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.
How to claim

Book a 45–60 minute appointment with your doctor or health practitioner to discuss your claim. They will complete questions 21–28.

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.veteransaffairs.mil.nz

Use the Claimant's checklist on page 3 to make sure your application is complete.

Read and complete the Signature page on page 16.

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.veteransaffairs.mil.nz
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 21–28
  - and attached any supporting documentation
  - signed page 13.

☐ Attach the receipt for your doctor’s appointment and approved travel form if claiming reimbursement.

☐ Read the Privacy Statement on pages 14–15.

☐ **Sign the completed form on page 16.**

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 21–28
  - and attached any supporting documentation
  - signed page 13.

☐ Attach the receipt for your doctor’s appointment and approved travel form if claiming reimbursement.

☐ Read the Privacy Statement on pages 14–15.

☐ **Sign the completed form on page 16.**
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?
   - DD / MM / YYYY

4. What is your Work and Income number?
   This is needed for the purpose outlined in the Privacy Statement on page 14.
   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**.

### 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.

### Where do you live?

- Street address
- Suburb
- City
- Country
- Postcode

### Is your postal address different from where you live?

- No
- Yes  ➔ Please enter your postal address below

- Street address
- Suburb
- City
- Country
- Postcode
Please enter your contact details.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile phone</td>
<td>( )</td>
<td>Work phone</td>
</tr>
<tr>
<td>Home phone</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

We will email you to verify this email address

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

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Account name</td>
<td></td>
<td>Account number</td>
<td>Suffix</td>
</tr>
<tr>
<td>Bank</td>
<td>Branch</td>
<td>Account number</td>
<td>Suffix</td>
</tr>
</tbody>
</table>
### Your service history

11. What is your service number?

12. When did you serve?

<table>
<thead>
<tr>
<th>Commenced</th>
<th>Ended</th>
</tr>
</thead>
<tbody>
<tr>
<td>M M / Y Y Y Y</td>
<td>M M / Y Y Y Y</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Operational deployment</th>
<th>Role on deployment</th>
<th>Approx. start (month/year)</th>
<th>Approx. end (year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M M / Y Y Y Y</td>
<td>M M / Y Y Y Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M M / Y Y Y Y</td>
<td>M M / Y Y Y Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M M / Y Y Y Y</td>
<td>M M / Y Y Y Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M M / Y Y Y Y</td>
<td>M M / Y Y Y Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M M / Y Y Y Y</td>
<td>M M / Y Y Y Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M M / Y Y Y Y</td>
<td>M M / Y Y Y Y</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

### 18 Did you ever consume alcohol during your service?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

### 19 What medical practice do you normally go to?

Please enter the details below

Do you normally see the same doctor there?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Please enter the details below

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>Agency</th>
<th>Approx. date of claim (year)</th>
</tr>
</thead>
</table>
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 16.
- 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

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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>When did you first start experiencing this problem?</td>
<td></td>
</tr>
<tr>
<td>How has this impacted your daily life?</td>
<td></td>
</tr>
<tr>
<td>How do you think your service has caused or contributed to this problem?</td>
<td></td>
</tr>
</tbody>
</table>

#### Condition 1 — doctor or health practitioner to complete

What is the diagnosis for the condition described above?

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How has this condition been treated in the past?</td>
<td></td>
</tr>
<tr>
<td>How is this condition currently being treated?</td>
<td></td>
</tr>
</tbody>
</table>

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

- [ ] No
- [ ] Yes

Please enter the specialist name, contact details, and when they were seen, below.

<table>
<thead>
<tr>
<th>Specialist Name</th>
<th>Contact Details</th>
<th>When Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Claim for Disablement Pension**

VA01—April 2021

Claim for Disablement Pension

Page 11 of 16
Claiming for reassessment of an accepted condition

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?

Please describe how this condition has significantly deteriorated since the last assessment.

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

- No
- Yes  
  **Please enter the specialist name, contact details, and when they were seen, below**
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?
   MM / YY YY YY

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
   DD / MM / YY YY YY YY
This is our Privacy Statement. It tells you:

- why we collect your information
- how we collect, use, and share your information
- your rights to see your information and ask for it to be corrected if it's wrong.

We will always treat your information with respect and keep it safe to protect your privacy.

**Collecting your information**

Collection of your information is authorised by the Veterans’ Support Act 2014 and its regulations.

We only collect information needed to manage the entitlements we administer.

There’s certain information we need in order to accept your claim and provide you with an entitlement, service, or payment. You can choose not to give us this information but it may mean that your claim cannot be processed or may be declined.

We collect your personal information so we can:

- contact you
- identify you
- better assess your claim for entitlements or services
- and look at what other services you may be eligible for under the Veterans’ Support Act 2014.

We collect this information from you through our forms and through other interactions with you. We also collect your information from other people and organisations. We hold all the information that we collect about you.

**Using your information**

We use your information to:

- make decisions about you in relation to claims, entitlements and services under the Veterans’ Support Act 2014
- consider and review how we operate
- improve our processes and services, through monitoring of the operation of the Act and policy/law reform development.
Veterans’ Affairs Privacy Statement

Sharing your information

We sometimes need to share your information with people or organisations outside of Veterans’ Affairs. We share your information when:

- you give us permission to share it
- legislation authorises it
- we have legal authority to do so, under the Privacy Act 2020
- our reason for sharing the information matches the reason why we collect it.

Your information may be shared with other Government agencies for several purposes. The agencies that we share information with are listed below.

- The Ministry of Social Development, for provision of the Veteran’s Pension and consistency with other benefits.
- Accident Compensation Commission, for consistency with other claims.
- Maritime New Zealand, for Merchant Navy records.
- Inland Revenue, for personal income information on the rate assessment of taxable entitlements.
- Archives New Zealand, for service records.
- The Department of Internal Affairs, to verify your birth, birth of any children who may have entitlements, marriage and/or nationality records.

Veterans’ Affairs may exchange information about you with your health practitioners in order to:

- provide you with the correct entitlements and assistance
- clarify any health-related information you give us
- put in place treatment and rehabilitation if required.

Veterans’ Affairs may share your personal information, as well as next of kin information, with our service providers or contractors to enable them to provide support to you, for example the Veteran’s Independence Programme (VIP).

You have the right to access and correct your personal information

- You may access personal information that we hold about you.
- You can ask us to correct errors contained in the information we have about you.

Questions or concerns about your information

You can contact us at anytime if you have concerns on what information about you we are collecting, how it is being used, or how it may be used.

Please read and sign the next page
Signature page

This form must be signed by a person with authority to act on behalf of the claimant, if they are unable to sign due to physical or mental incapacity. If this situation applies, a copy of one of the following must be attached:

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

Claimant

I acknowledge that:

- The information I have given in this claim form is true and correct
- Veterans' Affairs may obtain further information in order to assess and decide on my claim
- I have read and understand the Privacy Statement on pages 14–15
- I authorise the collection and disclosure of health, clinical or other personal information, by or to Veterans' Affairs, held by any health practitioner or other named agencies, service providers, or contractors for the purpose of assessment of this claim, administration of any resulting entitlement, provision of any services, treatment or rehabilitation under the Veteran’s Support Act 2014
- I have read and understood my obligations described on page 1.

Claimant/authorised person name:  
Claimant/authorised person signature:  

D D / M M / Y Y Y Y

Helper

Please complete this section if you’ve helped the claimant to complete this form.

Helper name:  
Helper’s relationship to claimant:  

Page 16 of 16
Claiming for a new medical condition

**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.

[Blank space for description]

When did you first start experiencing this problem?

[Blank space for description]

How has this impacted your daily life?

[Blank space for description]

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

[Blank space for description]

**Condition □ — doctor or health practitioner to complete**

What is the diagnosis for the condition described above?

[Blank space for description]

How has this condition been treated in the past?

[Blank space for description]

How is this condition currently being treated?

[Blank space for description]

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

□ No

□ Yes  ➤ Please enter the specialist name, contact details, and when they were seen, below

[Blank space for description]
### Claiming for reassessment of an accepted condition

#### 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?

[ ]

Please describe how this condition has significantly deteriorated since the last assessment.

[ ]

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

[ ] Yes

[ ] No

Please enter the specialist name, contact details, and when they were seen, below:

[ ]

[ ]

[ ]

[ ]