E: paymentwaiver@oxf.co.nz
Freephone: 0800 88 44 68
www.oxfordfinance.co.nz

PO BOX 331248 Takapuna,
Auckland 0740

INCAPACITY WAIVER REQUEST FORM

Please return this waiver request form promptly to us with all questions fully answered and the MEDICAL REPORT on the reverse side of this form completed by your medical practitioner.

1. Personal Details

Surname..... First name .....

Date of birth ..... Loan number.....

Address ..... Suburb/Town .....

Telephone....( ).... Email.....

Name of employer..... Contact person .....

2. Illness Details

Date first contracted ..... Date first sought medical advice.....

Description of illness.....

Date illness diagnosed..... By whom .....

3. Injury Details

Place where injury was suffered .....

Time.....am / pm Date ..... Date you sought medical advice.....

What were you doing at the time?.....

How was it caused? .....

What injuries have you suffered? .....

Name and address of any witnesses.....

4. Hospitalisation Details

Date and place admitted to hospital .....

Medical practitioner consulted ..... Date discharged.....

Hospital contact details and address:.....

5. General Details

Have you been able to do limited work duties? ☐ Yes ☐ No

Provide details.....

Have you been engaged in any other occupation? ☐ Yes ☐ No

Provide details.....

Have you ever previously met with a similar injury or illness? ☐ Yes ☐ No

If so, give particulars (date, duration etc) .....

.....

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INCAPACITY WAIVER REQUEST FORM AND MEDICAL REPORT

5. General Details cont.

I have been unable to work for.....days....

From date..... To date.....

If still disabled please state how much longer this is likely to continue.....

Name of your doctor.....

Address ..... Suburb/Town .....

If you have known him/her for less than three years, who was you previous doctor?.....

6. Declaration and Privacy Act 1993

I acknowledge that this waiver request form collects personal information concerning me pursuant to the terms of the payment waiver terms and conditions for the purposes of evaluating my waiver request. The personal information provided in this waiver request form is collected by and will be held by Oxford Finance Limited. I have the right to access and to correct this information subject to the provisions of the Privacy Act 1993.

I authorise the use and disclosure of my personal information to Oxford Finance and others for the purposes of assessing my waiver request. I authorise any medical practitioner/s I have consulted to provide information and documents recording my medical condition and medical history.

I declare that all statements made in this form are true and correct and that no material has been withheld. I acknowledge that if I have not answered any questions correctly, completely or faithfully, my waiver request may be declined. I acknowledge that any approved waiver amount will be applied to my loan with Oxford Finance.

Signature of Customer X ..... Date .....

Medical Report - To be completed by your Medical Practitioner – **please print clearly**

1. Name of patient..... 2. Name of medical practitioner.....

3. Medical Practitioner contact details:

Postal address ..... Suburb/Town .....

Telephone....( ).... Email.....

4. What is your patient's occupation, business or profession? .....

5. Are you the patient's usual medical practitioner? ☐Yes ☐No If 'Yes', how long has he/she been a patient? .....

6. State the nature and extent of the injuries or illness:.....

.....

.....

7. What do you believe is the cause of the injury or illness?.....

.....

.....

.....

.....

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INCAPACITY CLAIM FORM AND MEDICAL REPORT cont.

8. Please give details of the treatment given:.....

.....

.....

9. Is the patient (to your knowledge) complying with your treatment instructions? ☐ Yes ☐ No

10. On what date did you first attend the patient in connection with this condition? .....

11. To your knowledge, has the patient previously suffered from this condition? ☐ Yes ☐ No

If 'Yes', please provide full details including when the condition was first diagnosed.....

.....

.....

12. Do you consider this injury or illness is terminal or will result in permanent disablement? ☐ Yes ☐ No

If 'Yes', please give details.....

.....

13. Has the patient been referred to a specialist or, do you intend to refer the patient to a specialist? ☐ Yes ☐ No

If 'Yes', please provide name and address of specialist .....

.....

14. To your knowledge, was the injury self-inflicted (if applicable)? ☐ Yes ☐ No

15. Is this condition directly or indirectly related to AIDS or an AIDS related condition, alcohol, drugs or poison? ☐ Yes ☐ No

If 'Yes', please give details.....

.....

16. Is the claimant suffering from any other conditions (additional to that described in question 6)? ☐ Yes ☐ No

If 'Yes', please state the nature of the condition and to what extent recovery may be affected:.....

.....

.....

.....

17. Please confirm – Patient has been unable to work from (date) .....

18. When do you expect the patient will resume: Part of their work?.....

Full time duties?.....

General remarks.....

.....

.....

Signature of Medical Practitioner X ..... Date .....