



PLEASE COMPLETE THIS APPLICATION IN BLACK PEN ONLY USING BLOCK LETTERS

Policy number

Important notes:

- a This form must be completed in **full** and returned to **PO Box 1692, Wellington 6140**, without delay so we can promptly assess any claim entitlement.
- b Completion of this form is at your expense.
- c It is your responsibility to obtain **all** information requested. Failure to complete this form in full or provide other requested information may result in delays in assessing any entitlement.

1 PERSONAL DETAILS

Title Given names(s) (please print) Surname

Male Date of birth / /

Female

RESIDENTIAL ADDRESS OF LIFE INSURED

Contact name for correspondence

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

Do you have medical insurance? No Yes

If yes, name the insurer

2 ACCIDENT DETAILS This section to be completed if the claim is in respect of an accident

a When did the accident occur? Date / / Time am/pm

b Where did the accident occur?

c State the nature and extent of your injury. If to a limb state whether left or right.

d Is your claim covered by Workers Compensation Insurance/ACC? No Yes

e What treatment/rehabilitation are you undergoing for this injury?

f Who is your Insurer in respect of this accident?

Please supply your Insurer's postal address along with details and copies of supporting documentation verifying your claim entitlement and progress.

3 SICKNESS DETAILS

This section to be completed if the claim is in respect of a Sickness

a Describe your symptoms?

b Date of onset of these symptoms?

	/		/	
--	---	--	---	--

c Have you ever had the same or similar symptoms before?

No Yes

If yes, give date, contact details and the name of the doctor or hospital that treated you

4 WORK CAPACITY DETAILS

a Are you currently limited by your disability?

No Yes

If yes, describe your limitations

b When did you stop work in your usual occupation?

	am/pm
--	-------

on

	/		/	
--	---	--	---	--

Give details

c Did you cease work solely due to sickness or injury?

No Yes

d Did you cease work on this date on medical advice?

No Yes

If no, explain

5 TREATMENT DETAILS

a Name of your usual doctor

--

Address

Does this doctor hold your full medical history notes?

No Yes

If no, advise the name of the doctor(s) who would hold this information

--

b Who was the treating doctor who **first** treated you for this sickness or injury? (Give name and address and when/where you were first treated for this sickness/injury).

c Date of first consultation

	/		/	
--	---	--	---	--

d Date of subsequent consultations

	/		/	
	/		/	

	/		/	
	/		/	

e Have you seen other medical professionals about your sickness/injury?

No Yes

If yes, give details and dates

f Have you received any treatment for your sickness/injury? No Yes

If yes, give details and date	/	/
	/	/
	/	/
	/	/

g Have you been hospitalised for your sickness/injury? No Yes

If yes, give details and dates of your admission and discharge	Admission	Discharge
	/ /	/ /
	/ /	/ /
	/ /	/ /

Provide a copy of your discharge form

6 INCOME DETAILS (Except Rural Income Protection plans)

- a Are you: (tick appropriate)
- self employed (sole trader, partner)
 - a salaried employee
 - contractor
 - unemployed
 - a salaried employee for a company in which you have a financial interest

b If you are a **waged or salaried worker**, state your gross earnings for any consecutive 12 month period over the last 36 months.

\$

c Name and address of your employer

Provide verification of your income from your employer by way of a wage slip, copy of your employment contract, tax return and tax assessment.

d If you are **self employed, a contractor or have a financial interest** in a company of which you are also an employee, complete the following:

Describe your business

- sole trader
- company
- partnership

Partnership – in the partnership there are currently partners and my percentage interest in the business is %

Provide details of the contractual agreement between partners.

Company – there are currently number of shareholders and my shareholding is on a ratio of

I receive remuneration from the company by way of

- shareholder salary
- dividends
- directors fees
- other

e Name of business	<input type="text"/>
f Number of full time employees	<input type="text"/>
g Number of part time employees	<input type="text"/>

i Has your business ceased trading since you became disabled? No Yes

If yes,

i provide date of cessation / /

ii If no, have you or any family members been involved in the continued running of the business? No Yes

Provide details of the financial arrangement

j Have you bought or sold any business during the six months prior to the date you are claiming from? No Yes

If yes, please provide details

k Provide verification of income details, financial statements, tax returns and assessments.

i Gross income less business expenses for a consecutive 12 month period over the past 36 months

Gross income from personal exertion before tax		Business expenses incurred in earning that income		Net income
\$ <input style="width: 100%;" type="text"/>	less	\$ <input style="width: 100%;" type="text"/>	equals	\$ <input style="width: 100%;" type="text"/>

Taxable income
\$

NOTE: Business expenses plan: provide verification of expenses fixed and ongoing, 12 months immediately prior to your disability

m While you are disabled, will you receive or are you entitled to receive any income from the following sources?

If yes, please give the monthly amounts

Workers Compensation Insurance, ACC	No <input type="checkbox"/>	Yes <input type="checkbox"/>	\$ <input style="width: 100%;" type="text"/>
Your employer	No <input type="checkbox"/>	Yes <input type="checkbox"/>	\$ <input style="width: 100%;" type="text"/>
Your business (include any income generated net of expenses)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	\$ <input style="width: 100%;" type="text"/>
Any other disability policy	No <input type="checkbox"/>	Yes <input type="checkbox"/>	\$ <input style="width: 100%;" type="text"/>
Income support services	No <input type="checkbox"/>	Yes <input type="checkbox"/>	\$ <input style="width: 100%;" type="text"/>
Any superannuation fund or group scheme	No <input type="checkbox"/>	Yes <input type="checkbox"/>	\$ <input style="width: 100%;" type="text"/>
Any other source	No <input type="checkbox"/>	Yes <input type="checkbox"/>	\$ <input style="width: 100%;" type="text"/>
Total monthly amount			\$ <input style="width: 100%;" type="text"/>

n Have you ever made a claim under the Workers Compensation Insurance Act/ACC or any other disability policy before? No Yes

If yes, give details

o Have you been disabled through accident or sickness this year? No Yes

If yes, how many days sick leave did you receive? days

p Are you entitled to receive sick leave for your present disablement? No Yes

If yes, how many days? days

7 OCCUPATION DETAILS

a What is your occupation?

b Business/employer's name

c Business/employer's address

d Provide details of your occupation(s) over the last five years including periods of unemployment, beginning with your current occupation.

From		To		Occupation	Employer/name of business
month	year	month	year		

e Did you work prior to becoming disabled? No Yes

f How many hours per day/week were you working prior to your disability?
 per day
 per week

g List your duties before you became disabled; e.g. staff supervision 20%, administration 10%, manual labour 30%, sales 40% = 100%

	% before disability
i	
ii	
iii	
iv	
v	
vi	
vii	
viii	
TOTAL	

h Since your injury/sickness, have you been: (tick appropriate box)

- able to perform your usual occupation
- unable to perform your usual occupation
- able to do partial work, if yes advise date you commenced work

/ /

i State details of duties you are able to do

j How many hours did you work each week **following** the incapacity?

Week	Hours worked	Amount earned per week
week 1		
week 2		
week 3		
week 4		
week 5		
week 6		

k When do you expect to return to your usual occupation? Please provide dates

Part time / / Full time / /

PRIVACY ACT 1993 ("The Act")

Personal information collected in connection with this Application will allow AXA New Zealand to evaluate and process the Application and to administer the Policy and/or claim and may also be used to provide you with information about other products or services offered by AXA New Zealand. Under the Act you have the right to access and correct any personal information about you. The personal information will be held by AXA New Zealand at 80 The Terrace, Wellington.

AUTHORITIES

COLLECTION OF INFORMATION

I authorise any doctor, health professional, hospital or medical institution, who has or may be, consulted by me to give AXA New Zealand any information it may require.

RELEASE OF INFORMATION

I authorise my employer, any government department, other insurer, or other person who holds information relevant to the assessment of this claim including, but not limited to, information about my sickness/injury, my employment history, to provide to AXA New Zealand any information it may require. I also authorise AXA New Zealand to release all medical information and any other relevant information pertinent to the claim to any person they require me to consult with in respect of the claim or any person engaged by AXA New Zealand in connection with the management of the claim. A photocopy of this authority will be sufficient evidence of my consent to such release.

DECLARATION

I hereby declare that the statements in this form are true and correct in every respect and that I have not abstained from engaging in or attending to any profession, business or occupation either totally or partially longer than absolutely necessary as a result of injury or sickness. I will provide AXA New Zealand such further evidence of my claim as may reasonably be required. If any answer is not in my handwriting, I declare that it has been written down at my dictation.

Name of Life Insured

Signature

Date

BANK ACCOUNT DETAILS

If the claim is accepted, entitlement will be directly credited to this account. Please supply details of your bank account. Attach a deposit slip of bank account details as verification. Attach your deposit slip here.

ADVISER INVOLVEMENT

If you would like your financial adviser to be involved with the progress of your claim, sign the authorisation below.

I authorise AXA New Zealand to release all relevant information pertinent to my claim to my financial adviser.

Name of financial adviser

Signature

Date



Certificate of Medical Attendant
FORM

Policy number

To the Medical Attendant:

- a This medical certificate and requested information must be completed in **full** and returned to **PO Box 1692, Wellington 6140**.
- b **Completion of this form is at your patient's expense.**
- c Please supply **photocopies of the patient's full history notes**, including any reports and results of investigations. 50 cents per page of photocopying will be paid by AXA New Zealand, please include an itemised account.

1 Title Given name(s) (please print) Surname

2 Patient's date of birth / /

3 Patient's current occupation

4 Nature of sickness or injury

5 If applicable, please give a DSM-IV diagnosis. (Provide a copy of the assessment)

6 Cause of injury (if applicable).

7 How long has the patient suffered from this condition?

8 Date of **first** consultation and treatment in respect of this condition. / /

9 Dates of **subsequent** consultations and treatment in respect of this condition.

<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"/>	<input type="text"/>

10 Advise the date on which you advised the patient to cease work solely due to their sickness or injury. / /

11 What is your proposed treatment plan?

12 Has the patient been referred or are you considering referring the patient to any other treating practitioner for further opinion, investigation or treatment? No Yes

If yes, provide details

13 Has the patient been hospitalised? No Yes

If yes, when were they admitted / /

Discharged / /

14 Is this patient still under your care for this condition? No Yes

If no, state

- i the date discharged from your care / /
- ii the name of the treating doctor

15 Is there any complicating factor affecting or extending this condition?
(eg: family, work situation, other disorders) No Yes

If yes, provide details

16 In your opinion was the injury or sickness caused or aggravated by the patient's occupation, sport or pastime? No Yes

If yes, provide details

17 If you are not the patient's regular treatment provider, state the name and address of the patient's regular treatment provider.

18 How long has this person been a patient of your practice?

19 Has the patient ever suffered from the same or any other disease or condition related to this disablement? No Yes

If yes, provide details

20 Has previous treatment been given prior to this period of disablement? No Yes

If yes, state dates

21 Have you issued a certificate or completed any other reports regarding this injury or sickness? No Yes

If yes, provide details

22 Is, or has the patient been unable to attend his/her usual occupation solely due to sickness or injury? No Yes

If yes, state the dates

23 Is, or has the patient been partially disabled? No Yes

If yes, state how long the patient was or will be continuously partially disabled, so that he/she is prevented from attending to a material portion of the daily duties pertaining to his/her occupation.

Indicate the number of hours per week the patient is capable of working.

State the date the patient is capable of returning to their work

24 In your opinion, what rehabilitation is appropriate for your patient and how can we support this?

25 Any other comments?

I confirm that I have examined this patient and the information provided is correct and complete.

Doctor's name Qualifications

Address

Telephone Fax

Doctor's signature Date