Monthly Benefit Claim Form

1. Life Assured claim details

Policy number

Mr/Mrs/Miss/Ms — Surname — First name(s)

Home address

Postal address

Date of birth — DD / MM / YYYY — Business phone

Home phone — Mobile phone

Email

2. Policy Owner's details (if different from above)

Mr/Mrs/Miss/Ms — Surname — First name(s)

Postal address

Home phone

Business phone — Mobile phone

Email

Complete this section if your claim is for illness. If your claim is for an accident or injury please go straight to section 4

3. Questions – illness

(a) What is the illness that you are claiming for?

(b) When did you first become aware of symptoms? What were they?

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

(d) What treatment are you receiving for this illness?

(e) Have you ever suffered from the same or similar illness? If **yes**, please provide details. Yes ◯ No ◯

Please continue to section 5

4. Questions – accident or injury

(a) What is the accident or injury that you are claiming for?

(b) Date of accident or injury. DD / MM / YYYY

(c) Time and place of accident or injury.

(d) Describe how the accident or injury happened.

(e) Did the police attend the accident? If **yes**, please provide details. Yes ◯ No ◯

(f) Are the police investigating the accident? If **yes**, please provide details. Yes ◯ No ◯

(g) Have you ever suffered from the same or similar injury? If **yes**, please provide details. Yes ◯ No ◯

(h) Date that you first consulted a doctor for your injury. DD / MM / YYYY

(i) What treatment are you receiving for your injury?

(j) Have you lodged a claim with ACC for this injury? Yes ◯ No ◯

If **no**, please provide details as to why not.

If **yes**, Case Manager's name.

ACC Branch

ACC Claim number

For all claims

5. Questions – medical

(a) Date that you were medically certified to totally cease work. DD / MM / YYYY

(b) Date that you were medically certified for a partial return to work. Number of hours per week.

(c) State names of all providers consulted by you for this condition, including any doctors, physiotherapists, psychologists etc. to whom you were referred for further opinion or treatment and the date of the first attendance with each one.

First seen on	Provider	Address
DD / MM / YYYY		
DD / MM / YYYY		
DD / MM / YYYY		
DD / MM / YYYY		
DD / MM / YYYY		
DD / MM / YYYY		

(d) Name and address of your usual doctor and the doctor holding your records if different.

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

6. Questions - financial

(a) In the 12 months prior to ceasing work due to your condition have you been:

A full time employee ◯ A part time employee ◯ Self employed ◯ Unemployed ◯

(b) What has been your average monthly income earned for the best 12 consecutive months during the previous 36 months immediately prior to the Life Assured becoming disabled?

c) Are you receiving any other income, benefit or compensation from any other organisation (including WINZ or another insurance company) in relation to this condition? If **yes**, please provide details. Yes ◯ No ◯

(d) Have you received any income from your employer or business since ceasing work due to your condition?

If **yes**, please provide details. Yes ◯ No ◯

(e) If you are self employed, do you income split with a spouse or family member?

If **yes**, what percentage of the income does the spouse or family member generate? Yes ◯ No ◯

7. Questions – occupational

(a) What was your occupation at the time you ceased work due to your condition?

(b) Describe your usual occupational duties and the percentage of time spent on each of these duties.

(c) What is the average number hours you usually worked per week?

(d) Are there any light/alternative or reduced hours/duties available? If **yes**, please provide details. Yes ◯ No ◯

(e) Have you been able to perform any part of your normal duties since ceasing work? If **yes**, please provide details. Yes ◯ No ◯

(f) Is your job available for you to go back to? If **no**, please provide details. Yes ◯ No ◯

(g) Please advise the date you anticipate you will resume full time work or that you have resumed full time work DD / MM / YYYY

8. Payment details

◯ Please pay direct into bank account premiums are being deducted from

◯ OR attach a preprinted bank deposit slip

◯ OR pay claim direct to bank account

Name of Account

Account Number

Bank	Branch	Account number	Suffix

Please note that if you are making a claim under Mortgage Extra the payments will be made to the account that your mortgage is deducted from

9. Declaration and consent

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 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 and any Life Assured have the right to request access to and correction of your respective personal information at any time.

Declaration

I am the Policy Owner and hereby claim the benefit amounts 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 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).

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 Policy Owner(s)

Signature of Policy Owner(s) ✗ Date DD / MM / YYYY

Full name of Life Assured

Signature of Life Assured ✗ Date DD / MM / YYYY

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