CHUBB®

Income Cover

Employer claim questionnaire

1. Policy details

Policy number

Life Assured

Surname

First name(s)

The above Life Assured has made a claim with Chubb Life Insurance New Zealand Limited (Chubb Life) under their Income Cover benefit. To help us to assess this claim we require the following information from you. We have attached an authorisation signed by the Life Assured giving you authority to release this information to us. The answers you give to our questions will help us to ascertain the best approach to help the Life Assured return to normal life and work activities.

2. Questions

(a) How long has the Life Assured been employed by you?

(b) What was their gross monthly income immediately prior to ceasing work due to their disability (this amount includes motor vehicle allowances and fringe benefits)?

(c) What, if any, is the average monthly amount of overtime earned over the previous 12 months immediately prior to ceasing work due to their disability?

(d) What were their main pre-disability duties?

(e) How many days off work had the Life Assured taken due to illness or injury in the six months immediately prior to ceasing work due to their disability?

(f) If possible would you be willing to allow the Life Assured to work for reduced hours or at restricted duties? Yes ☐ No ☐

(g) How long will the Life Assured continue to receive income from you including any sick leave payments following their disablement?

(h) Do you provide your employees with any type of disability benefit other than sick leave?
If **yes**, please provide details. Yes ☐ No ☐

3. Declaration

Name of person who completed this questionnaire	
Position within the company	
Contact phone number	
Email	

I hereby declare that to the best of my knowledge the above information is true and complete in every respect. I consent and authorise Chubb Life Insurance New Zealand 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 ✗ Date DD / MM / YYYY

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