

Claim

Policy number

partners life

Monthly Benefit - Dependent Caregiver Option

1.0 Adviser involvement

Your adviser will be kept informed of your claim. Please indicate 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:

Income

Mortgage Repayment

Household Expenses

3.0 Life assured's details

Title	<input type="text"/>	First name(s)	<input type="text"/>	Surname	<input type="text"/>
Date of birth	<input type="text"/>				
Street address	<input type="text"/>			Suburb	<input type="text"/>
Town/City	<input type="text"/>			Postcode	<input type="text"/>
Email address	<input type="text"/>				
Contact number	<input type="text"/>	Alternate contact number	<input type="text"/>		

4.0 Policy owner(s) details

First owner

Title	<input type="text"/>	First name(s)	<input type="text"/>		
Surname or company name	<input type="text"/>				
Street address	<input type="text"/>				
Town/City	<input type="text"/>	Postcode	<input type="text"/>		
Email address	<input type="text"/>				
Contact number	<input type="text"/>				
Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Date of birth	<input type="text"/>

Second owner

Title	<input type="text"/>	First name(s)	<input type="text"/>		
Surname or company name	<input type="text"/>				
Street address	<input type="text"/>				
Town/City	<input type="text"/>	Postcode	<input type="text"/>		
Email address	<input type="text"/>				
Contact number	<input type="text"/>				
Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Date of birth	<input type="text"/>

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 Dependents details

a) What is the full name and date of birth of the dependent requiring full time care?

First name(s)	<input type="text"/>	Surname	<input type="text"/>
Date of birth	<input type="text"/>		

b) What is the life assured's relationship to the dependent?

c) Please explain why the dependent requires full time care, including when symptoms first commenced, the diagnosis and treatment requirements

6.0 Life assured's occupation details

a) What is your occupation?

b) What is your business/employer's name?

c) How many hours per week did you work immediately prior to the dependent requiring care?

d) Have you taken leave or ceased work completely to care for the dependent?

Yes No

If yes, when did you stop?

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

Part time Full time

f) Are you receiving any financial support from any other sources to help care for the dependent?

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

It's important that you complete this section properly.

Please pay direct into the nominated bank account below.

Account holder

Bank/building society name

Bank

Branch

Account number

Suffix

(Please attach an encoded deposit slip to ensure your number is loaded correctly)

8.0 Declaration and consent

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)

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

Signature/authorised signature of first policy owner

Date

Name/company name of second policy owner

Signature/authorised signature of second policy owner

Date

Name of life assured

Signature of life assured

Date

- 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.

9.0 Final checklist of documents you need to send to us

- Medical evidence from the specialist or medical doctor supporting the need for full time care