



Total and Permanent Disablement CLAIM FORM – CONFIDENTIAL

PLEASE COMPLETE THE FOLLOWING AND RETURN TO

AXA New Zealand Claims
PO Box 1692
WELLINGTON

Policy number

STATEMENT OF CLAIM Before submitting a claim, refer to your Policy Document

Title Given name(s) (please print) Surname

Male Age last birthday Date of birth Date of last day at work

Female / / / /

RESIDENTIAL ADDRESS OF LIFE INSURED

Street number and name Suburb

Town/City Postcode Country

Home phone Business phone Mobile phone

() () ()

Email address

POSTAL ADDRESS OF LIFE INSURED (IF DIFFERENT FROM ABOVE)

Street number and name/PO Box Suburb

Town/City Postcode Country

SECTION A: DETAILS OF DISABLEMENT Attach documentary evidence of your disability

1 State the exact nature and cause of your disability?

2 State the date when you first attended a doctor, specialist or hospital for your disability along with the name and addresses of the doctor or hospital.

Date of visit / / Name of doctor/specialist/hospital

Address of doctor/specialist/hospital

3 Has any other doctor/specialist attended you for your disability? No Yes

If yes, give details

Date	Name and address of doctor/specialist

4 Has any other doctor/specialist attended you during the last five years for any other disability, injury or illness? No Yes

If yes, give details

Date	Reason	Name and address of doctor

5 Have you as a direct result of your disability, been incapable of following the normal duties of your usual occupation? No Yes

If yes, give details

Period from	Period to	Details

6 When do you expect to be able to return to work?

7 Have you previously made a claim against AXA New Zealand or National Mutual in respect of this or any other disability? No Yes

If yes, give details

Date	Reason	Details

8 Are you insured elsewhere against illness, injury or disability? No Yes

If yes, give details including whether or not you have made or intend to make a claim

9 Have you made a claim in respect of this disability under ACC or any other compensation or pension plan? No Yes

If yes, give details

10a Are you in receipt of benefits from any other source (e.g. sickness benefit, invalid pension, service pension)? No Yes

If yes, give details

10b If you are not in receipt of other benefits but intend to apply for benefits, please provide details.

SECTION B: DETAILS OF OCCUPATION

Attach a copy of your job description

11 What is your exact job title?

12 How long have you been in this job?

13 Describe the exact nature of your duties in detail

14 Did you operate machines or use special equipment or tools? No Yes
 If yes, give details

15a In what area did you work (office, loading dock, etc)?

15b Were you employed in a supervisory capacity? No Yes
 If yes, how many people did you supervise? Give details

16 Please indicate the following requirements of the job, where applicable.

	A	B	C			% per day
Lifting, 20 kgs and over				A = occasional	Walking	
Lifting, 7-19 kgs				1/3 of time or less	Standing	
Lifting, under 7 kgs				B = frequent	Climbing - ladders, scaffolding, etc	
Carrying, 20kgs and over				1/3 to 2/3 of time	Crawling	
Carrying, 7kgs – 19 kgs				C = continuous	Kneeling	
Reaching above shoulders				more than 2/3 of time	Climbing - ramps, steps, etc	

17a What level of education or other qualifications does this job require, e.g. special courses etc?

17b What qualifications do you have?

18 What hours did you work? From To

19 Did you travel on the job? No Yes
 If so, how many kilometres per week? kms

What type of vehicle?

20 How far from home was your place of business?

How did you get to work?

21 Have you been able to work in any job since you were disabled? No Yes

If yes, give details

From	To	Occupation
/ /	/ /	
/ /	/ /	
/ /	/ /	

22 Before your present occupation, did you work in any other occupation(s)?

No

Yes

If yes, give details

From	To	Occupation
/ /	/ /	
/ /	/ /	
/ /	/ /	

23 Please describe your hobbies, interests and social activities?

24 Any other comments that you consider may be relevant to your claim.

DECLARATION

I, the Life Insured, hereby declare that the above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy whether the answers have been written by me or by any person on my behalf.*

/ /

Signature of Life Insured if 16 years or over otherwise signature of parent or guardian

Date

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*If the above declaration is completed by a person other than the Life Insured, please specify the relationship with the Life Insured and the terms of authority. (e.g. legal policy owner, Power of Attorney with Certificate of Non-Revocation, Enduring Power of Attorney).

Relationship/Authority

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The National Mutual Life Association of Australasia Limited (Incorporated in Victoria, Australia) PO Box 1692, Wellington.



**Disablement Claim Form
MEDICAL AUTHORITY**

MEDICAL AUTHORITY – Life Insured to sign

To

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Name of Life Insured (Please print)

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In connection with a claim for a Total and Permanent Disablement Benefit which has been submitted to AXA New Zealand, I authorise and request you to make available from your records any information about my medical history which AXA New Zealand or its medical officer may request, and I hereby expressly authorise and request AXA New Zealand at any time to complete and forward this authority to my doctor or other medical practitioner who is currently attending me or has at any time in the past attended or examined me. In the event that I have instructed you not to release certain information to AXA New Zealand or to insurance companies generally, I expressly authorise you to disclose that fact to AXA New Zealand.

I understand that by not releasing information it may not be possible to process my claim. Any information which is provided to AXA New Zealand pursuant to the authority is confidential and for the use of AXA New Zealand solely.

Signature of Life Insured if 16 years or over otherwise signature of parent or guardian.

Date

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/ /

The National Mutual Life Association of Australasia Limited (Incorporated in Victoria, Australia) PO Box 1692, Wellington.