

# Redundancy Claim Form

Only use this form for AIA REAL, Superior Health or other policies issued by AIA International Limited, New Zealand Branch.



## 1 Life Assured details

Policy number	<input type="text"/>	Date of birth	<input type="text" value="Day"/> <input type="text" value="Month"/> <input type="text" value="Year"/>
Full name	<input type="text"/>		
Street	<input type="text"/>	Suburb	<input type="text"/>
City	<input type="text"/>	Postcode	<input type="text"/>
Home phone	<input type="text"/>	Mobile	<input type="text"/>
Email address	<input type="text"/>		

## 2 Payment details

Please pay claim direct to bank account	<input type="checkbox"/>	Name of account <input type="text"/>											
	or	Bank	Branch number			Account number				Suffix			
<input type="checkbox"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Attach a preprinted bank deposit slip	<input type="checkbox"/>												
or	<input type="checkbox"/>	Pay direct into bank account premiums are being deducted from											
Full name of Policy Owner	<input type="text"/>	Date (dd/mm/yyyy)	<input type="text" value="Day"/> <input type="text" value="Month"/> <input type="text" value="Year"/>										
Signature of Policy Owner	<input type="text" value="X"/>												
Full name of Policy Owner	<input type="text"/>	Date (dd/mm/yyyy)	<input type="text" value="Day"/> <input type="text" value="Month"/> <input type="text" value="Year"/>										
Signature of Policy Owner	<input type="text" value="X"/>												

## 3 Authority for Adviser/Broker involvement

I authorise AIA to release any of my personal information and to discuss any details of my claim, including medical or financial details, with my Adviser/Broker

Name of Adviser/Broker	<input type="text"/>
Signature of Life Assured	<input type="text" value="X"/>

## 4 Employment details (To be completed by the Life Assured)

(a) Prior to ceasing employment, were you	<input type="checkbox"/> An employee?	<input type="checkbox"/> Self-employed?
(b) If you were an employee, state the name and address of your last employer	<input type="text"/>	

(c) Date you ceased employment

(d) Are you still unemployed?  Yes  No If No, on what date did you begin your new job?

(e) Reason for termination of employment?

(f) Are you registered with Work and Income New Zealand or any other agency?  Yes  No  
If Yes, please provide  
Name of agency   
Name of Case Manager   
Claim number

(g) How many hours did you work on average per week for the six month period immediately prior to redundancy?

(h) Have you received or are you entitled to receive, income replacement or redundancy benefits under:  
 ACC  
 Any other insurance policy  
 WINZ payments (e.g. sickness or unemployment benefits)  
 Other (e.g. medical retirement or redundancy settlement)  
 Unsure

Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>
<input type="text" value="/ /"/>	<input type="text" value="/ /"/>

Please provide full details

Please provide full details

If any of the above were ticked, please provide:

(i) Name of organisation or company making payment

(ii) Amount of monthly income or compensation or lump sum payment \$

## 5 Declaration and Consent

### Notice under the Privacy Act 2020

This claim form collects personal information about you. This information is collected for the purpose of assessing your claim with AIA New Zealand Limited ("AIA"). Failure to provide this information may result in your claim not being processed and monthly payments not being made to you. The personal information collected will be held at AIA's Auckland office at 74 Taharoto Road, Takapuna, Auckland. You have certain rights of access and correction of personal information under the Privacy Act.

I declare that the answers on this form, made in relation to my claim with AIA are true and complete. I, the **Life Assured**, declare that all occupational and financial information pertaining to me has been provided and disclosed to AIA.

I understand that failure to provide full disclosure of all occupational and financial information that AIA would deem as relevant in the assessment of my claim under my policy(ies) would be considered to be material misrepresentation and/or material non-disclosure and as such AIA is entitled to use legal remedy, should this occur.

I further understand that the occupational and financial information provided is the basis on which AIA will base the on-going assessment of my claim under my policy(ies) and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information or the provision of false information may result in my claim being declined or unable to be assessed.

I further declare that if the answers to the questions in this Redundancy Claim Form are not in my handwriting, then they have been correctly written down at my dictation.

I consent and give authority to AIA to request from AIA New Zealand Limited, or disclose to AIA, any information pertaining to me and relevant to the assessment of my insurance claim.

I consent to AIA sharing information regarding my claim

As a part of a redundancy claim with AIA, I, the **Life Assured**, consent and give authority to AIA and any related entities to seek from and for all and any of the following, their officers and employees, to disclose to AIA and any related entities, their advisers, reinsurers and to any legal tribunal before which any questions concerning the insurance may arise, any financial, or other personal information affecting such insurance which they may hold in respect of me/us:

- > Accountant and other financial advisers;
- > Accident Compensation Corporation;
- > Banks and other financial institutions;
- > Employers (whether current or not);
- > Government departments, agencies, organisations and enterprises eg: IRD;
- > Insurers (whether public or private);
- > Your adviser/broker/insurance agent.

I understand that AIA may share my claim details with related insurers to enable co-ordination of claims resolution.

I, the **Life Assured**, agree that a photocopy of this authority will be valid as an original.

I/We, the policy owner(s), hereby claim the benefit amounts on the basis of the statements and information provided by the Life Assured in this claim form which I/we believe to be accurate and complete in every respect.

Full name of Life Assured

Signature of Life Assured

Date

Day Month Year

/ /

Name of Policy Owner

Signature of Policy Owner

Date

Day Month Year

/ /

Name of Policy Owner

Signature of Policy Owner

Date

Day Month Year

/ /

**6 Employer details** (Please ask your last employer to complete this section)

- (a) Name of employer
- (b) Employer address
- (c) Full name of employer's representative completing this form
- (d) Life Assured was employed by you From  To
- (e) Have you employed anyone else to fill this Life Assured's position?  Yes  No
- (f) Did the Life Assured accept voluntary redundancy?  Yes  No
- (g) Was the Life Assured in full time employment with the employer at the date of redundancy?  Yes  No If No, please provide details of the basis of their employment (e.g. contract worker, seasonal worker, casual employee, etc) and hours worked on a regular basis
- (h) If this person was not made redundant, what is the reason for his/her unemployment?
- (i) Does the Life Assured or a relative of the Life Assured have ownership or control (e.g. a majority shareholding, ownership) of the employer from which the Life Assured has been made redundant?  Yes  No If Yes, please provide full details
- (j) Please give the date that the Life Assured was notified that he/she would or might be made redundant
- (k) What date was it generally known that redundancies were being considered by your company?
- (l) How many other personnel were made redundant at the same time as the Life Assured?

**7 Employer's Declaration**

I hereby declare the information given is true, correct and complete and that no material information has been withheld.

Name of Employer's Representative

Title

Company name

Signature of Employer's Representative

Date  
(dd/mm/yyyy)

Company stamp

X

