CLAIM FORM

Redundancy, Disability (injury, illness) or Death

Consumer Insurance Services Limited

CONTRACT NUMBER:

Please complete where applicable and return within 7 days. Please print.

As required by the Privacy Act 1993, the following is brought to your attention:

(a) Parts of the claim form and any further enquiries we make of you in order to consider your claim is the collection of personal information about you;
(b) The information is collected to evaluate your claim;
(c) The intended recipient of the information is Consumer Insurance Services Limited;
(d) The information is collected and held by Consumer Insurance Services Limited and its agents for the purpose of processing your claim;
(e) The collection of this information is required pursuant to your insurance policy;
(f) The failure to provide this information may result in your claim being declined;
(g) You have certain rights of access to and correction of this information, subject to the provisions of the Privacy Act 1993. But subsequent correction of false information will not affect our right to decline your claim;
(h) The making of a false representation with a view of obtaining benefit under an insurance policy constitutes an offence under the Crimes Act 1961.

Insured's Name		Agreement Date	
Insured's Date of Birth		Employer's name	
Address		Employer's address	
Occupation		Employer's Phone number	
Telephone		Hours/Week at Date of Liability	**(attach latest payslip)**

Death If claim is in respect of death

Claimant's Name — Title | First Name/s | Surname

Address

Telephone | Relationship to Deceased

Please attach a copy of the Full Death Certificate. Please arrange for the deceased's Doctor to complete the reverse side of the claim form as appropriate.

Injury If claim is in respect of bodily injury resulting from an accident

Date/time of accident / : am/pm | Date you stopped work due to this accident

Place of accident

How did the injury occur

(provide full details)

Doctor(s) in attendance — Name | Address | Telephone

Your Doctor must complete the reverse side of this form. Please forward copies of any ACC certificates in relation to your injury.

Illness If claim is in respect of an illness

Date when doctor first examined you | Date you stopped work due to this illness

Name of illness

Have you suffered previously from the same or similar illness for which you are now claiming for? Yes No

If yes, give details

Doctor(s) in attendance — Name | Address | Telephone

Your Doctor must complete the reverse side of this form.

Redundancy If claim is in respect of redundancy (To be completed by your Former Employer)

Name of Employer | Position held

Name of Company | Contact Telephone No.

Effective Date of Redundancy | What date was our Customer first made aware of their redundancy?

How long was our Customer employed with your Company?

Position held by our Customer with your Company?

Was this a temporary, part-time, seasonal or fixed term contract position?

Average hours worked per week | Was redundancy voluntary? Yes No

Reason for Redundancy

I declare that the foregoing statements and particulars are true and correct in every detail and that no relevant information has been withheld.

Signature of Former Employer | Date

A letter from your employer advising of redundancy or suspension must be attached. Please forward confirmation from Work and Income NZ that you have registered with them as unemployed, including the date you first registered, together with your Claim Form.

I, the undersigned, hereby declare that the above statements are true in every respect and made without reservation. I also hereby authorise the collection, use and disclosure of any personal information by Consumer Insurance Services Limited and its agents in relation to this claim.

Signature | Date

NOTE Please ensure that both sides of this claim form are completed where applicable, and complete the authority at the bottom of the back page.

MAIL TO Consumer Insurance Services Ltd, 111 Carlton Gore Road, Newmarket, Auckland 1023, Private Bag 94013, Manukau City, Auckland 2241.
Ph (09) 525 4770 Fax (09) 525 4771 Freephone 0800 855 333

FCL1295 06/17

Medical Report

If claiming for disability (injury/illness) or death, **this report must be fully completed by your Doctor.**

Name of Patient

1 Date of accident or disability (if treatment included an operation, onset date of accident or disability necessitating operation) or cause of death.

2 Please detail nature of injury, illness or cause of death.

3 On what date did the Patient first consult you in connection with this event/condition?

4 Are you the Patient's usual Medical Attendant? Yes ☐ No ☐

If "Yes", how long have you known him/her?

5 Has the patient consulted other doctors prior to you about this event/condition? Yes ☐ No ☐

If "Yes", who?

6 Has the Patient previously suffered from this type of injury or illness from which they are now suffering or which caused their death? Yes ☐ No ☐

If "Yes", please detail history of condition

Would the Patient have been aware of this condition? Yes ☐ No ☐

What treatment was the Patient receiving and how long have they been receiving this?

7 If claim is for injury, are the appearances of the injuries consistent with the causes stated? Yes ☐ No ☐

8 Is the Patient suffering from any other injury or illness irrespective of that stated above? Yes ☐ No ☐

If "Yes", please state the nature of this and to what extent it may effect the patient's recovery from this event/condition.

9 In your opinion is the injury, illness or death attributable to, or as a result of, any physical defects or illness existing at a prior date? Yes ☐ No ☐

If "Yes", please give details i.e. name and dates of diagnosis for defects/disability and date and type of treatments/medication given for these.

10 Is the Patient totally disabled from attending his/her occupation (unable to work at all)? Yes ☐ No ☐

If "Yes", anticipated length of total disablement from working From for wks/mths

11 Date Patient is, or should be released to return to work (if known)

12 Is it likely that the Patient will have to change their occupation due to this illness/accident? Yes ☐ No ☐

If "Yes", why?

13 Is the Patient seeing any specialists about his/her condition? Yes ☐ No ☐

If "Yes", who?

Other Remarks

PLEASE PRINT: I certify that to the best of my belief the foregoing statements are correct:

Name: Qualifications:

Address:

Date: Signature: Doctors Stamp:

AUTHORITY TO OBTAIN FURTHER INFORMATION (To be completed by claimant in all cases)

I (full name)

of (address)

Insured's Name

hereby authorise full disclosure of any information regarding the insured's employment terms and history, accident or injury/ illness, and medical history, including copies of any medical reports, clinical reports or otherwise to Consumer Insurance Services Limited on their request.

Signed: Date:

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