



The New Zealand Anglican Church Pension Board

HEALTH FUND APPLICATION FOR GRANT

As part of its pastoral care for clergy and their families the Pension Board has established THE HEALTH FUND to assist retired clergy, clergy widows and orphans, and in specified circumstances, other dependants, in meeting some of the cost of MAJOR medical expenses they may incur. Assistance is by way of a charitable grant, and in accordance with a schedule of procedures and treatments for which grants are available.

New Zealand has a first-rate public health system, which promptly deals with serious medical conditions. In non life threatening situations the provision of treatments or tests may take longer.

THE HEALTH FUND is designed to supplement the public health system, NOT replace it. At the same time the Pension Board wants to ensure that clergy and their spouses maintain a good quality of life in retirement. The Board is aware that it is sometimes not possible to get treatment or diagnostic tests from the public health system when they are most needed. THE HEALTH FUND gives you "a back-up". If the public health system is unable to offer the appropriate treatment or it is going to take an unreasonable length of time to receive this treatment then the availability of THE HEALTH FUND grants allows you to discuss alternative arrangements with your doctor or specialist.

PLEASE COMPLETE ALL SECTIONS:

PERSONAL DETAILS

Name of applicant (Eligible person) _____

Address _____

_____ Phone No. _____

Name of person(s) receiving treatment _____

Applicants needing surgery, diagnostic imaging, or scans MUST investigate the availability of help from the Public Health System in the first instance. Please supply details of this [e.g specialist's report (including reason for work to be done earlier than waiting list period), length of waiting lists etc].

PLEASE ANSWER QUESTIONS ON NEXT PAGE

1. Attach original accounts, receipted or for payment (or send as soon as received).
2. Applications must be lodged within six months of the treatment.

**IF YOUR APPLICATION IS UNDER THE
FOLLOWING CATEGORIES**

SURGERY

- (a) General Surgery
- (b) Cardiac Treatments
- (c) Oral Surgery

OR

IMAGING

- (a) X-Ray, Ultrasound, Scintigraphy, Mammography etc
- (b) CT and MRI Scans

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Applicants needing surgery, diagnostic imaging, or scans must investigate the availability of help from the Public Health System in the first instance. Please supply details of this [eg specialist's report (including reason for work to be done earlier than waiting list period), length of waiting lists etc].

1. Is your procedure able to be carried out through the Public Health System?

YES / NO

2. If yes, how long is the waiting list for your procedure? **Please provide letter from local Health Board or Medical Practitioner.**

3. Does your specialist say work should be done within a shorter time than the waiting list period?

YES / NO

4. If answer to 3 is yes, then why? **Letter from Specialist giving reason, must accompany Application.**

CLAIMS

Please complete these details if you are claiming for surgical costs:

Name of Surgeon	Fee Charged	Date of Surgery	Description of Surgery	<u>Office Use</u>
Name of Anaesthetist	Fee Charged	Date(s)	Description of Treatment	
Name of Hospital	Fee Charged	Date(s)	Describe Charges <i>(or attach account)</i>	
Other Practitioner	Fee Charged	Date(s)	Description of Treatment	
<i>Sub Total</i>				

Please complete these details if you are claiming for non-surgical costs: (Over \$100)

Provider of Medical Service: <i>Specialist, Radiology, etc</i>	Fee Charged	Date(s)	Description of Illness/Treatment	<u>Office Use</u>
<i>Total</i>				HFD -\$ _____

- 1. PLEASE** attach original accounts, receipted or for payment (or send as soon as received).
- 2.** Applications must be lodged within six months of the treatment.

PAYMENT TO PROVIDER

Who do you want payments made directly to on your behalf?

Surgeon

Anaesthetist

Hospital

Other (please specify) _____

PAYMENT TO APPLICANT

How would you like to receive your reimbursement?

Direct Credit to your bank account. Payments are made around the 1st and 16th of each month, and will appear in your bank account as cleared funds.

If the Board does not have your bank details or you want the grant deposited into a different bank account, please supply account details.

OR

Cheque. Payments are made around the 1st and 16th of each month. Once received, cheques will take approximately 5 working days to clear.

DECLARATIONS

1. (Sign the following declaration if the treatment was received by the Eligible person)

I hereby certify that all particulars of this Claim are true and correct and I am not in regular paid employment.

This application is made only after assistance from the public health system has been sought and after all possible fees have been reclaimed from other medical insurance, ACC, WINZ etc.

Eligible person's Signature _____ Date _____

*or on behalf of Eligible person _____ Date _____

*Name and relationship to Eligible person _____

2. (Sign the following declaration if the treatment was received by a person other than the Eligible person)

I hereby certify that I financially support the person in receipt of the treatment described, and that the cost thereof has a negative financial impact upon us both, and all particulars of this Claim are true and correct.

This application is made only after assistance from the public health system has been sought and after all possible fees have been reclaimed from other medical insurance, ACC, WINZ etc.

Eligible person's Signature _____ Date _____

The information provided by the applicant is for the purpose of ascertaining eligibility for a grant from the Health Fund. The information will not be used for any other purpose.

POST THIS APPLICATION TO:

The Funds Administrator

The Health Fund

P O Box 12-287

WELLINGTON

Telephone: (04) 473-9369