

Insurer: Swann Insurance (NZ) Limited. A wholly owned subsidiary of IAG New Zealand Limited.

**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 INSTALLMENTS \$ PROPOSAL NO. OCCUPATION AT TIME OF CONDITION

YOUR USUAL OCCUPATION CURRENT EMPLOYER (OR PREVIOUS EMPLOYER)

ADDRESS POSTCODE

TELEPHONE NO. DATE EMPLOYED FROM

ON WHAT BASIS ARE YOU CURRENTLY EMPLOYED? (tick as appropriate) AVERAGE HOURS WORKED PER WEEK?

FULL TIME  CASUAL  PART TIME  CONTRACT  SEASONAL  TEMPORARY

EMPLOYER AT POLICY COMMENCEMENT DATE ADDRESS

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

YES  NO

**About Your Trauma**

WHAT ARE YOU CLAIMING FOR? (tick as appropriate) HEART ATTACK  CORONARY ARTERY SURGERY  STROKE  CANCER

DATE ON WHICH YOUR TRAUMA FIRST OCCURRED (tick as appropriate) WHAT WAS YOUR LAST WORKING DAY

**Trauma** (complete only if you are claiming for heart attack, coronary artery surgery or stroke)

WHEN DID YOU FIRST BECOME AWARE OF YOUR CONDITION AND WHAT WAS THE NATURE OF YOUR SYMPTOMS?

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? (tick as appropriate) NO  YES  STATE ONSET DATE OF SYMPTOMS

DATE	SYMPTOM	DATE	SYMPTOM
/ /	<input type="checkbox"/> CHEST PAIN	/ /	<input type="checkbox"/> PINS AND NEEDLES
/ /	<input type="checkbox"/> SHORTNESS OF BREATH	/ /	<input type="checkbox"/> WEAKNESS OF UPPER LIMB
/ /	<input type="checkbox"/> DIFFICULTY WITH SPEECH	/ /	<input type="checkbox"/> WEAKNESS OF LOWER LIMB
/ /	<input type="checkbox"/> FITS OF ANY KIND	/ /	<input type="checkbox"/> NUMBNESS OF PART OF BODY

**Trauma** (complete only if you are claiming for cancer)

PLEASE STATE THE NATURE AND SITE OF YOUR MALIGNANCY AND DETAILS OF ANY TREATMENT YOU HAVE RECEIVED

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 **ALL** DOCTORS AND HOSPITALS CONSULTED BY YOU FOR THIS CURRENT DISABILITY

NAME  TELEPHONE NO. (  )

ADDRESS

NAME  TELEPHONE NO. (  )

ADDRESS

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

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

IF YES PLEASE PROVIDE DETAILS OF MEDICATION AND CONDITION

## 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.

Insurance and Savings Ombudsman Scheme  
PO Box 10-845, Wellington  
Ph: 0800 882-202

**Swann Insurance (NZ) Limited**  
Telephone Numbers are (09) 373 0500 or Toll free 0800 807926  
Facsimile (09) 302 0805

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**Important Note**

**THIS CERTIFICATE MUST BE COMPLETED BY THE QUALIFIED AND REGISTERED MEDICAL PRACTITIONER TREATING YOU FOR YOUR TRAUMA. 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 patient's 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
<input type="text"/>	( <input type="text"/> ) <input type="text"/>	/ / <input type="text"/>

PATIENT'S NAME	OCCUPATION
<input type="text"/>	<input type="text"/>

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

STATE NATURE AND CAUSE OF TRAUMA

WHEN DID YOU FIRST TREAT THE PATIENT FOR THIS CONDITION?  /  /

PLEASE PROVIDE DETAILS OF TREATMENT

PLEASE PROVIDE DETAILS OF ANY MEDICATION

ARE THERE ANY MEDICAL CONDITIONS WHICH HAVE A BEARING ON THIS CURRENT CONDITION? NO  YES  IF YES PLEASE EXPLAIN

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

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

DATE	NATURE OF CONDITION	DATE	NATURE OF 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"/>	<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"/>

IF NOT BY YOURSELF, NAME AND ADDRESS OF DOCTOR

WHAT IS YOUR PROGNOSIS?

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

HAS THE INSURED BEEN HOPITALISED? YES  NO

**Please make sure all questions have been answered and printed clearly**

SIGNATURE OF MEDICAL PRACTITIONER	DATE	QUALIFICATIONS
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>

ADDRESS OF PRACTICE	TELEPHONE NO.
<input type="text"/>	( <input type="text"/> ) <input type="text"/>

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**Important Note**

**This page must be completed by the Doctor treating you in the 6 months prior to the Commencement of your Policy.**

INSERT YOUR POLICY COMMENCEMENT    /    /

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

NAME OF YOUR TREATING DOCTOR IN THE 6 MONTHS PRIOR TO THE START OF YOUR POLICY      TELEPHONE NO.  
 (    )

ADDRESS      POSTCODE

**TO BE COMPLETED By Doctor** (Please "PRINT ALL" information and attach your account)

PATIENT'S NAME

HOW LONG HAVE YOU KNOWN THIS PATIENT?    YEARS    MONTHS

PLEASE PROVIDE DETAILS OF CONSULTATIONS AND DIAGNOSIS FOR THE 6 MONTHS PRIOR TO THE POLICY COMMENCEMENT, WHEN PATIENT FIRST NOTICED SYMPTOMS AND TYPE OF MEDICATION PRESCRIBED. (If insufficient room, please provide details on separate A4)

WAS THIS THE FIRST TREATMENT OR CONSULTATION FOR THE ILLNESS OF INJURY? IF "NO", PROVIDE FIRST DATE

CONSULTATION DATE  
/ /

YES    NO  
/ /

/ /

YES    NO  
/ /

/ /

YES    NO  
/ /

/ /

YES    NO  
/ /

/ /

YES    NO  
/ /

/ /

YES    NO  
/ /

MEDICAL INFORMATION SUPPLIED BY      SIGNATURE      DATE  
 / /

**PLEASE RETURN TO ADDRESS BELOW**

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