Income Protection Claim Form

What we need to support your claim:

- Medical Certificates
- Hospital Discharge Summary/s (if applicable)
- Any other relevant medical information (e.g. specialist reports)

Please provide copies of any of these you have available.

1 Life Assured details

Policy number

Full name

Date of birth (dd/mm/yyyy) / /

Address — Street | Suburb

City | Postcode

Contact details — Home phone | Work phone | Mobile

Email address

2 Off work details

Please provide copies of any medical certificates you have available.

a. On what date did you first seek medical attention for your current illness/injury? / /

b. On what date did you totally cease work? / /

c. On what date were you medically certified to cease work? / /

d. When did you reduce your hours or go on restricted duties? / /

e. When were you medically certified to reduce hours or go on restricted duties? / /

f. What is your diagnosis and how is this causing your incapacity to work?

g. Have you ever suffered from the same or similar illness or injury? ☐ Yes ☐ No

If yes, please tell us about it:

h. Have you spent a period/s of time in hospital for your current illness/injury? ☐ Yes ☐ No Hospital name

Please provide copies of any hospital discharge summaries you have available.

i. In the case of an injury, is ACC being claimed? ☐ Yes ☐ No ACC Claim number

j. Your current GP details

Name

Medical practice

Email address

Off work details (continued)

k. Specialist details (continue on separate sheet if more than two specialists)

Name	
Specialty	
Email address	
Name	
Specialty	
Email address	

3 About your job

a. What was your occupation immediately prior to your current illness/injury?

b. What duties does your role involve?

c. Number of hours usually worked per week

d. Is your job available for you to go back to? If not, please provide details

4 Financial details

a. Please indicate how your income is obtained from all sources at the date of your disability.

Salaried Employment ☐ Full-time ☐ Part-time ☐ Seasonal

Name of Employer	
Contact person	
Contact number	

Self Employment

		Name of Entity	% Profit share entitlement
☐	Sole proprietor		
☐	Contractor		
☐	Shareholder employee		
☐	Companies		
☐	Partnerships		
☐	Trusts		
☐	Other Please specify		

Financial details (continued)

b. Please state the names of all the entities you are involved in

c. If your spouse or family member is receiving a profit share, please provide specific details including the hours they work and the duties they perform

Duties	% of time on each duty

d. Are you receiving any benefit/compensation for your current condition?

☐ Yes ☐ No

Please tick the appropriate box to advise if other compensation or income by way of regular payment or lump sum settlement is being or will be claimed for your current condition/claim by any of the following:

☐	ACC	$
☐	Any other insurer policy/ policies	$
☐	Any sick leave	$
☐	WINZ payments (Government support)	$
☐	Other	$

Please make any benefit payment into the following account:

☐ Use existing premium direct debit account

Account Holder/s name(s)

Account — Bank | Branch number | Account number | Suffix

Full name of Policy Owner

Signature of Policy Owner X

Date DD/MM/YYYY

Additional Full name of Policy Owner (if applicable)

Signature of Policy Owner X

Date DD/MM/YYYY

5 Consent

I, _____ , the **Life Assured**, consent and give authority to AIA New Zealand Limited ("AIA") to seek from, and for all and any of the following, their officers and employees, to disclose to AIA, their 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:

- Dentists
- Advisers
- Employers (whether current or not)
- Medical laboratories
- Accident Compensation Corporation
- Banks and other financial institutions
- Accountants and other financial advisers
- Insurers or reinsurers (whether public or private)
- Counsellors, psychologists and therapists
- Government departments, agencies, organisations and enterprises
- Registered medical practitioners and Specialists (which may include an entire copy of my/our medical file)

I, the Life Assured, understand that the supply of the information gathered from the above sources is voluntary and that AIA may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my Insurance. I understand that AIA may share my claims details with related insurers to enable co-ordination of claims resolution. I understand that my personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.

I, the Life Assured, understand that my personal information will be stored at AIA's Auckland office, 74 Taharoto Road, Takapuna and by AIA's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I understand that AIA will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).

I consent and give authority to ASB Bank Limited and/or AIA to request from AIA International Limited (trading as AIA New Zealand 'AIA'), or disclose to AIA, any information pertaining to me and relevant to the assessment of my insurance claim.

I understand that AIA may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of my personal information may be requested by me.

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following:

I consent to the disclosure of my claims information to ASB for the purposes of notifying ASB of issues or disputes arising in respect of my claim. ☐ Yes ☐ No

Full name of Life Assured _____

Signature of Life Assured _____ X

Date DD/MM/YYYY _____

6 Declaration – Important, please read carefully

I, _____ , the **Life Assured**, declare that all occupational, medical and financial information pertaining to me has been provided and disclosed to AIA.

I understand that failure to provide full disclosure of all occupational, medical and financial information that AIA would deem as relevant in the assessment of my claim would be considered to be material misrepresentation and/or material non-disclosure and as such AIA is entitled to use legal remedy, should this occur.

I further understand that the occupational, medical and financial information provided is the basis on which AIA will assess and manage my claim and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed.

I declare that all the answers to questions in this form are true and complete. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I further agree that a photocopy of this authority will be valid as an original.

Full name of Life Assured

Signature of Life Assured X

Date DD/MM/YYYY

I/We, _____ hereby claim the benefit amounts payable on the basis of the statements and information provided by the Life Assured in this form which I/we believe to be accurate and complete in every respect.

Full name of Policy Owner

Signature of Policy Owner X

Date DD/MM/YYYY

Additional Full name of Policy Owner (if applicable)

Signature of Policy Owner X

Date DD/MM/YYYY

7 Consent to disclose personal information to a third party

This section is to be used when you want AIA to give details about you to a third party.
e.g. spouse, partner, broker etc

Name of person that information is to be released to

Their address

Phone number

Email Address

Authorisation

I authorise AIA New Zealand Limited to release and/or discuss any of my personal and health information, including medical or financial details with the above-named person(s). ☐

Full name of Life Assured

Signature of Life Assured X

Date DD/MM/YYYY

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