Terminal Illness 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

PERSONAL DETAILS (must be completed by the insured)		
Loan Account Number		
Name		
Address		Date of Birth
Phone – Home	Phone - Work	Phone - Mobile
Occupation	Employer	Employer Phone No.

About Your Illness	
Date on which the illness first occurred / /	
What is the condition for which you are claiming?	
Who is your usual doctor?	For how long? _____ Years_____ Months
Your doctor's address	Phone number ( )
Name and address of doctor at policy commencement date	

Please give the names and addresses of **ALL** doctors, specialists and hospitals consulted by you for this current illness:

Name	Address
Name	Address
Name	Address

Your Medical History

Have you previously suffered from this illness, or any similar or related illness? Yes No If Yes, please provide details

Name of Doctor Town/City Phone number ( )

Date(s) of consultation (1) / / (2) / / (3) / / (4) / /

Nature of the complaint:

Period(s) of disability (1) from / / to / / (2) from / / to / /

Have you previously suffered from any **other** major illness or injury **unrelated** to this illness? Yes No

If Yes, please provide details of the nature of the complaint

Do you take regular medication for **any** illness or injury? Yes No

If Yes, please provide details of all medications, prescribed dosage and related medical condition

(1)

(2)

MEDICAL DECLARATION (must be signed by the Insured)

I declare that the information given above is true and complete.

I am fully aware and agree that any false statements and particulars made on this claim form or any further declarations will result in my claim being declined.

I authorise any doctor, medical practitioner, specialist, hospital, clinic, A.C.C., insurance company, employer, WINZ, or any other authority to disclose to Southsure Assurance Limited any and all information concerning my medical/employment history for the purpose of assessing this claim. A photocopy of this authorisation shall be as valid as the original.

I authorise the disclosure of personal information held by other parties which relate to this claim.

I agree to Southsure Assurance Limited disclosing to other parties personal information regarding this claim.

I authorise any licensed Private Investigator instructed by you to make enquiries into my claim to take such audio transcription, photographic or video surveillance as might be necessary for your proper assessment of my claim, such audio transcriptions, photographic or video surveillance may be carried out without my prior knowledge or any other consent.

I understand that all claim payments will be made to my financier and I authorise the creditor to provide Southsure Assurance with details of my loan for administration of this claim.

Full name of Insured

Signature of Insured

Date _____ / _____ / _____