Premium Cover

(Redundancy/Bankruptcy Claim Form)

1. Policy Owner's name and postal address

Policy number

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

Street Address

Town/city — Has your address changed? Yes ◯ No ◯

Email

Home phone — Mobile phone

2. Life Assured claim details (if different from the details above)

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

Street Address

Town/city — Date of birth DD / MM / YYYY

Email

Home phone — Mobile phone

3. Questions

Company Name — Date of redundancy DD / MM / YYYY

Date of employment DD / MM / YYYY (please tick one) Full time ◯ Part time ◯ Hours worked per week

(a) Reason for redundancy.

(b) Have you voluntarily chosen redundancy?

(c) Describe your usual occupational duties.

(d) During the last 12 months, have you been:

Self employed/partnership ◯ Unemployed ◯ Employed full time ◯ Employed part time ◯

(e) Have you ever been convicted of fraud or any offence involving dishonesty?

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

(f) Is there any further information that you think may affect this claim?

4. 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. I understand payments approved by the Company will be forwarded to me on receipt of accounts specifying the service provided and the amount payable.

As part of a redundancy/bankruptcy 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 employment, medical, financial or other personal information affecting such insurance which they may hold in respect of me:

- Registered Medical Practitioners and specialists.
- Employers.
- Dentists.
- Counsellors, psychologists and therapists.
- Government departments, agencies, organisations and enterprises.
- Hospitals (whether public or private).
- Accident Compensation Corporation.
- 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 this claim, service 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 employment 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 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

P3835 12-2020

Cigna Life Insurance New Zealand Limited
Private Bag 92131, Victoria Street West, Auckland 1142
Toll Free **T** 0508 464 999 **F** 0508 464 777
E insurancenz@cigna.com