

Disability 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.

DISABLEMENT following accident or illness DETAILS (must be completed by the insured)

How did your accident occur or illness originate?	
Date of accident or date you were first taken ill:	Date you ceased work due to accident/illness:
Have you ever suffered from this condition previously?	
Have you been able to attend to work of any kind since your disablement?	
Name and address of current doctor:	
What is your A.C.C. Claim Number?	Address of A.C.C. office

Please attach a letter from your employer confirming your incapacity to work to this claim form.

Please ensure that the Medical Certificate on the reverse of this page is completed by your doctor

MEDICAL DECLARATION (must be completed by the insured)

I declare that the information given above is true and complete, and that I was in no way under the influence of intoxicating liquor or drugs when the disability occurred, and that the disability being claimed for in this claim is the sole cause of my Disablement and my inability to attend work.

I hereby authorise any doctor, medical practitioner, hospital, clinic, A.C.C., insurance company, employer, Department of Social Welfare, WINZ, or any other authority to disclose to Southsure Assurance Limited all information concerning my medical and employment history. I agree to meet any costs including medical expenses associated with obtaining this information. A photocopy of this authorisation shall be as valid as the original.

I understand that all claim payments will be made to my financiers.

I authorise the disclosure of personal information held by other parties which relate to this claim and 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 the assessment of my claim, such audio transcriptions, photographic or video surveillance may be carried out without my prior knowledge or any other consent.

Name _____ Signature _____ Date _____

MEDICAL CERTIFICATE (To be completed by your doctor)

Name of Attending Doctor

Phone number ()

Insured's Name

Insured's Occupation

Are you the Insured's usual Doctor? Yes ☐ No ☐ For how long have you been his/her doctor? years
months

State the nature and cause of the disablement:

When did you first treat the Insured for this illness/injury? / /

Please provide details of the treatment:

Please provide details of any prescribed medication:

Please give details of any medical conditions which have a bearing on this current disablement:

Has the insured ever received any previous medical diagnosis, treatment, operation or attention for this or any similar disablement or related cause? Yes ☐ No ☐ If Yes, Please supply details of dates and nature of disability:

What is your prognosis of the present disablement?

Have you any reason to: (please tick as appropriate)

- | | | |
|--|------------------------------|-----------------------------|
| 1. Suspect that the disablement has resulted from in any way the use of intoxicating liquor or drugs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Test for Human Immunodeficiency Virus (if Yes, please provide a copy of the results) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Suspect that the disablement has resulted from or been contributed to by any intentionally self-inflicted injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Has the insured been hospitalised? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

I hereby declare that the person named above:

1. Is totally unable to work solely due to the disablement giving rise to this claim: Yes ☐ No ☐

Period from / / to / /

OR

2. Is capable of performing light, limited or restricted duties whether available or not: Yes ☐ No ☐

Period from / / to / / For _____ hours per day and _____ days per week

If total disablement still exists, on what date is it likely to cease? / /

Signature of Medical Practitioner:

Medical Practice
Address/Office Stamp

Date / /