

Claim Form



Premium Holiday and Policy Suspension

Policy number

1.0 Life assured's details

Title	Surname	First name(s)
Street address		Suburb
Town/city	Postcode	
Home phone ()		Business phone ()
Email address		Mobile ()

2.0 Requirements

Please tick one of the following options

Claim Cause	Premium Holiday	Policy Suspension	Requirements
Redundancy	<input type="checkbox"/>	<input type="checkbox"/>	Letter from employer
Bankruptcy	<input type="checkbox"/>	<input type="checkbox"/>	Client details & Company Name
Carer for spouse, defacto partner, civil union	<input type="checkbox"/>	<input type="checkbox"/>	Letter from GP
Death of spouse, partner, or child	<input type="checkbox"/>	<input type="checkbox"/>	Certified copy of death certificate
Leave without pay	N/A	<input type="checkbox"/>	Letter from employer
Overseas travel	N/A	<input type="checkbox"/>	Itinerary
Parental leave	N/A	<input type="checkbox"/>	Letter from employer
Tertiary Education	N/A	<input type="checkbox"/>	Acceptance Letter from institution

3.0 Final checklist of documents you need to send to us

- Fully completed claim form
- Copies of any formal documentation in line with the requirements listed

4.0 Declaration and consent

❖ Please read and sign this declaration

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 Partners Life Limited ("the Company").

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 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.

As part of a medical insurance 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

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.

- Hospitals (whether public or private)
- Accident Compensation Corporation
- Insurers (whether public or private)
- Credit rating and collection agencies
- Employers (whether current or not)

I agree that a photocopy, facsimile or scan 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 this claim; service and administer the policy; maintain relevant statistical records; and provide you with information about other products and services offered by Partners Life 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 insurance.
- The information will be held by Partners Life Limited at the address on this form.
- Under the Privacy Act 1993 you have the rights of access to, and correction of, any information provided.

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

Name of life assured

Signature of life assured

Date