

# WAR DISABLEMENT PENSION APPLICATION

Please complete this form to make your first application for a War Disablement Pension or to reinstate a pension that has been cancelled or declined.

Please ensure all sections are completed so your application can be processed without delay.

You should attach the following to your application:

- Two certified copies of identification. One of these must be either your birth certificate or a current passport. Copies are deemed to be certified as a true copy of the original if a Work and Income staff member, a Justice of the Peace, a solicitor or an officer duly authorised to take Statutory Declarations has signed the documents.
- Verification of your bank account name and number. This can be a pre-printed deposit slip, bank statement or a letter from the bank that contains these details.

## PRIVACY STATEMENT

The Privacy Act 1993 requires us to inform you that:

The information in this form is being collected for the functions and purposes of War Pension Services and Veterans' Affairs New Zealand, and in particular:

- The granting of benefits and other financial assistance under the War Pensions Act 1956;
- Statistical and research purposes
- The provision of advice to Government

War Pension Services may require extra information from other agencies that you have dealt with. We need your authority to contact those agencies for information. The kind of information we may require includes:

- Copies of your Service and medical documents from New Zealand Defence Force Headquarters
- Information on any claimed disability from a Medical Specialist, your General Practitioner or other health professional
- Details of any claim you may have made to Accident Compensation Commission or similar organisation for any claimed disability.

The medical information collected regarding any claimed disability may be made available to other health professionals concerned with your health.

I agree to War Pension Services obtaining and releasing such information as outlined above and understand that such information will only be used for the described purposes.

**Applicant's Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



Was any treatment given for your claimed disabilities? \_\_\_\_\_

At the time of disablement: \_\_\_\_\_

While still serving: \_\_\_\_\_

Since your discharge from the forces: \_\_\_\_\_

What is your General Practitioner's name? \_\_\_\_\_

Address: \_\_\_\_\_

Are you currently seeing a Specialist for your claimed disability/ies? Yes / No

What is the Specialist's Name? \_\_\_\_\_

Address: \_\_\_\_\_

Have you applied to ACC at any time for any of the disabilities claimed? Yes / No

If "yes" are you receiving ACC payments or have you received a lump sum payment? Yes / No

At which office did you lodge your ACC claim? \_\_\_\_\_

What disability did you apply to ACC for? \_\_\_\_\_

If you have any **ADDITIONAL INFORMATION** you wish to submit in support of your claim, please write it here or attach another sheet of paper.

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**DOCTOR TO COMPLETE THIS SECTION**

Please complete the following table for each of the disabilities claimed by the veteran.

Table with 4 columns: Claimed Disability, Is the veteran currently suffering from this disability?, Date Disability Diagnosed, Name of Specialist consulted for claimed disability. Contains 7 empty rows.

Doctor's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Doctor or Practice Stamp

**Applicant please turn page to sign**

