

Disablement Pension

APPLICATION FORM



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 1 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 21–27**.
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 freephone 1800 483 837
- Rest of the world +64 4 495 2070
- Or email us at veterans@nzdf.mil.nz

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

Privacy Statement

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 the privacy statement posted to you, please email veterans@nzdf.mil.nz to request it.

Signature and acknowledgement

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 claimant' section at the start of this form.

Claimant's or authorised person's signature

Signature of claimant or authorised person:

First names:

Surname:

Today's Date:

/ /

Helper | Complete this section if you've helped the claimant to complete the 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 the Veterans' Affairs website, at www.va.mil.nz/privacy
- 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 the Veterans' Affairs website, at www.va.mil.nz/privacy
- 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 names

Family name

Preferred name

3 What is your date of birth?

 / /

4 What is your Work and Income number?

This is needed for the purpose outlined in the Privacy Statement on the Veterans' Affairs website, at www.va.mil.nz/privacy

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

Your personal details *continued ...*

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	<input type="text"/>		
Suburb	<input type="text"/>		
City	<input type="text"/>	Postcode	<input type="text"/>
Country	<input type="text"/>		

8 If your postal address is different to where you live, enter details below.

Street address	<input type="text"/>		
Suburb	<input type="text"/>		
City	<input type="text"/>	Postcode	<input type="text"/>
Country	<input type="text"/>		

Your personal details *continued ...*

9

Please enter your contact details.

Email

We will contact you to verify this address

Home phone

Mobile phone

Work phone

10

What bank account do you want payments to be made to?

Name of the account

You must attach **one** of the following



A bank account statement, printout, or letter issued within the last six months that includes the bank's letterhead and stamp, **account holder's name and the account number**, or



A screenshot from a banking app or website that displays **all** of the following:

- The account holder's full name
- The name or logo of the bank, and
- The bank account number.

Your service history

11 What is your service number?

12 When did you serve?

Commenced / /

Ended / /

↓ 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

What was your employment immediately **before** your service in the New Zealand Armed Forces?

Not employed

Employed **↓ Enter your employment details below**

Employer

Nature of work

Approximate start

Approximate end

16

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

Not employed

Employed **↓ Enter your employment details below**

Employer

Nature of work

Approximate start

Approximate end

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 Which medical practice do you normally go to?

Do you normally see the same doctor or health practitioner there?

- No
 Yes **↓ 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 **↓ Enter the details below, including the claim number if known**

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.

Claim for a new medical condition

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

Condition number **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 number **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  **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

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

Condition number **1** — **claimant** to complete

What is the accepted condition you are wanting reassessed?

Describe how your accepted condition has deteriorated

 Condition number **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.x

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

No

Yes  **Attach 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

Middle names

Family name

24

What is your patient's National Health Index (NHI) number, or equivalent in your country?

25

When did your patient enrol with your practice?

 /

26

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

No

Yes **↓ Enter the condition below**

27

Health practitioner information

First name

Family name

Practice phone

Practice email

What is your CPN (HPI number)?

What is your Medical Council registration number?

Stamp your practice stamp, otherwise write your full contact details

Signature

Today's Date:

 / /

Claim for a new medical condition (Optional – spare page if needed)

21

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

Condition number — **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 number — **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  **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)

22

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

Condition number — **claimant** to complete

What is the accepted condition you are wanting reassessed?

Describe how your accepted condition has deteriorated

 Condition number — **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.x

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

No

Yes  **Attach copies of clinical notes and reports from the specialist.**

 **Enter the specialist name, contact details, and when they were seen.**