

# SIMPLE LIFE LOAN AND RENT ASSISTANCE CLAIM FORM

SOVEREIGN

(Please print clearly)

## 1 About you

Policy number

Client	Mr/Mrs/Ms	Name and surname		
Date of birth				
Mailing address				
Residential address (If different from above)				
Telephone	Home ( )	Mobile ( )	Business ( )	
Email				

## 2 About your absence from work

(a) On what date did you first seek medical assistance for your current condition/claim?	/ /
(b) On what date did you totally cease work?	/ /
(c) On what date were you medically certified to cease work?	/ /
(d) Please describe your illness or injury	
(e) What diagnosis has been given?	
(f) What symptoms prevent you from working?	
(g) Have you ever suffered from the same or similar illness or injury? If yes, please give full details including dates.	
(h) What medical investigations have been undertaken?	
(i) What treatment is being provided?	
(j) What medications are you currently taking?	
(k) What have you been told is the expected date of return to light/part-time work duties?	
(l) What have you been told is the expected date of return to full and unrestricted work duties?	

(m) Your current GP details

Name
Medical practice
Address
Telephone number (    )
Fax number (    )
Email Address

**3 About your job**

(a) Employment status

Employed   
  Self employed   
  Other   
  Homemaker   
  Leave without pay

(b) What was your occupation immediately prior to ceasing work?

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(c) Describe your exact duties and the percentage of time spent on each duty

	% of time on each duty
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(d) Number of hours usually worked per week

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(e) What duties are you able to perform?

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(f) What duties are you unable to perform?

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(g) Is your job available for you to go back to? If not please provide details

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**4 About your payment**

Please make any benefit payment into the following account

Name of account

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Account

Bank	Branch		Account number								Suffix										

Full name of policy owner

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Signature of policy owner

	Date    /    /
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Full name of policy owner

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Signature of policy owner

	Date    /    /
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5 Consent

As part of an insurance claim with Sovereign Assurance Company Limited (Sovereign), I, the life assured consent and give authority to Sovereign and any of its related companies and agents to request any of my medical or other personal information affecting my insurance or the assessment of my claim from any third party which Sovereign reasonably considers may hold that information.

I also authorise those third parties to disclose that information to Sovereign, its advisers and reinsurers, and to any legal tribunal before which any question concerning my insurance may arise. Those third parties may include:

- > Registered medical practitioners and Specialists (which may include an entire copy of my/our medical file)
> Medical laboratories and testing facilities
> Accident Compensation Corporation governmental departments or bodies
> Insurers or reinsurers (whether public or private)
> Counsellors, psychologists and therapists, and
> Any other person or organisation which holds information which is relevant to my insurance or the assessment of my claim.

I understand that the supply of the information gathered from the above sources is voluntary and that Sovereign may or may not seek information from the above agencies - whether they seek information is dependent on what information is required to make a decision on my Insurance. I understand that my personal information will only be held for as long as is necessary to achieve the purpose for which it was collected or longer if required by law.

I understand that my personal information will be stored at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I understand that Sovereign will take reasonable steps to keep such information secure (whether in New Zealand or elsewhere).

I understand that Sovereign may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of my personal information may be requested by me.

6 Declaration - Important, please read carefully

I, \_\_\_\_\_ declare that all occupational, medical and financial information pertaining to me, and relevant to my insurance claim, has been provided and disclosed to Sovereign.

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

I further understand that the occupational, medical and financial information provided is the basis on which Sovereign will assess and manage my claim and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information may result in my claim being declined or being unable to be assessed.

I declare that all the answers to questions in this form are true and complete. If any answer is not in my handwriting I declare that this has been written down at my dictation.

I further agree that a photocopy of this authority will be valid as an original

Form fields for Life Assured: Full name of Life Assured, Signature of Life Assured, Date

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

Form fields for Policy Owner 1: Full name of policy owner, Signature of policy owner, Date

Form fields for Policy Owner 2: Full name of policy owner, Signature of policy owner, Date

