please enter their name below**

20 Have you applied to any agency such as ACC, NZDF Accredited Employment Programme (AEP), or other insurer for any of the medical conditions, injuries or illnesses you are claiming? This includes any hearing claims.

- ☐ No
- ☐ Yes ➡ **Please enter the details below**

Medical condition	Agency	Approx. date of claim (year)

Information required to complete the conditions claimed

Claimant:

- We need some medical information to assess or reassess your claim.
- Complete the **Claimant to complete** section for each separate medical condition, injury, or illness that you are claiming. Additional copies of this section are provided after page 14.
- Take this form to the medical appointment so that your doctor/medical practitioner can complete their sections.

Doctor or Health Practitioner:

We consider all the information provided by you and your patient before applying the decision tools prescribed in the Veterans' Support Act 2014.

A connection to eligible service must be demonstrated for each condition before we approve the claim.

Please complete the **Doctor or health practitioner to complete** section for each condition that your patient has listed in questions 21 and 22. You need to include:

- the clinical diagnosis that you associate with each condition
- a summary of any past or current treatments for each condition
- include copies of clinical notes and documents related to each diagnosis, including any specialist assessments or reports and,
- in the case of reassessment, please provide clinical evidence of how a previously accepted condition has significantly deteriorated.

Once completed, return the form, along with any supporting documentation, to your patient.

If you have any questions, contact us on:

- New Zealand freephone 0800 483 8372
- Australia 1800 483 837.

Claiming for a new medical condition

21 Fill out a separate page for each **new** medical condition, injury, or illness you are claiming for.

Condition 1 — claimant to complete

What is the medical condition, injury, or illness you are applying for? Describe any symptoms, for example, pain in left arm, shortness of breath, hearing loss.

When did you first start experiencing this problem?

How has this impacted your daily life?

How do you think your service has caused or contributed to this problem?

Condition 1 — doctor or health practitioner to complete

What is the diagnosis for the condition described above?

How has this condition been treated in the past?

How is this condition currently being treated?

Is your patient seeing a specialist for this condition, or have they seen a specialist for this condition in the past?

☐ No.

☐ Yes. **If yes:**
- **Include copies of clinical notes and reports from the specialist.**
- **Enter the specialist name, contact details, and when they were seen:**

Claiming for reassessment of an accepted condition

22 Fill out a separate page for each **existing** accepted condition you are claiming reassessment for.

Condition 1 — claimant to complete

What is the accepted condition you are wanting reassessed?

Describe how your accepted condition has deteriorated

Condition 1 — doctor or health practitioner to complete

What is the diagnosis for the condition described above?

How has this condition been treated in the past?

How is this condition currently being treated?

Describe how this condition has significantly deteriorated since the last assessment.

Is your patient seeing a specialist for this condition (or have they seen a specialist for this condition in the past)?

☐ No

☐ Yes **If yes:**
- **Include copies of clinical notes and reports from the specialist.**
- **Enter the specialist name, contact details, and when they were seen:**

Doctor or health practitioner to complete

23 What is the claimant's full name?

First name

Family name

24 What is the claimant's NHI number, or equivalent in your country?

25 When did the claimant enrol with your practice?

M M / Y Y Y Y

26 Are any of the conditions the claimant has applied for terminal, that is, likely to cause death within 12 months?

No

Yes ➡ **Please enter the condition below**

27 What is your full name?

First name

Family name

28 What is your practice phone number?

29 What is your practice email?

Please stamp your practice stamp, otherwise write your full contact details

Signature

D D / M M / Y Y Y Y

Claiming for a new medical condition (Optional — spare page if needed)

30 Fill out a separate page for **each new** medical condition, injury, or illnessyou are claiming for.

Condition ☐ — claimant to complete

What is the medical condition, injury, or illness you are applying for? Describe any symptoms, for example, pain in left arm, shortness of breath, hearing loss.

When did you first start experiencing this problem?

How has this impacted your daily life?

How do you think your service has caused or contributed to this problem?

Condition ☐ — doctor or health practitioner to complete

What is the diagnosis for the condition described above?

How has this condition been treated in the past?

How is this condition currently being treated?

Is your patient seeing a specialist for this condition, or have they seen a specialist for this condition in the past?

☐ No.

☐ Yes. **If yes:**
- **Include copies of clinical notes and reports from the specialist.**
- **Enter the specialist name, contact details, and when they were seen:**

Claim for reassessment of an accepted condition (Optional — spare page)

31 Fill out a separate page for **each existing** accepted condition you are claiming reassessment for.

Condition ☐ — claimant to complete

What is the accepted condition you are wanting reassessed?

Describe how your accepted condition has deteriorated.

Condition ☐ — doctor or health practitioner to complete

What is the diagnosis for the condition described above?

How has this condition been treated in the past?

How is this condition currently being treated?

Describe how this condition has significantly deteriorated since the last assessment.

Is your patient seeing a specialist for this condition (or have they seen a specialist for this condition in the past)?

☐ No

☐ Yes **If yes:**
- **Include copies of clinical notes and reports from the specialist.**
- **Enter the specialist name, contact details, and when they were seen:**