SIMPLE LIFE REDUNDANCY CLAIM FORM

SOVEREIGN

1 Life Assured details to be completed for all claims

Policy number

Mr/Mrs/Miss/Ms (please circle)

Last name | First name(s)

Mailing address

Residential address (if different from above)

Telephone

Home ( ) | Mobile ( ) | Business ( )

Date of birth / /

2 Payment Details

Please pay claim direct to bank account ☐

Name of account

or

Attach a preprinted bank deposit slip ☐

Bank | Branch | Account number | Suffix

or

Pay direct into bank account premiums are being deducted from ☐

Names(s) and signature(s) of Policy Owners(s)

Name

Signature | Date / /

Name

Signature | Date / /

3 Authority for Adviser

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

Name of Adviser

Signature of Life Assured

Signature | Date / /

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

(a) Were you employed for financial reward in a permanent position for the 90 days prior to the termination of your employment? ☐ Yes ☐ No

(b) Prior to ceasing employment, were you ☐ An employee ☐ Self-employed ☐ On leave without pay

Employment details continued

(c) If you were an employee, state the name and address of your last employer

(d) Date you ceased employment

/ /

(e) Are you still unemployed?

☐ Yes ☐ No

If no, on what date did you begin your new job? / /

(f) Reason for termination of employment?

(g) Are you registered with Work and Income New Zealand or any recruitment agency?

☐ Yes ☐ No

If yes, please provide

Name of agency/Recruitment agency

Name of Case Manager/Consultant

Claim number

(h) How many hours did you work on average per week for the 90 day period immediately prior to redundancy?

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/or other premises in New Zealand occupied by Sovereign 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 medical 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 medical 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 medical 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

Please print full name of Life Assured		
Signature of Life Assured		Date / /
Signature(s) of Policy Owner(s)		Date / /
		Date / /

7 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) Did the Life Assured accept voluntary redundancy? ☐ Yes ☐ No

(f) 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

(g) If this person was not made redundant, what is the reason for his/her unemployment?

(h) 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

(i) Please give the date that the Life Assured was notified that he/she would or might be made redundant

Date / /

(j) What date was it generally known that redundancies were being considered by your company?

Date / /

8 Declaration (To be signed by Employer)

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

Signature

Name

Date / /

Title

Company name

Company stamp

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