Continuing claim form.

Your details.

Insured person name

Policy number

Residential address (please only advise if this has changed)

Email address

Preferred contact method
◯ Post ◯ Email

Contact numbers: Home ◯ Preferred phone number

Mobile ◯ Preferred phone number

Medical conditions.

Current symptoms

Over the past month, I believe my symptoms have: (please tick)

- Improved significantly
- Improved somewhat
- Remained the same
- Deteriorated somewhat
- Deteriorated significantly

Over the past month, I have engaged in the following treatment(s) and/or rehabilitation:

Vocational.

Please advise if you have undertaken any work over the past month.

Work type			Hours per week
Volunteer	◯ Yes	◯ No	
Unpaid	◯ Yes	◯ No	
Paid	◯ Yes	◯ No	
Contract	◯ Yes	◯ No	
Other (please specify)	◯ Yes	◯ No	

Please describe the duties undertaken.

Continuing claim form.

Vocational (continued).

If you have not undertaken any work this month, has a Graduated return to work plan or estimated return to work date been discussed with you by any of your treating medical practitioners? If yes, please give details below or provide a copy of the plan.

◯ Yes ◯ No

Finance.

Since your last claim payment, have you received any income from any other source, including:

			Amount per month	Gross/net
ACC	◯ Yes	◯ No	$	
Other insurer	◯ Yes	◯ No	$	
Sickness benefit from government or other agency	◯ Yes	◯ No	$	
Sick pay from an employer	◯ Yes	◯ No	$	
Income for work undertaken with your employer	◯ Yes	◯ No	$	
Income and/or profit from your business	◯ Yes	◯ No	$	
Other (please specify)	◯ Yes	◯ No	$	

Other.

Is there any other information we should be aware of? ◯ Yes ◯ No

If yes, please provide further details.

Consent to provide information to adviser.

Adviser name

Company

☐ I consent to the release of all information relating to my claim including, but not limited to, medical and financial information to my adviser and their company.

☐ I provide restricted consent. Please do not provide any medical information to my adviser and their company.

☐ Please do not provide any information to my adviser or their company.

Please return your completed form and any accompanying documents to:

@ claims@fidelitylife.co.nz 09 303 5732 Freepost 1893, PO Box 37275, Parnell, Auckland 1151.

If you have any questions please contact us on 0800 88 22 88, option 2.

See overleaf for Disclosure of information and Declaration and Consent.

Continuing claim form.

Disclosure of information.

You are required to provide Fidelity Life with all the information relevant to your claim. Where you have an on-going claim you will need to provide relevant information on an on-going basis. This information must be true, complete and accurate. If you fail to disclose information or provide false information this may result in your claim being declined and/or your policy being cancelled.

If you refuse to provide information, Fidelity Life may not be able to assess your claim.

Privacy Consent - Privacy Act 2020 and the Health Information Privacy Code 2020.

'Fidelity Life' refers to Fidelity Life Assurance Company Limited and 'you' and 'your' refers to the insured person filling out this form.

This claim form collects personal information about you. The personal information (including medical information or financial information if required) will be used by Fidelity Life to investigate and determine the validity of your claim and to confirm the information in your application for insurance. The information may also be used for statistical purposes provided you are not identified.

This privacy consent authorises Fidelity Life, its subsidiaries, its advisers, reinsurers and any agents appointed by Fidelity Life to collect from, use, and disclose to any third party, your information that is reasonably necessary to assess, administer and manage the claim. This privacy consent authorises those third parties to disclose that information to Fidelity Life, its subsidiaries, its advisers, reinsurers and any agents appointed by Fidelity Life.

Those third parties include (but are not limited to): advisers, agents, health service providers including recognised private and public hospitals, registered medical practitioners and specialists, medical authorities, health insurers, Accident Compensation Corporation (ACC), banks and financial institutions, accountants, counsellors, psychologists and therapists, insurers and reinsurers, and any other individual organisation where the collection/disclosure is required by law.

The information collected is held securely at Fidelity Life's Auckland Office or by one of Fidelity Life's storage providers and through cloud-based services in New Zealand or Australia who store information on our behalf.

Under the Privacy Act 2020 you have the right of access to request and correction of the information that Fidelity Life holds about you. Fidelity Life will rely on you to keep them informed of any changes to your information.

Insured person's responsibilities.

You understand and accept that while you receive benefit payments from Fidelity Life, you have the following responsibilities:

1. You must notify Fidelity Life before you return to work, paid or unpaid, in any capacity.
2. You must advise Fidelity Life immediately if you:
   - have any increase in your work hours
   - have an increase in any pay that you receive
   - receive any other income, such as holiday pay or sick leave pay, that may affect your benefit.
3. You acknowledge that if you do not meet these responsibilities, Fidelity Life may cease your benefit payments and/or cancel your policy.
4. You must allow us to do a financial review of your claim at our discretion at a frequency determined by us. We will do this by:
   - Requesting all relevant financial information for the review period from you, and
   - Reviewing all included* income you have received while on claim for the period we are reviewing, and
   - Comparing this total income against the total benefit you're entitled to receive for the review period under the terms of your policy wording

   * included income meaning any income that's considered as income to be offset in line with the terms of your policy wording. This may be called "post-disability income" or "monthly earned income". It'll depend on your policy wording.
5. You acknowledge that where there's an overpayment as a result of the above, we'll need you to repay the amount that has been overpaid by us to you. If there is an underpayment as a result of the above, Fidelity Life will pay you the underpayment amount.
6. You understand that you are responsible for paying the costs of medical reports in support of your claim as set out in the terms and conditions of your policy.

Declaration and consent.

By completing this form you acknowledge your responsibilities set out above, and

1. declare that you have provided Fidelity Life with all the information relating to this claim, that the information is true and correct and that no material information has been withheld.
2. agree to the Privacy Consent.

If you are providing information on behalf of the insured person, you must confirm in writing that you are authorised to do so and provide proof of authorisation.

Insured person name (please print)	Signature	Date (DD/MM/YYYY)

If this form has been completed by someone other than the insured person, please complete the following:

Name (please print)	Signature	Date (DD/MM/YYYY)

Relationship to the insured person	Phone number	Reason you have completed the form on behalf of the insured person