Claim

Policy number

partners life

Terminal Illness & Early Payment of Life Cover

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 Life assured's details

Title | First name(s) | Surname

Male ☐ Female ☐ Date of birth

Street name | Suburb

Town/City | Postcode

(if different from above)

Postal address

Email address

Contact number | Alternate contact number

3.0 Policy owner(s) details **(if different to Life Assured)**

First owner

Title | First name(s)

Surname or company name

Postal address

Town/City | Postcode

Email address

Contact phone

Male ☐ Female ☐ Date of birth

Second owner

Title | First name(s)

Surname or company name

Postal address

Town/City | Postcode

Email address

Contact phone

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 ☐

4.0 Please answer the following

a) Please name the medical condition you have been diagnosed with.

b) Please list the specialists that you have seen regarding this condition.

Specialist	Location	Date first seen

c) Please give the name and address of your usual doctor (GP) and the doctor holding your records (if different).

Name | Address

Name | Address

d) How long have you been a patient of your usual doctor?

Months | Years

e) Has your specialist discussed your prognosis for life expectancy with you? Yes ☐ No ☐

If yes, what did they advise?

5.0 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)

6.0 Declaration and consent

Please read and sign this declaration.

This claim form 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"). The Company collects, stores, uses and discloses personal information in accordance with its privacy policy available at www.partnerslife.co.nz / privacy-policy.

You are required to provide the information requested by the Company so as to comply with your common law duty to disclose all matters material to the insurance 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.

I, the life assured, authorise the Company and its agents to seek from, and disclose to, any medical, financial or other personal information which they may hold in respect of me, third parties including but not limited to:

- 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)
- Reinsurers
- Advisers
- Any legal tribunal before which any question concerning the insurance may arise

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

Parent or guardian if life assured is under the age of 16.

Name of life assured

Signature of life assured

Date

Name of parent or guardian

Signature of parent or guardian

Date

Terminal Illness & Early Payment of Life Cover Medical Questionnaire (to be completed by Treating Specialist)

Policy number

Life assured

Title | First name(s) | Surname

To the medical attendant:

The above life assured is claiming a lump sum benefit from Partners Life Limited and we require the following information from you, as the registered medical practitioner for the life assured, in order to assess this claim as quickly as possible. Thank you for your assistance.

Specialist

Title | First name(s) | Surname

Address

Contact number | Facsimile

Email address

a) How long has the patient been under your care?

Months | Years

b) Do you hold all medical records for the last five years? Yes ☐ No ☐

If **no,** please give details of the previous doctor(s) if known.

Name | Address

Name | Address

c) What is the client's diagnosis?

d) Date of diagnosis Date

e) When did the signs and/or symptoms of this condition become apparent to the life assured for the very first time? Date

f) Has all conventional medical treatment with the 'intent to cure' or improve the condition been exhausted? If no, please advise what treatment options are still available.

g) In your professional medical opinion, what is your patient's prognosis / life expectancy based on their current medical condition?

Please attach a copy of clinical notes supporting this prognosis.

Declaration

- I declare that the above information, and other information supplied by me in relation to this form, is true and correct and that no information relevant to the life assured has been omitted from this form.
- I declare that I am registered as a medical practitioner with the Medical Council of New Zealand and am not the patient, the policy owner or either of their respective partners or relatives.
- I consent and authorise Partners Life Limited to disclose to its associated companies, advisers, reinsurers or any other party authorised by the life assured, any information provided by me in connection with this form for any of the purposes authorised by the life assured.

Signature of Doctor/Specialist

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