Claim Form

partnersLIFE

Lump Sum

Policy number

1.0 Type of cover

a) Please state which type of Policy you hold. ☐ Personal Protection Plan ☐ Business Protection Plan

b) Please state what type of cover you are claiming for.

☐ Trauma ☐ TPD ☐ Ownership Buyout ☐ Key Person ☐ Debt Protection ☐ Specific Condition ☐ Severe Trauma

2.0 Life assured's details

Title | Surname | First name(s)

Male | Female | Date of birth / /

Street address | Suburb

Town/city | Postcode

Postal address (if different from above)

Email address | Business phone ( )

Home phone ( ) | 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) Please name the medical condition you have been diagnosed with.

b) When did you first become aware of symptoms and what were they?

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

d) What is the name of the doctor who initially diagnosed the condition and when?

Name | Date / /

e) Have you ever suffered from the same or similar condition? Y | N
If **yes** please give details.

f) Please list the specialists that you have seen regarding this condition.

Specialist	Location	Date first seen
		/ /
		/ /
		/ /
		/ /
		/ /

g) Please give the name and address of your usual doctor (GP) and the doctor holding your records (if different).

Name	Address
Name	Address

h) How long have you been a patient of your usual doctor?

Months | Years

i) When did you stop work completely due to your condition? / /

j) What procedure or treatment plan have you been recommended to undergo for your diagnosed condition?

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)

The following sections only need to be completed if claiming for Total and Permanent Disability, Ownership Buyout, Key Person and Debt Protection Covers, if not please skip to Section 11.0

7.0 Work capacity details

a) Are you limited by your disability? Y | N
If **yes** please describe your limitations.

b) When did you stop work in your usual occupation?
Please give details.

Date / / Time am/pm

c) Did you cease work solely due to sickness or injury? Y | N

d) Did you cease work on this date on medical advice? Y | N
If **no** please give details.

8.0 Occupation details

a) What is your occupation?

b) What is your business/employer's name?

c) What is your business/employer's address?

d) Please give details of your occupation(s) over the last five years including periods of unemployment, beginning with your current occupation.

From	To	Occupation	Employer/name of business
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

e) Did you work prior to becoming disabled? Y | N

f) How many hours per day/week were you working prior to your disability? per day per week

g) List your duties before you became disabled; (e.g. staff supervision 20%, administration 10%, manual labour 30%, sales 40% = 100%)

	% before disability
i	
ii	
iii	
iv	
v	
vi	
TOTAL	

h) Since your injury/sickness, have you been: (please tick appropriate box)

☐ able to perform your usual occupation?

☐ unable to perform your usual occupation?

☐ able to do partial work? If you **ticked this box** please give date you commenced work / /

The following sections only need to be completed if claiming for Business Protection Plan, if not please skip to Section 11.0

9.0 Business details

a) If applying for cover under a Business Protection Plan, do any of the following currently apply?

i) Bankruptcy of the owners of the Business where Bankruptcy may have a significant impact on the on-going viability of the Business. Y | N

ii) Receivership of the Business. Y | N

iii) Liquidation of the Business. Y | N

iv) Winding-up of the Business. Y | N

v) Court-order for winding-up of the Business. Y | N

vi) The compromise of creditors of the Business. Y | N

vii) Did any of the above actions occur as a direct result of the death or disability of the life assured. Y | N

10.0 Income details

a) Are you: (please tick appropriate box)

☐ **Self employed (sole trader, partner)** ☐ **Salaried employee**

☐ **Contractor** ☐ **Unemployed**

☐ **Salaried employee for a company in which you have a financial interest.**

b) If you are a waged or salaried worker, please state your gross earnings for any consecutive 12 month period over the last 36 months.

$

Please provide verification of your income from your employer by way of a wage slip, copy of your employment contract tax return and tax assessment.

c) If you are self employed, a contractor or have a financial interest in a company of which you are also an employee, please complete the following:

☐ **Sole trader**

☐ **Partnership**

i) In the partnership there are currently _____ partners and my percentage interest in the business is _____

ii) Please provide details of the contractual agreement between partners.

☐ **Company**

i) There are currently _____ number of shareholders and my shareholding is on a ratio of _____

ii) I receive remuneration from the company by way of ☐ Shareholder salary ☐ Dividends Director's fees ☐ Other

d) Name of business. _____

e) Number of full time employees. _____

f) Number of part time employees. _____

g) Have you bought or sold any business during the six months prior to the date you are claiming from? Y | N
If **yes** please give details.

Please provide verification of your income details, financial statements, tax returns and assessments.

h) Gross income less business expenses for a consecutive 12 month period over the past 36 months.

Gross income from personal exertion before tax	$
Business expenses incurred in earning that income	$
Net income	$
Taxable income	$
LESS EQUALS	$

11.0 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 all claims proceeds received from any Debt Protection Cover benefits will be used to repay business debt in accordance with the terms and conditions laid out in the Debt Protection Cover Protection Benefit Sheet.

I hereby declare that all claims proceeds received from any Ownership Buyout Cover benefits will be used to activate a Buy/Sell agreement between the owners of the Business in accordance with the terms and conditions laid out in the Ownership Buyout Cover Protection Benefit Sheet.

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 / /

Parent or guardian if life assured is under the age of 16.

Name of parent or guardian

Signature of parent or guardian

Date / /

12.0 Final checklist of documents you need to send to us

If applying for Ownership Buyout cover do you currently have an ownership buyout agreement? If so could you please provide a copy of it to Partners Life.

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

Lump sum medical doctor's questionnaire (To be completed by a registered medical practitioner or dentist at the client's expense)

Policy number

Life assured

Title	Surname	First name(s)

To the medical attendant:

The above life assured is claiming a lump sum benefit from Partners Life Limited and we require the following information from you, as the registered medical practitioner for the life assured, in order to assess this claim as quickly as possible. Thank you for your assistance.

Doctor/dentist

Title	Surname	First name(s)

Address

Business phone ( )

Facsimile ( )

Email address

a) How long has the patient been under your care?

Months	Years

b) Do you hold all medical records for the last five years? Y | N

If **no** please give details of the previous doctor(s) if known.

Name	Address
Name	Address

c) What is the medical condition or suspected condition requiring treatment or investigation?

Please also provide the ICD 10 reference code.

d) When did the signs and/or symptoms of this condition become apparent to the life assured for the very first time? / /

e) When did the life assured first consult with a medical professional including you or your practice in regards to this condition? / /

f) Is the claim accident or injury related? Y | N

If **yes** please give the date the accident or injury or symptoms of this condition occurred. / /

g) How often has the life assured consulted a medical practitioner regarding this condition?

Please give dates.

Name of medical practitioner	Date
	/ /

h) Has the life assured consulted you, or any other treatment provider for any other symptoms or conditions that may be associated with the condition they are claiming for? Y | N

If **yes** please give details.

i) Please give date of referral to specialist.
Please attach a copy of the referral letter and the specialist report received in response.

/ /

j) Please give details of any other treatment options that have been, or may be considered.

k) Please advise how long you anticipate the patient to be off work for and specify why, as well the date that you first gave this prognosis.

Declaration

- I declare that the above information, and other information supplied by me in relation to this form, is true and correct and that no information relevant to the life assured has been omitted from this form.
- I declare that I am registered as a medical practitioner with the Medical Council of New Zealand and am not the patient, the policy owner or either of their respective partners or relatives.
- I consent and authorise Partners Life Limited to disclose to its associated companies, advisers, reinsurers or any other party authorised by the life assured, any information provided by me in connection with this form for any of the purposes authorised by the life assured.

Signature of doctor/dentist

Date / /

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