Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Independence Allowance Lump Sum (Scheme Two)

Claimant's Personal Details

1	**Veterans' Affairs number (if known)**																				
2	**Title**	Rank			Mr		Mrs		Ms		Other										
3	**Last name**																				
4	**First name/s**																				

12 month lump sum

5 ☐ **I wish to have my Independence Allowance paid in a 12 month lump sum.**

Prior to the end of the 12 month period, covered by the Independence Allowance lump sum, you will be asked if you wish to receive a further 12 month Independence Allowance lump sum.

If we do not hear from you, your Independence Allowance will automatically change back to fortnightly payments.

If at anytime thereafter you wish to receive a 12 month Independence Allowance lump sum, you will need to complete this form again.

Send your completed application to:

Veterans' Affairs
PO Box 5146
WELLINGTON 6140

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, held by any doctor or health practitioner or named agencies, or service providers, 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.

Signature | Please sign

Claimant or authorised person

Claimant or authorised person name

Claimant or authorised person signature

D D / M M / Y Y Y Y

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

Helper name

Helper's relationship to claimant