Death Claim Form

Pursuant to the Privacy Act 1993 the following is brought to your attention:

a. This claim form collects personal information about you
b. The information is collected to evaluate your claim
c. The collection of this information is required pursuant to the terms of your insurance policy
d. The failure to provide this information may result in your claim being declined
e. The information is being collected and held by Southsure Assurance Limited, PO Box 1404, Invercargill
f. The intended recipient of the information is Southsure Assurance Limited, PO Box 1404, Invercargill
g. You have the right of access to and correction of this information in accordance with the Privacy Act 1993

In order for us to consider a claim under the policy please forward the following documentation:

a. A certified copy of the Death Certificate

b. A certified copy of the Birth Certificate

c. A signed Authority to Release Medical Information form (enclosed)

d. Name and address of Insured's usual doctor

e. If applicable, a certified copy of the Marriage Certificate

f. If applicable, a copy of the Coroner's Report

When we are in receipt of the above documentation we will be able to consider the claim and advise you of the outcome.

If you have any queries, please do not hesitate to contact us on 0800 002 002 or email ssadmin@southsure.co.nz.

Authority to Release Medical Information

I hereby authorise any doctor, hospital, clinic, institution, medical practitioner, surgeon, specialist, A.C.C., insurance company, or any similar authority to disclose to Southsure Assurance Limited all information concerning the medical history, treatment or advice concerning _____.

Name of insured

This authority is granted in my capacity as _____.

e.g. Executor, Legal Representative, Next of Kin

Signature _____

Name _____

Relationship to Insured _____

Contact Phone Number _____

Date _____ / _____ / _____

Details of Insured's usual doctor:

Name: _____

Address: _____

_____

Death Claim Form

Pursuant to the Privacy Act 1993 the following is brought to your attention:

a. This claim form collects personal information about the insured and you
b. The information is collected to evaluate the claim
c. The collection of this information is required pursuant to the terms of the insurance policy
d. The failure to provide this information may result in the claim being declined
e. The information is being collected and held by Southsure Assurance Limited, PO Box 1404, Invercargill
f. The intended recipient of the information is Southsure Assurance Limited, PO Box 1404, Invercargill
g. You have the right of access to and correction of this information in accordance with the Privacy Act 1993

Executor/Administrator of the Deceased – Personal Details		
Mr/Mrs/Miss/Ms/Dr (please circle) First Names	Surname	
Residential Address		
Suburb	City	Postcode
Contact Address (if different)		
Suburb	City	Postcode
Phone – Home	Phone – Work	Phone - Mobile

Insured – Personal Details		
Mr/Mrs/Miss/Ms/Dr (please circle) First Names	Surname	
Residential Address		
Suburb	City	Postcode
Cause of Death:		Date of Birth: / /
Was death the result of an accident?		Date of Death: / /
Place of Death:		
Name of Usual Medical Practitioner:		Phone No. (wk)
Address		
Suburb	City	Postcode

Please attach certified copies of the Insured's Birth Certificate and Death Certificate

DECLARATION

I/we declare that the statements contained in this claim are true and I/we have not suppressed or mis-stated any facts that are relevant to this claim.

Executor/Administrators Name _____

Signature _____ Date _____