

## Early Payment of Life Cover Claim Form

### 1. Policy Owner's name and postal address

Policy number	<input type="text"/>	
Mr/Mrs/Miss/Ms	<input type="text" value="Surname"/>	<input type="text" value="First name(s)"/>
Home address	<input type="text"/>	
	<input type="text"/>	
Postal address	<input type="text"/>	
	<input type="text"/>	
Home phone	<input type="text"/>	Mobile phone <input type="text"/>
Email	<input type="text"/>	

### 2. Life Assured claim details (if different from above)

Mr/Mrs/Miss/Ms	<input type="text" value="Surname"/>	<input type="text" value="First name(s)"/>
Home address	<input type="text"/>	
	<input type="text"/>	
Date of birth	<input type="text" value="DD / MM / YYYY"/>	
Home phone	<input type="text"/>	Mobile phone <input type="text"/>
Email	<input type="text"/>	

### 3. Questions (for completion by the Life Assured)

(a) What is your diagnosis/condition?

(b) When was the diagnosis made?

(c) When did you first consult a doctor regarding your condition?

(d) Name and address of your treating specialist.

(e) Name and address of your usual doctor (GP) and the doctor holding your records if different.

## 4. Declaration and consent

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 Chubb Life Insurance New Zealand Limited ("the Company") and the information collected will be held at the Company premises.

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.

### Declaration

I am the Policy Owner and hereby claim the benefit amounts 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 an early Life Cover 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 employment, medical, financial or other personal information affecting such insurance which they may hold in respect of me:

- › Registered Medical Practitioners and specialists.
- › Employers.

- › Dentists.
- › Counsellors, psychologists and therapists.
- › Government departments, agencies, organisations and enterprises.
- › Hospitals (whether public or private).
- › Accident Compensation Corporation.
- › Insurers (whether public or private).

I agree that a photocopy 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 Chubb Life Insurance New Zealand Limited.
- › You are required to provide the employment 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 Chubb Life Insurance New Zealand Limited.
- › Under the Privacy Act you have the rights of access to, and correction of, any information provided.

Full name of Policy Owner(s)  
(please print)

Signature of Policy Owner(s)

Date

Full name of Life Assured  
(please print)

If a claim is being made by a child under 16 years of age, a parent or guardian must sign on the child's behalf. Please insert parent's or guardian's full name and sign below.

Signature of Life Assured

Date

If a policy owner is so incapacitated to be unable to complete and sign this claim form then a person authorised to act on their behalf must do so. Please state the reason for requirement for Authorised Officer below.

Full name of Authorised Officer  
(please print)

Nature of relationship  
to Policy Owner (please print)

Signature of Authorised Officer

Date

Address and phone number  
of Authorised Officer