Initial Medical Questionnaire

The below Life Assured is claiming a disability benefit from Cigna and we require the following information from you, as the Registered Medical Practitioner for the Life Assured, in order to assess the claim. The more information you are able to provide, the more accurately we will be able to assess the claim. Thank you for your assistance. Please note that this form is to be completed at the expense of the Life Assured.

1. Policy details

Policy number

Life Assured — Surname | First name(s)

Date of birth — DD / MM / YYYY

2. Claim details

(a) What is the primary diagnosis that has caused the current disability?

(b) When did the Life Assured first consult you for the condition they are claiming for?

(c) When did the Life Assured first experience symptoms of the condition?

(d) Has the Life Assured suffered from this condition in the past? If so, please provide details. Yes ◯ No ◯

(e) Are there any other illnesses or injuries that the Life Assured is suffering from? Yes ◯ No ◯

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

(g) Is the Life Assured compliant with the treatment you have recommended? Yes ◯ No ◯

(h) Are you aware of any rehabilitation plan that is in place for the Life Assured? Yes ◯ No ◯

(i) When did the Life Assured last consult you for the condition they are claiming for?

3. Work capacity

(a) What was the Life Assured's occupation at the time of diagnosis of their current disability?

(b) Have you advised the Life Assured to totally cease work? Yes ◯ No ◯

(c) If yes, on what date? DD / MM / YYYY

(d) If no, have you advised the Life Assured to reduce the number of hours they work? Yes ◯ No ◯

(e) If yes, on what date? DD / MM / YYYY

(f) How many hours per week did you advise the Life Assured to work?

(g) In your opinion on what date will the Life Assured make a full return to their pre-disability occupation?

(h) In your opinion are there any barriers to the Life Assured returning to full capacity in their pre-disability occupation?

(i) Are you completing any other medical questionnaires or certificates for the Life Assured? Yes ◯ No ◯

If so, please provide details.

(j) Please provide any comments you feel may assist us with the assessment of this claim and how to assist the Life Assured with a return to normal life and work activities.

4. Contact

If you would like an Cigna Claims Consultant or our Chief Medical Officer to contact you with respect to this claim please provide your phone number and the best time to call. Please note that you are able to invoice Cigna for this discussion.

Phone number | Contact time

5. Details of Registered Medical Practitioner

How long has the Life Assured been a patient of yours?

If less than 3 years do you hold the Life Assured's full medical records? Yes ◯ No ◯

Name

Address

Phone | Fax

Email

MCNZ number

Date DD / MM / YYYY

Signature ✗ Date DD / MM / YYYY

Declaration

- I declare that the above information, and other information supplied by me in relation to this form, is true and correct and that no information relevant to the Life Assured has been omitted from this form.
- I declare that I am registered as a medical practitioner with the Medical Council of New Zealand and am not the Patient, the Policy Owner or either of their respective partners or relatives.
- I consent and authorise Cigna Life Insurance New Zealand Limited to disclose to its associated companies, advisers, reinsurers or any other party authorised by the Life Assured, any information provided by me in connection with this form for any of the purposes authorised by the Life Assured.

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