

Chubb Life Insurance New Zealand Limited (Chubb Life)

Private Bag 92131, Victoria Street West, Auckland 1142 Toll Free **T** 0508 464 999 **E** Getintouch.NZ@chubb.com

Lump Sum Claim Form

1. Life Assured clain	n details
Policy number	
Mr/Mrs/Miss/Ms	Surname
	First Names
Home address	
Postal address	
Date of birth	Day Month Year Business phone
Home phone	
Email	
2. Policy Owner's na	ame and postal address (if different from above)
Mr/Mrs/Miss/Ms	
	Surname
Postal address	First Names
r ostar address	
Home phone	
Business phone	
Email	
3. Questions (for con	npletion by the Life Assured)
(a) Name of the medical co	ndition which you have been diagnosed with.
(b) When did you first beco	ome aware of symptoms and what were they?
(c) When did you first seek	medical advice for this condition?
(d) Name of the doctor wh	o initially diagnosed the condition and when?

Chubb Life Lump Sum Claim Form Page **1** of 2

Full name of Life Assured (please print) If a claim is being made by a child under 16 years of age, a parent or guardian must sign on the child's behalf.	(e) Have you ever suffered from t	he same or similar condition? If yes , please	provide	details.									
Specialist Location Date first seen (In) How long have you been a patient of your usual doctor? 4. Declaration and consent This application collects personal information about you and any Life Assured fror whom you are chaining under your reduce. The intended recipient of this information about you and any Life Assured fror whom you are chaining under your reduce. The intended recipient of this information is Chubb. Life insurance New Zealand Limited (the Company) and the information collected will be held at the Company persons. 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. Family to request access to and correction of your respective personal information in a rany time. The half of your provided the information provided by the Life Assured in this claim for myticin believe to be assurate and complete in the benefit amounts payable on the basis of the statements and information provided by the Life Assured in this claim for myticin believe to be assurate and complete in the Company, Its advisers, refersores and converted to the Company, Its advisers, refersores and converted to the Company, Its advisers, refersores and to any legal tribunal before which any question concern ring the insurance may as its, arm weld and financial or other personal information affecting such insurance which they may hold in respect for me. Registered Medical Practitioners and specialists. Dentits. Full name of Policy Owner(s) preserve from the first such as the provided preserve in the such as the provided pro													
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(please print) If a claim is being made by a child under 16 years of age, a parent or guardian must sign on the child's behalf.	(please print) Signature of Policy Owner(s)	Х								Day Mor	nth	Year	
· · · · · · · · · · · · · · · · · · ·	Full name of Life Assured												
Please insert parent's or guardian's full name and sign below.	(please print)				guardiar	n must s	sign on	the child	's behalf.				

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Date

Day

Month

Year

X

Signature of Policy Owner(s)