Claim

Policy number

partners life

Monthly Benefit

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:

☐ Income ☐ Premium ☐ Mortgage Repayment ☐ Household Expenses ☐ Loss of Revenue

☐ Variable Loss of Revenue

2.0 Life assured's details

Title | Surname | First name(s)

Place of birth | Male ☐ | Female ☐

Street address | Suburb

Town/City | Postcode

Postal address (if different from above)

Email address

Contact number | Alternate contact number

a) Do you have medical insurance? Yes ☐ No ☐

If **yes,** please name the insurer.

3.0 Policy owner(s) details

First owner

Title | First name(s)

Surname or company name

Street address

Town/City | Postcode

Email address

Contact number

Male ☐ Female ☐ Date of birth

Second owner

Title | First name(s)

Surname or company name

Street address

Town/City | Postcode

Email address

Contact number

Male ☐ Female ☐ Date of birth

a) Are you notifying a change of address? Yes ☐ No ☐

b) If yes, do you want Partners Life to update your records? Yes ☐ No ☐

4.0 Accident details

a) When did the accident occur? Date Time am/pm

b) Where did the accident occur?

c) Please state the nature and extent of your injury. If the accident involves a limb, please state whether left or right.

d) Is your claim covered by ACC, workplace insurance, or group insurance policy? Yes ☐ No ☐
If **yes,** please give your insurer's name and postal address along with details and copies of supporting documentation verifying your claim entitlement and progress.

e) What treatment/rehabilitation are you undergoing for this injury?

5.0 Sickness details (This section to be completed if the claim is in respect of a sickness)

a) Describe your symptoms.

b) Please provide the date of onset of these symptoms. Date

c) Have you ever had the same or similar symptoms?
If **yes,** please give date, the name of the doctor or hospital that treated you, and their contact details.

Date	Name of doctor or hospital	Contact details

6.0 Treatment details

a) Please give the name and address of your usual doctor.

Name Address

b) Does this doctor hold your full medical history notes? Yes ☐ No ☐
If **no,** please give the name of the doctor(s) who would hold this information.

Name Address

c) Who was the doctor who first treated you for this sickness or injury?
Please give name and address and when/where you were first treated for this sickness/injury.

Name of doctor	Doctor's address	Location dated	Date

d) Date of first consultation. Date

e) Dates of subsequent consultations. Date Date Date Date

f) Have you seen other medical professionals about your sickness/injury? Yes ☐ No ☐
If **yes,** please give details and dates.

Details of treatment	Date

g) Have you received any treatment for your sickness/injury? Yes ☐ No ☐
If **yes,** please give details and dates.

Details of treatment	Date

h) Have you been hospitalised for your sickness/injury? Yes ☐ No ☐
If **yes,** please give details and dates of your admissions and discharges and provide copies of your discharge forms.

Details of hospitalisation	Admission date	Discharge date

7.0 Income details

a) Are you claiming for Income cover? Yes ☐ No ☐
Yes. Continue to answer all questions. | **No**. Go to section 8.0 Occupation Details.

b) Is your Income cover Indemnity style cover? Yes ☐ No ☐
Yes. Continue to answer all questions. | **No**. Go to section 8.0 Occupation Details.

c) Are you: (please tick appropriate box)

- ☐ **Self employed (sole trader, partner)**
- ☐ **Contractor**
- ☐ **Unemployed**
- ☐ **Salaried employee for a company in which you have a financial interest**

d) 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.

$

e) Please give the name and address of your employer.

Name

Address

* 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.

f) 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

g) Name of business.

h) Number of full time employees.

i) Number of part time employees.

j) Has your business ceased trading since you became disabled? Yes ☐ No ☐

If **yes,** please provide date of cessation. Date _____

If **no,** have you or any family members been involved in the continued running of the business? Yes ☐ No ☐

Please give details of the financial arrangement.

k) Have you bought or sold any business during the six months prior to the date you are claiming from? Yes ☐ No ☐

If **yes,** please give details. Please provide verification of your income details, financial statements, tax returns and assessments.

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

l) 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	$	

m) While you are disabled, will you receive or are you entitled to receive any income from the following sources? Yes ☐ No ☐

If **yes,** please give the relevant monthly amounts.

Source	Amount	Gross	Net
ACC	$	$	$
Your employer	$	$	$
Your business (include any income generated net of expenses)	$	$	$
Any other insurance policy*	$	$	$
Income support services	$	$	$
Any work place fund or group scheme	$	$	$
Any other source	$	$	$
Total monthly amount	$	$	$

* If you have any other insurance benefits please complete the following.

Type of benefit: e.g. Income Cover, Mortgage Cover, Business Insurance, Household Expenses Cover, etc.	Company that policy is with	Amount	Start date

n) Have you ever made a claim under ACC/the Workers Compensation Insurance Act or any other disability policy before? Yes ☐ No ☐

If **yes,** please give details.

o) Have you been disabled through accident or sickness this year. Yes ☐ No ☐

If **yes,** how many days sick leave did you receive? days

p) Are you entitled to receive sick leave for your present disablement? Yes ☐ No ☐

If **yes,** how many days? days

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? Yes ☐ No ☐

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		%
vii		%
	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 — Date

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

j) How many hours did you work each week following the incapacity?

Week		% before disability	Amount earned per week	
1		%	$	
2		%	$	
3		%	$	
4		%	$	
5		%	$	
6		%	$	

k) When do you expect to return to your usual occupation? Please give dates.

☐ Part time ☐ Full time

9.0 Work capacity details

a) Are you limited by your disability? Yes ☐ No ☐

If **yes,** please describe your limitations.

b) When did you stop work in your usual occupation? Date — Time am/pm

Please give details.

c) Did you cease work solely due to sickness or injury? Yes ☐ No ☐

d) Did you cease work on this date on medical advice? Yes ☐ No ☐

If **no,** please give details.

10.0 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)

11.0 Adviser involvement

Would you like your financial adviser to be involved with the progress of your claim? Yes ☐ No ☐

Once completed please scan and email to claims@partnerslife.co.nz or post to:
Partners Life Limited. Private Bag 300995, Albany, Auckland 0752, New Zealand

12.0 Monthly Benefit Employment Questionnaire

*** Complete this section if you are claiming for Income Protection or Loss of Revenue, and must be completed by the employer, if applicable.**

Policy number

Life assured

Title	First name(s)	Surname

Please answer the following

a) How long has the life assured been employed by you?

b) What was their gross monthly income immediately prior to ceasing work due to their disability?
This amount includes motor vehicle allowances and fringe benefits.

c) What, if any, was the average monthly amount of overtime earned over the previous 12 months immediately prior to ceasing work due to their disability?

d) What were their main pre-disability duties? Please provide a copy of their role description if available.

Duty	Hours	Percentage %
		%
		%
		%

e) How many days off work had the life assured taken due to illness or injury in the six months immediately prior to ceasing work due to their disability?

f) If possible would you be willing to allow the life assured to work for reduced hours or restricted duties? Yes ☐ No ☐

g) How long will the life assured continue to receive income from you including any sick leave payments following their disablement?

h) Do you provide your employees with any type of disability benefit other than sick leave? Yes ☐ No ☐
If **yes,** please give details.

Declaration and consent

I certify that the information provided is true and correct and that I am authorised to provide this information on behalf of the employer.

Name of person who completed this questionnaire	
Position within the company	Contact phone number
Email	
Signature	Date

Once completed please scan and email to claims@partnerslife.co.nz or post to:
Partners Life Limited. Private Bag 300995, Albany, Auckland 0752, New Zealand

13.0 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, and/or by Partners Life's data storage providers, which includes cloud-based data storage providers (both in New Zealand and overseas).
- Under New Zealand privacy law, 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

14.0 Final checklist of documents you need to send to us

- ☐ Fully completed claim form
- ☐ Fully completed certificate of medical attendant
- ☐ Fully completed monthly employer questionnaire (if applicable)
- ☐ Financial information i.e. pay slips, financial statements (if applicable)
- ☐ Mortgage repayment information (if applicable)
- ☐ Household expense statements 3 months i.e. rent, electricity, gas, water bills (if applicable)

Once completed please scan and email to claims@partnerslife.co.nz or post to:
Partners Life Limited. Private Bag 300995, Albany, Auckland 0752, New Zealand

Certificate of medical attendant

Policy number

To the medical attendant:

a) This medical certificate and requested information must be completed in **full** and returned to **Private Bag 300995, Albany, Auckland 0752** or alternatively you can send a scanned copy to **claims@partnerslife.co.nz**

b) **Completion of this form is at your patient's expense.**

c) Please supply **copies of the patient's full history notes**, including any reports and results of investigations. Partners Life will pay reasonable charges for providing this information. Please provide an itemised account.

d) If you wish to contact the Parners Life Claims Department, please email us at **claims@partnerslife.co.nz** or call on **0800 14 54 33**.

Title | First name(s) | Surname

Patient's current occupation

Nature of sickness or injury

a) If applicable, please provide the DSM-IV diagnosis and assessment to support this.

b) Cause of injury. If applicable.

c) How long has the patient suffered from this condition?

d) Please give the date of first consultation and treatment in respect of this condition?

Date	Treatments

e) Please give dates of subsequent consultations and treatments in respect of this condition?

Date	Treatments

f) Please give the date on which you advised the patient to cease work solely due to their sickness or injury. Date

g) What is your proposed treatment plan?

h) Has the patient been referred or are you considering referring the patient to any other practitioner for further opinion, investigation or treatment?
If **yes,** please give details.

i) Has the patient been hospitalised? Yes ☐ No ☐

If **yes,** when were they admitted? Date | Discharged

j) Please name other medical provider(s) involved with the patient's care for this condition or injury?

Name(s) of medical provider(s)

k) Are there any complicating factors affecting or extending this condition? (e.g. family, work situation, other disorders). Yes ☐ No ☐

If **yes,** please give details.

l) In your opinion was the injury or sickness caused or aggravated by the patient's occupation, sport or pastime? Yes ☐ No ☐

If **yes,** please give details.

m) If you are not the patient's regular treatment provider, please give the name and address of the patient's regular treatment provider.

Name | Address

n) How long has this person been a patient of your practice?

Months | Years

o) Has the patient ever suffered from the same or any other disease or condition related to this disablement? Yes ☐ No ☐

If **yes,** please give details.

p) Has previous treatment been given prior to this period of disablement? Yes ☐ No ☐

If **yes,** please give details. Date | Date | Date | Date

q) Have you issued a certificate or completed any other reports regarding this injury or sickness? Yes ☐ No ☐

If **yes,** please give details.

r) Is or has the patient been unable to attend his/her usual occupation solely due to sickness or injury? Yes ☐ No ☐

If **yes,** please give details. From | To

s) Is or has the patient been partially disabled? Yes ☐ No ☐

If **yes,** please state how long the patient was or will be continuously partially disabled, so that he/she is prevented from attending to a material portion of the daily duties of his/her occupation.

i) Indicate the number of hours per week the patient is capable of working. Hours

ii) Please state the date the patient is capable of returning to their work. Date

t) In your opinion, what rehabilitation is appropriate for your patient and how can we support this?

u) Any other comments?

Declaration

I confirm that I have examined this patient and that the information provided is correct and complete.

Doctor's name | Qualifications

Address

Business phone | Facsimile

Email address

Signature of doctor | Date

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Partners Life Limited. Private Bag 300995, Albany, Auckland 0752, New Zealand