

# Monthly Benefit Claim Form

## 1. Life Assured claim details

Policy number

Mr/Mrs/Miss/Ms    
Surname First Names

Home address

Postal address

Date of birth    Business phone   
Day Month Year

Home phone  Mobile phone

Email

## 2. Policy Owner's details (if different from above)

Mr/Mrs/Miss/Ms    
Surname First Names

Postal address

Home phone

Business phone  Mobile phone

Email

Complete this section if your claim is for illness. If your claim is for an accident or injury please go straight to section 4

## 3. Questions - illness

(a) What is the illness that you are claiming for?

(b) When did you first become aware of symptoms? What were they?

(c) When did you first seek medical advice for this illness?

(d) What treatment are you receiving for this illness?

(e) Have you ever suffered from the same or similar illness? If yes, please provide details.

Yes  No

Please continue to section 5

#### 4. Questions - accident or injury

(a) What is the accident or injury that you are claiming for?

(b) Date of accident or injury.

Day	Month	Year					

(c) Time and place of accident or injury.

(d) Describe how the accident or injury happened.

(e) Did the police attend the accident? If **yes**, please provide details.

Yes  No

(f) Are the police investigating the accident? If **yes**, please provide details.

Yes  No

(g) Have you ever suffered from the same or similar injury? If **yes**, please provide details.

Yes  No

(h) Date that you first consulted a doctor for your injury.

Day	Month	Year					

(i) What treatment are you receiving for your injury?

(j) Have you lodged a claim with ACC for this injury?

Yes  No

If **no**, please provide details as to why not.

If **yes**, Case Manager's name.

ACC Branch

ACC Claim number





## 9. 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 a monthly benefit 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).
- › 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 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 medical information which has been requested so as to comply with your common law duty to disclose all matters material to the insurer.
- › 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)

Signature of Policy Owner(s)

Date

Day	Month	Year					

Full name of Life Assured

Signature of Life Assured

Date

Day	Month	Year					