Claim Form

partnersLIFE

Monthly Benefit Update

Policy number

1.0 Life assured's details

Title | Surname | First name(s)

Street no./name

Town/city | Postcode

Date of birth / /

Home phone ( )

Business phone ( )

Email address

Mobile ( )

2.0 Please answer the following

a) Please list all the providers you have seen since your last benefit payment, including any doctors, therapists etc, and the date you consulted them.

Provider	Date seen
	/ /
	/ /
	/ /
	/ /
	/ /

b) Has there been any change in your condition since your last benefit payment? Y | N

If **yes** please provide details.

c) Are you working? Y | N

If **yes** please provide details including how many hours you have worked since the last benefit payment.

d) If you returned to work in the previous month please provide the date you commenced working. / /

e) Which of your occupational duties does your condition prevent you from performing?

f) Please give details of duties you are able to do.

g) Are there any alternative occupational duties available to you? Y | N
If **yes** please provide details.

h) Are you involved in any unpaid or volunteer work? Y | N
If **yes** please provide details including the number of hours per week.

i) Are you enrolled in or have you been participating in any study or training? Y | N
If **yes** please provide details.

j) Have you been participating in any fitness or sporting activity? Y | N
If **yes** please provide details.

k) Since the last benefit payment have you received any of the following:

Source received from	Gross	Net
ACC, Work and Income, or any other insurance company	**$**	**$**
Any income as a result of work undertaken	**$**	**$**
Mortgage repayment insurance paid to you or your mortgage lender	**$**	**$**

If you are not on claim for Mortgage Redundancy Cover please skip to Section 4.0

3.0 Mortgage details

a) Has the mortgage been discharged (paid off) in the last month? Y | N

4.0 Employment details

a) Are you currently working in any capacity, whether on contract, part time or full time? Y | N

If **no** please provide return to work date. / /

If **yes**

i) How much have you earned for this period?

ii) How many hours have you worked? Hours

iii) What type of duties have you performed?

5.0 Declaration

I am the life assured named above and to the best of my knowledge the information given here is accurate and correct.

Signature

Date / /

Monthly Benefit Diagnosis Update To be completed by the medical practitioner

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To the medical practitioner:
The below life assured is claiming a monthly benefit from Partners Life and we require the following information from you in order to manage the claim. The more information you are able to provide, the more accurately we will be able to manage the claim. This form is to be completed at the expense of the life assured. Thank you for your assistance.

1.0 Life assured's details

Policy number

Title | Surname | First name(s)

Date of birth | Date of incapacity

2.0 Claim details

a) What was the primary diagnosis that caused the life assured to cease work?

b) What is the current diagnosis preventing the life assured from working?

c) Are there any other conditions or injuries that the life assured is experiencing?

d) What treatment plan have you recommended for the current condition?

e) Is the life assured compliant with the treatment you have recommended? Y | N
If **no** please provide details.

f) Have you referred the life assured for any investigations or to other providers since the last update? Y | N
If **yes** please provide details, attach the referral and any reports.

g) In your opinion are there any non-medical factors that are delaying the life assured's recovery? (e.g. occupational, social, lifestyle) Y | N
If **yes** please provide details.

3.0 Work capacity

a) What was the life assured's occupation at the time they ceased work?

b) How is the current diagnosis preventing the life assured from working?

c) In your opinion is the life assured fit for full-time work in the above occupation? Y | N
If **yes** from what date.

If **no** in your opinion how many hours per week is the client fit for work in the above occupation?

d) In your opinion on what date will the life assured make a full return to the above occupation?

Part time: / / Full time: / /

e) Are you completing any other medical questionnaires or certificates for the life assured? Y | N
If **yes** please provide details.

f) Please provide any comments you feel may assist us with the management of this claim and how we can assist the life assured with a return to normal life and work activities. If you would like a Partners Life Claims Consultant or our Chief Medical Officer to contact you with respect to this claim please provide your phone number and the best time to call. Please note that you are able to invoice Partners Life for this discussion.

4.0 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.
- Under the Privacy Act 1993 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 / /

Partners Life Limited
Private Bag 300995, Albany
Auckland 0752
New Zealand
0800 14 54 33
partnerslife.co.nz