Claim

Policy number

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

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 owner

Title | First name(s)

Surname or company name

Street address

Town/City | Postcode

Email address

Contact number

Male ☐ Female ☐ Date of birth

Second owner

Title | First name(s)

Surname or company name

Street address

Town/City | Postcode

Email address

Contact number

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 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.

Name of doctor	Doctor's address	Location dated	Date

c) Date of first consultation. Date

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

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 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

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)

If the Kiwisaver Option is selected for the life assured in the Policy Schedule, then Partners Life will pay the Kiwisaver Option to the life assured's Kiwisaver scheme provider.

IRD number

To enable us to process this, please provide the life assured's individual IRD number.
(Note: this is only collected for the purpose of Kiwisaver payments)
Kiwisaver Option can only be paid if the life assured has opted into Kiwisaver.

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

9.0 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)
- 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

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

10.0 Final checklist of documents you need to send to us

- ☐ Fully completed claim form
- ☐ Fully completed certificate of medical attendant
- ☐ Copies of relevant medical notes including any histology reports and results of investigations

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

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

Policy number

To the medical attendant:

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? Yes ☐ No ☐

If **yes,** please advise:

i) when they were advised to cease work — Date

ii) when you expect they will be able to return to work — Date

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

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