

# Claim

Policy number

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partners life

## Monthly Benefit - Specific Injury

### 1.0 Adviser involvement

Your adviser will be kept informed of your claim. Please indicate here if you do not want your adviser kept informed about your claim.

No, I do not want my adviser involved ☐

### 2.0 Type of cover

Please state what type of cover you are claiming for:

☐

Income

☐

Mortgage Repayment

☐

Household Expenses

### 3.0 Life assured's details

Title	<input type="text"/>	First name(s)	<input type="text"/>	Surname	<input type="text"/>
Date of birth	<input type="text"/>				
Street address	<input type="text"/>			Suburb	<input type="text"/>
Town/City	<input type="text"/>			Postcode	<input type="text"/>
Email address	<input type="text"/>				
Contact number	<input type="text"/>	Alternate contact number	<input type="text"/>		

### 4.0 Policy owner(s) details

#### First owner

Title	<input type="text"/>	First name(s)	<input type="text"/>
Surname or company name	<input type="text"/>		
Street address	<input type="text"/>		
Town/City	<input type="text"/>	Postcode	<input type="text"/>
Email address	<input type="text"/>		
Contact number	<input type="text"/>		
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of birth	<input type="text"/>

#### Second owner

Title	<input type="text"/>	First name(s)	<input type="text"/>
Surname or company name	<input type="text"/>		
Street address	<input type="text"/>		
Town/City	<input type="text"/>		
Email address	<input type="text"/>		
Contact number	<input type="text"/>		
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of birth	<input type="text"/>

a) Are you notifying a change of address? Yes ☐ No ☐

b) If yes, do you want Partners Life to update your records? Yes ☐ No ☐

## 5.0 Injury details

a) Please describe the injury you are claiming for.


b) When did the injury occur?

Date

Time  
am/pm

c) How did your injury occur?


d) Please confirm if your injury has required surgery or cast/immobilisation


e) What treatment/rehabilitation are you undergoing for this injury?


## 6.0 Treatment details

a) Please give the name and address of your usual doctor.

Name

Address

b) Please provide the name and location of all medical providers you consulted for this injury

Yes ☐ No ☐

Name


Address


## 7.0 Occupation details and work capacity

a) What is your occupation?

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b) What is your business/employer's name?

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c) Have you stopped work due to this condition?

Yes ☐ No ☐

If **yes**, when did you stop work?

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d) When do you expect to return to work? Please give dates.

Part time

Full time

8.0 If your claim is accepted, please note payment will be made by direct credit into the nominated account

**It's important that you complete this section properly.**

Please pay direct into the nominated bank account below.

Suffix

(Please attach an encoded deposit slip to ensure your number is loaded correctly)

If the Kiwisaver Option is selected for the life assured in the Policy Schedule, then Partners Life will pay the Kiwisaver Option to the life assured's Kiwisaver scheme provider.

IRD number

To enable us to process this, please provide the life assured's individual IRD number.

(Note: this is only collected for the purpose of Kiwisaver payments)

**Kiwisaver Option can only be paid if the life assured has opted into Kiwisaver.**

Once completed please scan and email to [claims@partnerslife.co.nz](mailto:claims@partnerslife.co.nz) or post to:  
Partners Life Limited, Private Bag 300995, Albany, Auckland 0752, New Zealand

0800 14 54 33 | [partnerslife.co.nz](http://partnerslife.co.nz)

## 9.0 Declaration and consent

### Please read and sign this declaration.

This claim form collects personal information about you and any life assured for whom you are claiming under your policy. The intended recipient of this information is Partners Life Limited ("the Company"). The Company collects, stores, uses and discloses personal information in accordance with its privacy policy available at [www.partnerslife.co.nz/privacy-policy](http://www.partnerslife.co.nz/privacy-policy). You are required to provide the information requested by the Company so as to comply with your common law duty to disclose all matters material to the insurance. Failure to provide information requested by the Company 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 by contacting Partners Life on 0800 14 54 33.

#### Declaration

I am the policy owner and hereby claim the benefit amount 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 hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide Partners Life Limited such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

Name/company name of first policy owner

Signature/authorised signature of first policy owner

Date

Name/company name of second policy owner

Signature/authorised signature of second policy owner

Date

Name of life assured

Signature of life assured

Date

I, the life assured, authorise the Company and its agents to seek from, and disclose to, any medical, financial or other personal information which they may hold in respect of me, third parties including but not limited to:

- Registered medical practitioners and specialists
- Dentists
- Counsellors, psychologists and therapists
- Government departments, agencies, organisations and enterprises
- Hospitals (whether public or private)
- Accident Compensation Corporation
- Insurers (whether public or private)
- Credit rating and collection agencies
- Employers (whether current or not)
- Advisers
- Reinsurers
- Any legal tribunal before which any question concerning the insurance may arise

## 10.0 Final checklist of documents you need to send to us

- ☐ Fully completed claim form
- ☐ A copy of the x-ray/radiologist reports
- ☐ A copy of the discharge summary from the hospital