Individual Update Form (For completion by the Life Assured)

1. Details

Policy number			
Name	Surname	First name(s)	
Street address			
Suburb/Town		Date of birth	DD / MM / YYYY
Phone	Home	Work	Mobile
Email			

2. Questions

(a) Please list all the providers you have seen since your last claim payment, including any doctors, therapists etc and the date that you saw them.

Provider	Date seen
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY
	DD / MM / YYYY

(b) Has there been any change in your condition since your last benefit payment? If **yes**, please provide details. Yes ◯ No ◯

(c) Are you working in any capacity either from home or from your place of work? Have you attended your workplace since your last claim payment? If **yes**, please provide full details including how many hours you have worked since the last update and the time and reasons for your attendance at work. Yes ◯ No ◯

(d) Which of your occupational duties does your condition prevent you from performing?

(e) Are there alternative occupational duties available for you? If **yes**, please provide details. Yes ◯ No ◯

(f) Are you involved in any unpaid or volunteer work?
If **yes**, please provide details including the number of hours per week. Yes ◯ No ◯

(g) Are you enrolled in or have you been participating in any study or training? If **yes**, please provide details Yes ◯ No ◯

(h) Have you been participating in any fitness or sporting activity? If **yes**, please provide details. Yes ◯ No ◯

(i) Since the last claim payment, have you received any of the following:

Any benefit or compensation from ACC, WINZ or any other insurance company? Yes ◯ No ◯

Received from | Amount $ | Gross/Net

Any income as a result of work undertaken? Yes ◯ No ◯

Received from | Amount $ | Gross/Net

Mortgage repayment insurance paid to you or your mortgage lender? Yes ◯ No ◯

Received from | Amount $ | Gross/Net

4. Declaration and consent

This application collects personal information about the Life Assured.

The intended recipient of this information is Cigna Life Insurance New Zealand Limited ("the Company") and the information collected will be held at the Company premises.

Failure to provide this information may result in your claim being declined or unable to be assessed. You have the right to request access to and correction of your respective personal information at any time.

Declaration

I acknowledge the statements and information provided in this claim form are accurate and complete in every respect.

As part of a monthly benefit 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).
- Insurers (whether public or private).
- Accident Compensation Corporation

I agree that a photocopy 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 the policy, maintain relevant statistical records and provide you with information about other products and services offered by Cigna Life Insurance New Zealand 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 insurer.
- The information will be held by Cigna Life Insurance New Zealand Limited.
- Under the Privacy Act you have the rights of access to, and correction of, any information provided.

Full name of Life Assured
(please print)

Signature of Life Assured ✗ Date DD / MM / YYYY

Cigna Life Insurance New Zealand Limited
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