



Policy number

PLEASE COMPLETE THE FOLLOWING AND RETURN TO

AXA New Zealand Claims
PO Box 1692
WELLINGTON

LIFE INSURED DETAILS – Before submitting a claim, refer to your policy document.

TITLE	GIVEN NAME(S) (PLEASE PRINT)	SURNAME	PREVIOUS NAME, WHERE APPLICABLE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	DATE OF BIRTH
		<input type="text"/> / <input type="text"/> / <input type="text"/>

What is your occupation title and in which industry do you work?

Residential address of Life Insured

STREET NUMBER AND NAME	SUBURB	
<input type="text"/>	<input type="text"/>	
TOWN/CITY	POSTCODE	COUNTRY
<input type="text"/>	<input type="text"/>	<input type="text"/>

Postal address of life insured (if different from above)

STREET NUMBER AND NAME/PO BOX	SUBURB		
<input type="text"/>	<input type="text"/>		
TOWN/CITY	POSTCODE	COUNTRY	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
HOME PHONE	BUSINESS PHONE	MOBILE PHONE	EMAIL ADDRESS
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DETAILS OF TRAUMA

1 State the exact nature of your trauma – attach documentary evidence of your condition

2 Advise which of the covered definitions you are claiming for – refer to your Policy Document

3 When did you first attend a doctor or hospital for this illness?

DATE	NAME OF DOCTOR OR HOSPITAL
<input type="text"/>	<input type="text"/>

ADDRESS OF DOCTOR OR HOSPITAL

4 Give the name and address of your usual medical practitioner if different from above

NAME

ADDRESS

5 State the name and address of all specialist(s) you are currently attending for this illness

1 ST SPECIALIST'S NAME	ADDRESS
2 ND SPECIALIST'S NAME	ADDRESS
3 RD SPECIALIST'S NAME	ADDRESS

6 Have you attended any medical practitioner during the last five (5) years for any other reason? NO YES

If yes, give the dates, names and address of all medical practitioners attended during the last five (5) years and reasons for consultations.

NAME	DATE
 	 / /
ADDRESS	
REASON	
NAME	DATE
 	 / /
ADDRESS	
REASON	
NAME	DATE
 	 / /
ADDRESS	
REASON	

7 Have you made or do you intend to make any other claim against AXA New Zealand in respect of this illness or any other illness or injury? NO YES

If yes, give details and date of claim

DATE OF CLAIM	TYPE OF CLAIM	POLICY NUMBER
/ /		
/ /		
/ /		

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
 	 / /

* 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	SIGNATURE	DATE
 	 	 / /

Also please sign and date the following authority for any medical report which AXA New Zealand may need to assess the claim.



redefining / standards

Trauma Benefit Statement of Claim
Medical Authority

NAME OF LIFE INSURED (PLEASE PRINT)

In connection with a claim for a Trauma 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



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

S5956/DSXXX/0310



redefining / standards

AXA Claims
Advisor Involvement Authorisation

LIFE INSUREDS NAME

POLICY NUMBER

If you would like your financial adviser to be involved with the progress of your claim, please 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

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