CHUBB®

Lump Sum Claim Form

1. Life Assured claim details

Policy number

Mr/Mrs/Miss/Ms

Surname

First Names

Home address

Postal address

Date of birth

Day Month Year

Business phone

Home phone

Mobile phone

Email

2. Policy Owner's name and postal address (if different from above)

Mr/Mrs/Miss/Ms

Surname

First Names

Postal address

Home phone

Mobile phone

Business phone

Email

3. Questions (for completion by the Life Assured)

(a) Name of the medical condition which you have been diagnosed with.

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

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

(d) Name of the doctor who initially diagnosed the condition and when?

(e) Have you ever suffered from the same or similar condition? If **yes**, please provide details.

(f) Please list the specialists that you have seen regarding this condition.

Specialist	Location	Date first seen

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

(h) 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 for whom you are claiming under your policy.

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.

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.

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 lump sum 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 Chubb 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 Chubb 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)
(please print)

Signature of Policy Owner(s) ✗ Date Day Month Year

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.
Please insert parent's or guardian's full name and sign below.

Signature of Policy Owner(s) ✗ Date Day Month Year

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