

# Claim

Policy number

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partners life

## Redundancy Benefit

### 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 Life assured's details

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

### 3.0 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"/>	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"/>

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

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

### 4.0 Please answer the following

a) What date were you informed there may be a change in your workplace which could affect your position?

This information may have been provided verbally or in writing, or a proposal may have been provided requestion feedback on any changes being considered.

Date

b) When was your last working day?

Please include a copy of the formal letter advising your position has been made redundant.

Date

c) Was your position permanent? Yes  No

d) What were your hours of work and your annual income?

<input type="text"/>	hours
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e) When did you commence working for the employer?

Date

f) Have you since obtained further employment?

Yes  No

(please provide details, including part-time employment, or employment commencing at a future date)

5.0 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)

## 6.0 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

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

- Fully completed claim form
- Formal letter advising your position have been made redundant
- Written confirmation your position was permanent