TM swann insurance

Insurer: **Swann Insurance**. A business division of IAG New Zealand Limited.

N.Z. DISABLEMENT CLAIM FORM

claim

Your Personal Details (make sure all questions have been answered and printed clearly)

TITLE (eg. MR/MRS) | GIVEN NAME(S) | SURNAME

ADDRESS | POSTCODE

DATE OF BIRTH / / | BUSINESS TELEPHONE NO. ( ) | PRIVATE TELEPHONE NO. ( )

NAME OF CREDITOR | LOAN CONTRACT/ MEMBER NO. | DATE POLICY COMMENCED / /

MONTHLY INSTALMENTS $ | PROPOSAL NO. | OCCUPATION AT TIME OF DISABILITY

YOUR USUAL OCCUPATION | CURRENT EMPLOYER (OR PREVIOUS EMPLOYER)

ADDRESS | POSTCODE

TELEPHONE NO. ( ) | DATE EMPLOYED FROM / / TO / /

ON WHAT BASIS ARE YOU CURRENTLY EMPLOYED? (tick as appropriate)

FULL TIME | CASUAL | PART TIME | CONTRACT | SEASONAL | TEMPORARY

AVERAGE HOURS WORKED PER WEEK?

EMPLOYER AT POLICY COMMENCEMENT DATE | ADDRESS

TELEPHONE NO. ( )

ARE YOU CLAIMING ACCIDENT CORPORATION COMPENSATION? (tick as appropriate) YES NO

About Your Disability

DATE ON WHICH THE ILLNESS OR INJURY FIRST OCCURRED / / | TIME : | (tick as appropriate) AM PM

WHAT WAS YOUR LAST WORKING DAY / /

DESCRIBE THE CIRCUMSTANCES LEADING TO YOUR CURRENT DISABILITY

WHO IS YOUR USUAL DOCTOR? | FOR HOW LONG? YEARS MONTHS

YOUR DOCTOR'S ADDRESS

TELEPHONE NO. ( )

DOCTOR AT POLICY COMMENCEMENT DATE

ADDRESS

PLEASE STATE THE NAMES AND ADDRESSES OF <u>ALL</u> DOCTORS AND HOSPITALS CONSULTED BY YOU FOR THIS CURRENT DISABILITY

NAME | TELEPHONE NO. ( )

ADDRESS

NAME | TELEPHONE NO. ( )

ADDRESS

WAS INJURY CAUSED BY MOTOR VEHICLE ACCIDENT? YES NO | POLICE ATTENDED? YES NO (tick as appropriate)

I RESUMED MY WORK DUTIES ON / / | OR I EXPECT TO BE FIT FOR SOME WORK DUTIES BY / /

TRIO SIGE2203 08/07

PRN: 7445

Your Medical History

1. **HAVE YOU PREVIOUSLY SUFFERED FROM THIS INJURY OR ILLNESS OR ANY SIMILAR INJURY OR ILLNESS?** (tick as appropriate) YES ☐ NO ☐

IF YES, PLEASE PROVIDE DETAILS

NAME OF DOCTOR

TELEPHONE NO. ( )

ADDRESS

DATE(S) OF CONSULTATION (1) / / (2) / /

NATURE OF COMPLAINT

PERIOD OF DISABILITY FROM / / TO / /

2. **HAVE YOU PREVIOUSLY SUFFERED ANY OTHER MAJOR ILLNESS/INJURY UNRELATED TO THIS DISABILITY?** (tick as appropriate) YES ☐ NO ☐

IF YES, PLEASE PROVIDE DETAILS

COMPLAINT

DATE OF OCCURRENCE / / PERIOD OF DISABILITY / / (YRS/MTHS/DAYS)

3. **DO YOU TAKE REGULAR MEDICATION FOR ANY ILLNESS OR INJURY?** (tick as appropriate) YES ☐ NO ☐

IF YES PLEASE PROVIDE DETAILS OF MEDICATION AND CONDITION

Claims History

HAVE YOU EVER SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY OR ILLNESS? (tick as appropriate) YES ☐ NO ☐

IF YES, PLEASE PROVIDE DETAILS

NAME OF COMPANY

TELEPHONE NO. ( )

DATE / /

Declaration

I hereby declare that:

1. I am the person insured by this policy and referred to in the foregoing particulars.
2. 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 other person on my behalf.
3. I am fully aware and agree that any false statements and particulars made by me on this form or any further declarations will result in my claim being denied.
4. I authorise any hospital, institution or medical practitioner who has treated or examined me or any person or firm who has employed me, or any firm through which I have claimed compensation to provide Swann Insurance any information it may request in respect of any trauma, illness, injury, medical history, treatment or advice received by me including employment details and employment history. A photocopy of this authority can be acted upon as if it were the original.
5. I authorise the creditor to provide Swann Insurance with details of my loan for administration of this claim.
6. I authorise Swann to give to and/or obtain from other insurers, an Insurance Reference Service, the creditor, information relating to this claim.

SIGNATURE OF INSURED

SIGNATURE OF WITNESS

DATE / /

Swann Insurance is a member of the insurance industry's impartial Insurance and Savings Ombudsman Scheme.
This independent service is provided to the insuring public at no cost and aims to resolve claims complaints quickly and informally.

You should first take your complaint up with our local office. In most cases the problem will be resolved easily.

If you are not satisfied with the outcome you may contact the Insurance and Savings Ombudsman Scheme in your area for advice and assistance in resolving your claim.

Swann Insurance. PO Box 68-200, Newton, Auckland, New Zealand
Telephone Numbers are (09) 373 0500 or Toll free 0800 807 926
Facsimile (09) 302 0805

TM

swann insurance

Insurer: **Swann Insurance**. A business division of IAG New Zealand Limited.

MEDICAL CERTIFICATE

certificate

Important Note

THIS CERTIFICATE MUST BE COMPLETED BY THE QUALIFIED AND REGISTERED MEDICAL PRACTITIONER TREATING YOU FOR YOUR CURRENT DISABLEMENT. In the event of the medical practitioner being unable to answer, from personal knowledge, any of the following questions, this must be stated. The Certificate is to be completed at the insureds expense and forwarded by the Medical Practitioner to Swann Insurance at the earliest opportunity.

Please "PRINT ALL" information and ensure all questions have been answered

NAME OF ATTENDING DOCTOR

TELEPHONE NO. (   )

DATE OF BIRTH   /   /

INSURED'S NAME

OCCUPATION

ARE YOU THE INSURED'S USUAL DOCTOR? (tick as appropriate) YES ☐ NO ☐ FOR HOW LONG? YEARS ☐☐ MONTHS ☐☐

STATE NATURE AND CAUSE OF DISABLEMENT

WHEN DID YOU FIRST TREAT THE INSURED FOR THIS ILLNESS OR INJURY?   /   /

PLEASE PROVIDE DETAILS OF TREATMENT

PLEASE PROVIDE DETAILS OF ANY MEDICATION

ARE THERE ANY MEDICAL CONDITIONS WHICH HAVE A BEARING ON THIS CURRENT DISABLEMENT? (tick as appropriate) YES ☐ NO ☐

IF YES PLEASE EXPLAIN

HAS THE INSURED EVER RECEIVED A MEDICAL DIAGNOSIS, TREATMENT, OPERATION OR ATTENTION FOR THIS OR SIMILAR DISABLEMENT OR RELATED CAUSE? (tick as appropriate) YES ☐ NO ☐

PLEASE SUPPLY THE FOLLOWING DETAILS (provide on a separate page if insufficient space)

DATE	NATURE OF DISABILITY	DATE	NATURE OF DISABILITY
/ /		/ /	
/ /		/ /	
/ /		/ /	

IF NOT BY YOURSELF, NAME AND ADDRESS OF DOCTOR

WHAT IS YOUR PROGNOSIS?

PLEASE PROVIDE DETAILS OF OPERATION(S) IF ANY, AND DATE(S)

HAVE YOU ANY REASON TO: (tick as appropriate)

1. SUSPECT THAT THE INSURED'S DISABLEMENT HAS RESULTED FROM OR BEEN CONTRIBUTED TO BY THE INFLUENCE OF INTOXICATING LIQUOR OR DRUGS? YES NO
2. TEST FOR HUMAN IMMUNODEFICIENCY VIRUS? IF **YES**, PLEASE **PROVIDE** RESULTS, INCLUDING TEST RESULTS YES NO
3. SUSPECT THAT THE INSURED'S DISABLEMENT HAS RESULTED FROM OR BEEN CONTRIBUTED TO BY AN INTENTIONALLY SELF-INFLICTED INJURY? YES NO

HAS THE INSURED BEEN HOSPITALISED? YES NO

HAS THE INSURED BEEN **TOTALLY DISABLED** FROM PERFORMING: (tick as appropriate)

1. EACH AND EVERY DUTY PERTAINING TO HIS OR HER USUAL OCCUPATION? YES NO — STATE PERIOD FROM / / TO / /
2. ANY OTHER GAINFUL OCCUPATION? YES NO
3. IS THE INSURED CAPABLE OF PERFORMING LIGHT OR LIMITED DUTIES? YES NO — STATE PERIOD FROM / / TO / /

NATURE OF DUTIES

HOURS/DAY AND DAYS/WEEK

IF TOTAL DISABLEMENT HAS CEASED, ON WHAT DATE DID YOU RELEASE THE INSURED TO PERFORM ANY REMUNERATIVE DUTIES? / /

IF TOTAL DISABLEMENT STILL EXISTS, ON WHAT DATE IS IT LIKELY TO CEASE? / /

please make sure all questions have been answered and printed clearly

SIGNATURE OF MEDICAL PRACTITIONER

DATE / /

QUALIFICATIONS

TELEPHONE NO. ( )

ADDRESS OF PRACTICE

PLEASE RETURN TO ADDRESS BELOW

Swann Insurance, PO Box 68-200, Newton, Auckland. Tel (09) 373 0500, Fax (09) 302 0805.