Please fill in this form to let us know if you’ll agree to give us more time to make a decision about your claim.

When you’ve finished, please return this form in the reply-paid envelope or to your nearest ACC service centre or branch.

|  |  |
| --- | --- |
| 1. Client details | |
| Client name: [Client full name auto] | Claim number: [Claim number auto] |

|  |  |  |
| --- | --- | --- |
| 2. Declaration and signature | | |
| Please read the statements below and tick the box that applies to you. | | |
|  | I agree to give ACC until [cover decision due date + 2 months] to collect any relevant medical and other records needed to help make a decision about my claim. | |
|  | I don’t want to give ACC any more time to make a decision about my claim. Please make a decision based on the information you already have. | |
| Name: | | |
| Signature: | | Date: |