

Monthly Benefit Claim Form

1. Life Assured cla	im details
Policy number	
Mr/Mrs/Miss/Ms	Surname First Names
Home address	
Postal address	
Date of birth	Business phone
Home phone	
Email	
2. Policy Owner's	details (if different from above)
Mr/Mrs/Miss/Ms	Surname First Names
Postal address	
Home phone	
Business phone	
Email	
Compl	ete this section if your claim is for illness. If your claim is for an accident or injury please go straight to section 4
3. Questions - illn	ess
(a) What is the illness th	nat you are claiming for?
4224	
(b) When did you first b	ecome aware of symptoms? What were they?
(c) When did you first se	eek medical advice for this illness?
(d) \\(\begin{align*} \lambda \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	very receiving for this illness?
(d) what treatment are	you receiving for this illness?
(e) Have you ever suffer	red from the same or similar illness? If yes, please provide details.
Please continue to sec	tion 5

4. Questions - accident or injury		
(a) What is the accident or injury that you are claiming for?		
(b) Date of accident or injury.		
Day Month Year		
(c) Time and place of accident or injury.		
(d) Describe how the accident or injury happened.		
(e) Did the police attend the accident? If yes, please provide details.	Yes	No _
(f) Are the police investigating the accident? If yes, please provide details.	Yes	No 🗆
(1) The title pointer investigating the decidation in yes, prease provide decidis.		
(g) Have you ever suffered from the same or similar injury? If yes, please provide details.	Yes	No _
(h) Date that you first as wellted a destay for your initials.		
(h) Date that you first consulted a doctor for your injury. Day Month Year		
(i) What treatment are you receiving for your injury?		
(j) Have you lodged a claim with ACC for this injury? If no, please provide details as to why not.	Yes	No _
If yes , Case Manager's name.		
ACC Branch		
ACC Claim number		

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5.	Qu	estio	ns - r	nedic	al																													
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6.	Qu	estio	ns - f	inanc	ial																													
a) In	the	12 m	onths	prior t	to cea	sing	woı	rk dı	ıe to	you	ır cc	ondit	ion	hav	e yo	u be	en:																	
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				nployed														?														Yes		Vo [

Chubb Life Monthly Benefit Claim Form

7. Questions - occupational	
(a) What was your occupation at the time you ceased work due to your condition?	
(b) Describe your usual occupational duties and the percentage of time spent on each of these duties.	
(c) What is the average number hours you usually worked per week?	
(c) What is the average number hours you usually worked per week:	
(d) Are there any light/alternative or reduced hours/duties available? If yes, please provide details.	Yes No
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(e) Have you been able to perform any part of your normal duties since ceasing work? If yes, please provide details.	Yes No
(f) Is your job available for you to go back to? If no, please provide details.	Yes No
(g) Please advise the date you anticipate you will resume full time work or that you have resumed full time work Day Month Year	
8. Payment details	
Please pay direct into bank account premiums are being deducted from	
OR attach a preprinted bank deposit slip	
OR pay claim direct to bank account	
Name of Account	
Account Number	
Bank Branch Account number Suffix	

Please note that if you are making a claim under Mortgage Extra the payments will be made to the account that your mortgage is deducted from

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9. 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.

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.

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 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)						
Signature of Policy Owner(s)	Х	Date	Day	Month		
Full name of Life Assured						
Signature of Life Assured	Х	Date	Day	Month		