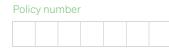
Claim



partners life

Monthly Benefit - Critical Illness

1.0 Adviser involvement

Your adviser will be kept informed of your claim. Please indicate here if you do not want your adviser kept informed about your claim.

No, I do not want my adviser involved

2.0 Type of cover

	In

Please state what type of cover you are claiming for:

Income Mortgage Repayment

Household Expenses

3.0 Life assured's details

Title	First name(s)	Surname
Date of birth		
Street address		Suburb
Town/City		Postcode
Email address		
Contact number	Alternate contact number	

4.0 Policy owner(s) details

First own	er		Second owner		
Title	First name(s)		Title	First name(s)	
Surname or company name			Surname or company name		
Street address			Street address		
Town/City		Postcode	Town/City		Postcode
Email address			Email address		
Contact number			Contact number		
Male Fer	nale Date of birth		Male Female	Date of birth	
a) Are yo	u notifying a change of address?	Yes No			
b) If yes, o	lo you want Partners Life to update your rec	ords? Yes No			

5.0 Sickness details

a) Please advise your current diagnosis and when this diagnosis was made.

b) Please provide the date of onset of these symptoms.	

Date

c) Have you ever had the same or similar symptoms?

If yes, please give date, the name of the doctor or hospital that treated you, and their contact details.

Date	Name of doctor or hospital	Contact details

6.0 Treatment details

a) Please give the name and address of your usual doctor.

Name	Address	

b) Please provide the name and location of all medical providers you have consulted for this condition.

Please give name and address and when/where you were first treated for this sickness/injury.

Date

Name of doctor	Doctor's address	Location dated	Date

c) Date of first consultation.

d) Have you received any treatment for this condition? If yes, please give details and dates.		Yes	No
Details of treatment	Date		

7.0 Occupation details and work capacity

a) What is your occupation?

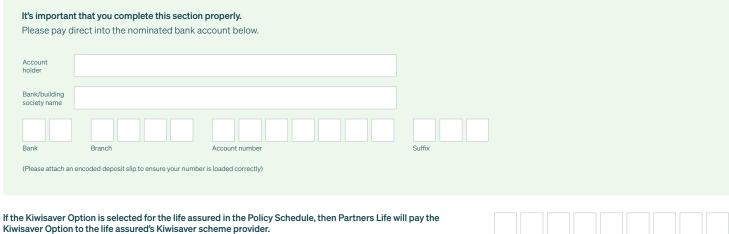
b)) What is your business/employer's name?		
c)	Have you stopped work due to this condition?	Yes	No
_	If yes, when did you stop work?		
d)	When do you evenest to return to wark? Places give dates		

When do you expect to return to work? Please give dates.

Part time

Full time

8.0 If your claim is accepted, please note payment will be made by direct credit into the nominated account



To enable us to process this, please provide your IRD number.

(Note: this is only collected for the purpose of Kiwisaver payments)



Please read and sign this declaration.

This application collects personal information about you and any life assured for whom you are claiming under your policy. The intended recipient of this information is Partners Life Limited ("the Company").

Failure to provide this information may result in your claim being declined or unable to be assessed. You and any life assured have the right to request access to and correction of your respective personal information at any time by contacting Partners Life on 0800 14 54 33.

Declaration

I am the policy owner and hereby claim the benefit amount payable on the basis of the statements and information provided by the life assured in this claim form which I believe to be accurate and complete in every respect.

As part of a medical insurance claim with the company, I, the life assured, consent and give authority to the company to seek from, and for all and any of the following, their officers and employees, to disclose to the company, its advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me:

- Registered medical practitioners and specialists
- Dentists
- Counsellors, psychologists and therapists
- Government departments, agencies, organisations and enterprises
- Hospitals (whether public or private)

- Accident Compensation Corporation
- Insurers (whether public or private)
- Credit rating and collection agencies
- Employers (whether current or not)

I agree that a photocopy, facsimile or scan of this authority will be valid as an original.

Privacy Act requirements

- This claim form and any supplementary material which may be required in connection with this claim is a collection of personal information.
- This information will be used to: assess and administer this claim; service and administer the policy; maintain relevant statistical records; and provide you with information about other products and services offered by Partners Life Limited.
- You are required to provide the medical information which has been requested so as to comply with your common law duty to disclose all matters material to the insurance.
- The information will be held by Partners Life Limited at the address
 on this form, and/or by Partners Life's data storage providers, which
 includes cloud-based data storage providers (both in New Zealand and
 overseas).
- Under New Zealand privacy law, you have the rights of access to, and correction of, any information provided.

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide Partners Life Limited such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

Name/company name of first policy owner	Name/company name of second policy owner
Signature/authorised signature of first policy owner	Signature/authorised signature of second policy owner
Date	Date
Name of life assured	
Signature of life assured	
Date	
10.0 Final checklist of documents you need to care	1 to up
10.0 Final checklist of documents you need to send	i to us
Fully completed claim form	
Fully completed certificate of medical attendant	
Copies of relevant medical notes including any histology reports and res	ults of investigations

Certificate of medical attendant (To be completed by a registered medical practitioner at the client's expense)

olicy number		
attar	adant:	

- a) This medical certificate and requested information must be completed in **full** and returned to **Private Bag 300995**, Albany, Auckland 0752 or alternatively you can send a scanned copy to claims@partnerslife.co.nz
- b) Please supply **copies of the patient's full history notes**, including any reports and results of investigations. Partners Life will pay reasonable charges for providing this information. Please provide an itemised account.

c) If you wish to contact the Partners Life Claims Department, please email us at claims@partnerslife.co.nz or call on 0800 14 54 33.

Life Assured					
Title	First name(s)	Surname			
a) What is the medical condition requiring treatment or investigation?					

b) When did the signs and/or symptoms of this condition become apparent to the patient for the very first time?

Date

c) When did the patient first consult with a medical professional in regards to this condition?

Date

e) Please give dates of subsequent consultations and treatments in respect of this condition?

Date	Treatments

g) What is the proposed treatment plan?

h)	Is the patient unable to work in their usual occupation due to this condition? If yes, please advise:		Yes	No
	i) when they were advised to cease work			
	ii) when you expect they will be able to return to work	Date		
i) A	i) Any other comments?			

Declaration

I confirm that I have examined this patient and that the information provided is correct and complete.

Doctor's name	Qualifications
Business phone	Facsimile
Email address	
Signature of doctor	Date

Once completed please scan and email to claims@partnerslife.co.nz or post to: Partners Life Limited. Private Bag 300995, Albany, Auckland 0752, New Zealand

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