Veteran Support form

Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Use this form if you have a condition (an illness or injury) you believe is related to your qualifying operational service on or after 1 April 1974, and you want to apply for any of the following.

- Financial compensation.
- Treatment and rehabilitation.
- Income Compensation.

Financial compensation, treatment and rehabilitation

You may be eligible for financial compensation and/or treatment and rehabilitation if your condition is related to your qualifying operational service on or after 1 April 1974.

You will have qualifying operational service if you were sent to an area that has been declared as qualifying operational service, as listed on our website. For more information, see: **www.va.mil.nz/list-of-qos**

Reassessment

You can apply for an annual reassessment of financial compensation and/or treatment and rehabilitation if you think the level of impairment from an accepted condition has changed.

Weekly Compensation

You may be eligible for Weekly Compensation if you are unable to work fulltime because of a condition related to your qualifying operational service on or after 1 April 1974.

Weekly Compensation focuses on treatment and rehabilitation to help you return to work when you're able.

Your obligations

Your obligations, described in section 27 of the Veterans' Support Act 2014, are summarised below.

- You must give us all the information we need to assess your claim.
- You may be required to participate in 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, the claim may be closed, and any compensation may be stopped.

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 17–24**.
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 1–19** of this form, including the **claimant** sections of **questions 17–19**. 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 will not be able to make a decision until we receive this.
- We'll pay for any medical assessments required.
- Once a decision has been made, we'll tell you what we've decided and why.
- If you're applying for Weekly Compensation, we need some information from Inland Revenue about your income. Contact us and we'll send you a consent form to complete and return with your claim form. This consent form enables Inland Revenue to provide us with information about income you've received in New Zealand.

Help completing this form

- You can ask someone you trust to help you complete this form. This might be whānau or family, someone from your local RSA, or a Veterans' Affairs Case Manager.
- If you're 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. Evidence of this authority must be provided with the application.

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

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** to Veterans' Affairs:

- [ ] Attach a copy of **one** of the following forms of identification (ID) with your signature:
  - passport
  - driver licence
  - firearms licence

  Full birth certificate – if you supply us with a birth certificate, we will also require another form of ID with your signature.

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

For **all** applications:

- [ ] Ensure your doctor or health practitioner has:
  - completed all their relevant questions and attached any related medical records or documents
  - signed page 15.
- [ ] Attach the receipt for your doctor or health practitioner's appointment and approved travel form if claiming reimbursement.
- [ ] **Sign and complete page 3.**

If you're applying for **Weekly Compensation**:

- [ ] Complete the additional information on page 14.

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? ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

4 What ethnic group do you most identify with?

☐ European

☐ Māori

☐ Pacific Peoples

☐ Asian

☐ Other

☐ Prefer not to answer

5 Where do you live?

Street address

Suburb

City

Country Postcode

Your personal details

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

Address

Suburb

City

Country

Postcode

7 What are your contact details?

Email

We will contact you to verify this address

Home phone

Mobile phone

Work phone

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

Account name

Account number

Bank — Branch — Account number — Suffix

9 Do you have a Work and Income number?

☐ No

☐ Yes ➡ **Enter the number below**

If you don't know this number, please leave it blank.

Your service history

10 What is your service number? ☐☐☐☐☐☐☐☐

11 Are you still serving?

☐ No – fill out both enlistment and discharge dates.

☐ Yes – fill out enlistment date only.

Enlistment ☐☐/☐☐☐☐ (MM/YYYY)

Discharged ☐☐/☐☐☐☐ (MM/YYYY)

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

12 Do you have operational service?

☐ No

☐ Yes ➡ **Enter your service details below**

Operational service	**Approximate start date** (MM/YYYY)	**Approximate end date** (MM/YYYY)

Your non-military employment

13 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 (year)

Approximate end (year)

14 What was 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 (year)

Approximate end (year)

Your medical information

15 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**

16 Have you applied to other agencies or insurers for any of the conditions you are claiming for, including hearing? This includes ACC, and NZDF Accredited Employment Programme (AEP).

☐ No

☐ Yes ➡ **Enter the details below, including the claim number if known**

Claimed condition	Agency	Year	Claim number

Information for completing claim forms

Claimant

- Complete the **Claimant to complete** section for each separate condition you are claiming. Additional copies of this section are provided on page 17 and 18.
- Only apply for conditions which relate to your qualifying operational service.
- Take this form to the medical appointment so your doctor or health practitioner can complete their sections.
- If you are applying for Weekly Compensation, complete question 19.

Doctor or health practitioner

Complete the **Doctor or health practitioner to complete** section for each condition that your patient has listed. You need to include:

- the clinical diagnosis for each condition
- a summary of any past or current treatments for each condition
- copies of clinical notes and documents related to each diagnosis, such as specialist assessments or reports.

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

Guidance for Weekly Compensation

Weekly Compensation is available to veterans who are unable to undertake full-time employment (30 hours per week or more) due to a condition related to their qualifying operational service.

Veterans' Affairs will meet the cost of the consultation and assessment on receipt of the completed application and your invoice.

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**

Claim for a new condition

17 Fill out a separate page for **each new** condition you are claiming for.

Condition ☐ — claimant to complete

What is the condition 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?

Date of clinical onset ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

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

18 Fill out a separate page for **each accepted** condition you want reassessed.

Condition ☐ — claimant to complete

Name the accepted condition you want reassessed:

How is this condition affecting your daily life?

Condition ☐ — Doctor or health practitioner to complete

How is this condition currently being treated?

How has this condition 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:**

Claim for Weekly Compensation

19 Complete this section if you want to apply for **Weekly Compensation** because you are unable to work full-time (30 hours per week or more) due to a condition related to your qualifying operational service on or after 1 April 1974.

Claimant to complete

What has stopped you from working full-time (30 hours per week or more)?

Do you think the condition in the previous question is related to your military service? If yes, how?

Doctor or health practitioner to complete

Is your patient able to work 30 hours per week or more?

☐ Yes

☐ No ➡ **If no, what are the conditions causing your patient's inability to work?**

When was the first date the claimant become unable to work 30 hours per week or more?

☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Doctor or health practitioner to complete

20 What is your patient's full name?

First name

Family name

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

22 When did your patient enrol with your practice? / (MM/YYYY)

23 Are any of the conditions your patient has applied for likely to cause their death within the next 12 months?

No

Yes ➡ **Enter the condition below**

24 **Health practitioner information**

What is your 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

/ / (DD/MM/YYYY)

Claim for a new condition (Optional — additional page if needed)

17 Fill out a separate page for **each new** condition you are claiming for.

Condition ☐ — claimant to complete

What is the condition 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?

Date of clinical onset ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

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 existing accepted condition (Optional — additional page if needed)

18 Fill out a separate page for **each accepted** condition you want reassessed.

Condition ☐ — claimant to complete

Name the accepted condition you want reassessed:

How is this condition affecting your daily life?

Condition ☐ — Doctor or health practitioner to complete

How is this condition currently being treated?

How has this condition 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:**