



CRITICAL ILLNESS CLAIM FORM

PLEASE READ THIS SECTION BEFORE YOU START COMPLETING THIS FORM. (Use black or blue pen)

Use this form to apply for a withdrawal from your Cook Islands Superannuation Fund account upon approval as a referred patient.

Important Information

Under the provisions of the CINSF Act 2000(the Act) Trust Deed, you may be able to make a withdrawal from the Cook Islands National Superannuation Fund if you are suffering a Critical Illness as defined in the Trust Deed. The withdrawal of savings from CINSF in the case of a Critical Illness is subject to the Trustee's Approval.

Critical Illness as defined in the Trust Deed and means an injury or illness that a Cook Islands Ministry of Health Medical Practitioner has determined by assessment or diagnosis that such injury or illness requires a member to obtain specialist treatment that is not available in the Cook Islands.

1| Your Details:

RMD Number

NSF Number

Mr ☐ Mrs ☐ Ms ☐ Dr ☐

Other (Please specify)

First Name(s)

Surname

Address

Home
Phone

Mobile

Email

Date of birth (DD/MM/YY)

Age

Gender: Male

☐

Female

☐

2|Withdrawal Request:

You can elect to receive a benefit in a single lump sum or claim a lesser amount and claim at a future time provided the combined total of the claim does not exceed \$5,000

Amount of Withdrawal (please tick one)

☐ A partial Withdrawal of; or \$

☐ A lump sum amount \$

3|Payment Details

If your application is approved, which bank account would you like payments to be made into?

Bank

Bank Number

Branch

Branch Number

Swift Code

Account Number:

Account Name

4|Critical Illness:

For a Critical Illness:

- ask your doctor to complete the declaration below:

DOCTOR'S DECLARATION OF CRITICAL ILLNESS PATIENT

PATIENT

Full Name

First Name (s)

Surname

Address

DOCTOR

I, Doctor

of

Address

Island/City/State/Country

Daytime
Number

Mobile

Email
Address

Confirm that:

- I am a registered medical practitioner with the Cook Islands Medical Council and Dental Council or with an equivalent registration regime outside the Cook Islands.
- The above-named is a patient of mine whom I have recently conducted a full medical examination and in my opinion, has a Critical illness that poses a serious and imminent risk of death.
- The above-named has within the last 90days returned from overseas following a medical procedure requiring specialist treatment unavailable in the Cook Islands.
- To support this claim please find attached the patient's medical report(s) along with confirmation of the TMO referral letter.

Signature of Medical Practitioner

Date

5| APPLICANT DETAILS

Applicant Name	<input type="text"/>		
Address	<input type="text"/>		
Home Phone	<input type="text"/>	Mobile Number	<input type="text"/>
Email Address	<input type="text"/>		
Relationship to Member	<input type="text"/>		
Applicant Signature	Date	/ /

6| Member Declaration Member Declaration

By completing this form, I understand and confirm.

- I. That I meet the requirements to qualify for the critical illness benefits.
- II. The Funds received from this claim are strictly to provide me with financial assistance due to my medical referral overseas.
- III. The information provided on this form is clear and all the answers provided by me are true and correct.
- IV. I hereby indemnify the CINSF Board and Trustee from any liability whatsoever, including any loss of benefits that may arise as a result of approving my applications.

Applicant Signature **Date** /..... /.....

7| Checklist

Make sure to send us everything listed below, as we can't consider your request without the following.

Before CINSF can process your claim, please ensure you submit **ALL** the following documents.

- ☐ Critical Illness Claim Form
- ☐ Valid copy of your passport
- ☐ TMO Referral Form – Confirming of referral and medical condition.
- ☐ Confirmation of bank account (Confirmation letter from your bank or a copy of your bank statement)

You can email this form, and all required supporting documents to **enquiry@superfund.gov.ck**

CINSF Office Use Only (Name and Signature)

Received and checked by:		Date	dd / mm /yyyy
Processed by:		Date	dd / mm /yyyy
Approve by:		Date	dd / mm /yyyy

Email: enquiry@superfund.gov.ck **Phone:** +682 25515 PO Box 3076, Avarua Rarotonga, Cook Islands