Claim

Policy number

partners life

Redundancy Update

1.0 Type of cover

☐ Mortgage Redundancy Cover ☐ Household Redundancy Cover

2.0 Life assured's details

Title		First name(s)		Surname	
Street address				Suburb	
Town/City				Postcode	
Date of birth					
Email address					
Contact number		Alternate contact number			

3.0 Mortgage details

The following section only needs to be completed if on claim for Mortgage Redundancy Cover.

a) Has there been any increase in your mortgage in the last month? Yes ☐ No ☐

b) Has there been any voluntary increase in repayments in the last month? Yes ☐ No ☐

c) Has there been any voluntary decrease in the term during the last month? Yes ☐ No ☐

d) Has the mortgage been discharged (paid in full) in the last month? Yes ☐ No ☐

4.0 Household Expenses

The following section only needs to be completed if on claim for Household Redundancy Cover.

a) Has there been any increase in your household expenses in the last 3 months? Yes ☐ No ☐

If **yes,** please provide the household expense statements for the last 3 months as proof.

5.0 Work details

a) Are you currently working in any capacity, whether on contract, part-time or full-time? Yes ☐ No ☐

i. If **yes,** please provide return to work date.

ii. How much have you earned in this period?

iii. How many hours have you worked?

iv. What type of work have you done?

6.0 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

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