

## $Individual\ Update\ Form\ \ \hbox{(For completion\ by\ the\ Life\ Assured)}$

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						
	oviders you have seen sir	nce vour last clair	m pavment, ir	cluding any doctors, the	erapists etc and the	date that you saw them.
Provider		,	,,	,,		ate seen
						DD/MM/YYYY
						DD/MM/YYYY
						DD/MM/YYYY
(b) Has there been any	change in your condition	since your last b	enefit payme	ent? If yes, please provide	e details.	Yes No
	any capacity either from yes, please provide full det tendance at work.					
(d) Which of your occup	pational duties does you	r condition preve	ent you from p	performing?		
(e) Are there alternativ	ve occupational duties av	railable for you?	f <b>yes</b> , please p	rovide details.		Yes No
(f) Are you involved in a	any unpaid or volunteer v	work? If yes, plea	se provide de	tails including the numbe	er of hours per week.	Yes No

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(g) Are you enrolled in or have you been participating in any study or training? If yes, please provide details					
(h) Have you been participating in any fitness or sporting activity? If yes, please provide details.					
(i) Since the last claim payment, have you received any of the following:  Any benefit or compensation from ACC, WINZ or any other insurance or		Yes No			
Received from	Amount \$	Gross/Net			
Any income as a result of work undertaken?		Yes No			
Received from	Amount \$	Gross/Ne			
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.	<ul> <li>Government departments, agencies, organisations</li> </ul>	and enterprises.			
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 premises.	<ul> <li>Hospitals (whether public or private).</li> <li>Insurers (whether public or private).</li> <li>Accident Compensation Corporation</li> </ul>				
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.	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				
Declaration	required in connection with this claim is a collection of personal				
I acknowledge the statements and information provided in this claim form are accurate and complete in every respect.	<ul> <li>information.</li> <li>This information will be used to; assess and administer the policy, maintain relevant statistical records and provide you with</li> </ul>				
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	information about other products and services offered by Chubb Life Insurance New Zealand Limited.				
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,	<ul> <li>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.</li> </ul>				
financial or other personal information affecting such insurance which they may hold in respect of me:	<ul> <li>The information will be held by Chubb Life Insurance</li> <li>New Zealand Limited.</li> </ul>				
<ul> <li>Registered Medical Practitioners and specialists.</li> <li>Dentists.</li> </ul>	<ul> <li>Under the Privacy Act you have the rights of access to, and correction of, any information provided</li> </ul>				
<ul> <li>Counsellors, psychologists and therapists.</li> </ul>					
Full name of Life Assured (please print)					
Signature of Life Assured	Date DD/	MM / YYYY			

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