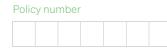
Claim



partners life

Monthly Benefit - Specific Injury

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

Please state what type of cover you are claiming for:

ncome

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 owner	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
Email address	Email address
Contact number	Contact number
Male Female Date of birth	Male Female Date of birth
a) Are you notifying a change of address? Yes No	
b) If yes, do you want Partners Life to update your records? Yes No	

5.0 Injury details

a)	Please describe the injury you are claiming for.
b)	When did the injury occur? Date Time am/pm
c)	How did your injury occur?
-	
	Please confirm if your injury has required surgery or cast/immobilisation
u)	
_	
e)	What treatment/rehabilitation are you undergoing for this injury?
F	
-	

6.0 Treatment details

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

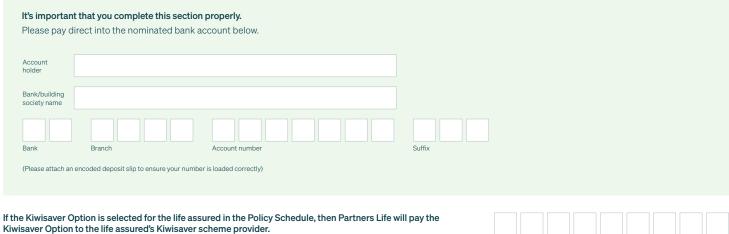
Name		Address	
b) Plea	ase provide the name and location of all medical providers you consulted fo	or this injury	Yes No
Name		Address	

7.0 Occupation details and work capacity

a) What is your occupation?

b)	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)	d) 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	
	7
Date	
10.0 Final checklist of documents you need to send	d to us
Fully completed claim form	

A copy of the x-ray/radiologist reports

A copy of the discharge summary from the hospital