

Claim

Policy number

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Monthly Benefit - Dependent Caregiver Option

1.0 Adviser involvement

Your adviser will be kept informed of your claim. Please indicate 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 First name(s) Surname

Date of birth

Street address Suburb

Town/City Postcode

Email address

Contact number Alternate contact number

4.0 Policy owner(s) details

First owner

Title First name(s)

Surname or company name

Street address

Town/City Postcode

Email address

Contact number

Male Female Date of birth

Second owner

Title First name(s)

Surname or company name

Street address

Town/City Postcode

Email address

Contact number

Male Female Date of birth

- 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 Dependents details

a) What is the full name and date of birth of the dependent requiring full time care?

First name(s) Surname

Date of birth

b) What is the life assured's relationship to the dependent?

c) Please explain why the dependent requires full time care, including when symptoms first commenced, the diagnosis and treatment requirements

6.0 Life assured's occupation details

a) What is your occupation?

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

c) How many hours per week did you work immediately prior to the dependent requiring care?

d) Have you taken leave or ceased work completely to care for the dependent?

Yes No

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

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

Part time Full time

f) Are you receiving any financial support from any other sources to help care for the dependent?

7.0 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.

Account holder

Bank/building society name

Bank

Branch

Account number

Suffix

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

8.0 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. 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

9.0 Final checklist of documents you need to send to us

Medical evidence from the specialist or medical doctor supporting the need for full time care