Claim Form

partnersLIFE

Redundancy Benefit

Policy number

1.0 Type of cover

☐ Mortgage Redundancy ☐ Household Redundancy

2.0 Life assured's details

Title | Surname | First name(s)

Street address | Suburb

Town/city | Postcode | Date of birth / /

Home phone ( ) | Business phone ( )

Email address | Mobile ( )

3.0 Policy owner(s) details

First owner

Title | First name(s)

Surname or company name

Postal address

Town/city | Postcode

Email address

Contact phone number ( )

Male | Female | Date of birth / /

Second owner

Title | First name(s)

Surname or company name

Postal address

Town/city | Postcode

Email address

Contact phone number ( )

Male | Female | Date of birth / /

a) Are you notifying a change of address? Y | N

b) If yes do you want Partners Life to update your records? Y | N

4.0 Please answer the following

a) What date were you informed there may be a change in your workplace which could affect your position? / /
This information may have been provided verbally or in writing, or a proposal may have been provided requestion feedback on any changes being considered.

b) When was your last working day? / /
Please include a copy of the formal letter advising your position has been made redundant.

c) Was your position permanent? Y | N

d) What were your hours of work and your annual income?

Hours

e) When did you commence working for the employer? / /

5.0 Adviser involvement

Would you like your financial adviser to be involved with the progress of your claim? Y | N

6.0 If your claim is accepted, please note payment will be made by direct credit into the nominated account

It's important that you complete this section properly
Please pay direct into the nominated bank account below

Account holder

Bank/Building society name

Bank	Branch	Account number	Suffix
☐☐	☐☐☐☐	☐☐☐☐☐☐☐☐	☐☐☐

(Please attach an encoded deposit slip to ensure your number is loaded correctly)

7.0 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 / /

8.0 Final checklist of documents you need to send to us

- ☐ Fully completed claim form
- ☐ Formal letter advising your position have been made redundant
- ☐ Written confirmation your position was permanent
- ☐ Copies of the last 2 months payments on your mortgage including confirmation of the mortgage start date (if applicable)
- ☐ Household expense statements 3 months i.e. rent, electricity, gas, water bills (if applicable)

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

Scan and email to claims@partnerslife.co.nz or post to:
Partners Life Limited, Private Bag 300995, Albany, Auckland 0752, New Zealand | 0800 14 54 33 | partnerslife.co.nz