**Chubb Life Insurance New Zealand Limited (Chubb Life)**
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# Medical Update Form

The below Life Assured is claiming a monthly benefit from Chubb Life Insurance New Zealand (Chubb Life), and we require the following information from you in order to manage the claim. The more information you are able to provide, the more accurately we will be able to manage the claim. Please note that this form is to be completed at the expense of the Life Assured. Thank you for your assistance.

## 1. Life Assured details

Policy number

Life Assured's full name — Surname | First name(s)

Date of birth — DD / MM / YYYY

Date of incapacity — DD / MM / YYYY

## 2. Claim details

(a) What was the primary diagnosis that caused the Life Assured to cease work?

(b) What is the current diagnosis preventing the Life Assured from working?

(c) Are there any other conditions or injuries that the Life Assured is experiencing?

(d) What treatment plan have you recommended for the current condition?

(e) Is the Life Assured compliant with the treatment you have recommended?
If **no**, please provide details — Yes ☐ No ☐

(f) Have you referred the Life Assured for any investigations or to other providers since the last update?
If **yes,** please provide details and attach the referral and any reports. — Yes ☐ No ☐

(g) In your opinion is a specialist medical review necessary at this time?
If **yes**, in which discipline and why? — Yes ☐ No ☐

(h) In your opinion are there any non-medical factors that are delaying the Life Assured's recovery?
(e.g. occupational, social or lifestyle) If **yes**, please provide details. — Yes ☐ No ☐

## 3. Work capacity

(a) What was the Life Assured's occupation at the time they ceased work?

(b) How is the current diagnosis preventing the client from working?

(c) In your opinion is the client fit for full time work in the above occupation?
If **yes**, from what date? Yes ☐ No ☐

If **no**, in your opinion how many hours per week is the client fit to work in the above occupation?

(d) In your opinion on what date will the Life Assured make a full return to the above occupation?

(e) Are you completing any other medical questionnaires or certificates for the Life Assured?
If **yes**, please provide details? Yes ☐ No ☐

(f) In your opinion has the Life Assured received the appropriate treatment to maximise recovery? If not, do you have further recommendations for further treatment including rehabilitation measures, for the Life Assured?.

## 4. Declaration

I have personally examined the Life Assured named above today and to the best of my knowledge the information given above is accurate and correct.

Name Surname First name(s)

Address

Phone

Email

MCNZ number

Date examined DD / MM / YYYY

Signature ✗ Date DD / MM / YYYY

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