



Statement of Claim
TERMINAL ILLNESS BENEFIT FORM

Upon completion of parts A and B below, please return to the following person at AXA New Zealand:

Customer Service Officer
AXA New Zealand
PO Box 1692
WELLINGTON

Part A – TO BE COMPLETED BY POLICY OWNER/S

Policy Number

Policy Owner/s

I wish to formally request consideration for a Terminal Illness Benefit.

If the claim is admitted I wish to take the full Terminal Illness Benefit Value of the Policy.

Signature/s

Date

Part B – TO BE COMPLETED BY THE LIFE INSURED

Mr Mrs Miss Ms

Surname

Given Names

Private Address

Phone Number

Date of Birth

Occupation

1 State the Exact Nature of Your Illness

2 When did You first Attend a Doctor or Hospital for this Illness?

Date

Name of Doctor or Hospital

Address of Doctor or Hospital

3 Please give the Name and Address of Your usual Medical Practitioner if different from above

Name

Address

4 Please State the Name and Address of any Specialist(s) You are currently attending for this Illness

1st Specialist's Name	<input type="text"/>	Address	<input type="text"/>
			<input type="text"/>
			<input type="text"/>
2nd Specialist's Name	<input type="text"/>	Address	<input type="text"/>
			<input type="text"/>
			<input type="text"/>
3rd Specialist's Name	<input type="text"/>	Address	<input type="text"/>
			<input type="text"/>
			<input type="text"/>

5 Have You attended any Medical Practitioner during the last five (5) Years for any other reason?

No Yes

If 'Yes', then please give the dates, names and address of all Medical Practitioners attended during the last five (5) years and reasons for consultations.

Date	Name/Address	Reason
<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
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	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

6 Have you made or do you intend to make any other claim against AXA New Zealand in respect of this Illness or any other Illness or Injury?

No Yes

If 'Yes', please give details and date of claim

Date	Type of Claim	Policy Number
<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"/>

I, the Life Insured, hereby declare that 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 person on my behalf.

I waive privilege in relation to any medical or other evidence requested by AXA New Zealand.

Signature/s

Date

If the above declaration is completed by a person other than the Life Insured, please specify the relationship with the Life Insured and the terms of authority (e.g. Power of Attorney or Next of Kin) held to act on his/her behalf.

Relationship/Authority

Signature

Date

Also please sign and date the following authority for any medical report which AXA New Zealand may need to assess the claim.

MEDICAL AUTHORITY

To

Name of Life Insured (BLOCK LETTERS PLEASE)

In connection with a claim for Terminal Illness Benefit which has been submitted to AXA New Zealand, I authorise and request you to make available from your records any information about my medical history which AXA New Zealand or its medical officer may request, and I hereby expressly authorise and request AXA New Zealand at any time to complete and forward this authority to my doctor or other medical practitioner who is currently attending me or has at any time in the past attended or examined me. In the event that I have instructed you not to release certain information to AXA New Zealand or to insurance companies generally, I expressly authorise you to disclose that fact to AXA New Zealand. Any information which is provided to AXA New Zealand pursuant to the authority is confidential and for the use of AXA New Zealand solely.

Signature/s

Date

MEDICAL AUTHORITY

To

Name of Life Insured (BLOCK LETTERS PLEASE)

In connection with a claim for Terminal Illness Benefit which has been submitted to AXA New Zealand, I authorise and request you to make available from your records any information about my medical history which AXA New Zealand or its medical officer may request, and I hereby expressly authorise and request AXA New Zealand at any time to complete and forward this authority to my doctor or other medical practitioner who is currently attending me or has at any time in the past attended or examined me. In the event that I have instructed you not to release certain information to AXA New Zealand or to insurance companies generally, I expressly authorise you to disclose that fact to AXA New Zealand. Any information which is provided to AXA New Zealand pursuant to the authority is confidential and for the use of AXA New Zealand solely.

Signature/s

Date



**INVESTMENTS INSURANCE
SUPERANNUATION**

The National Mutual Life Association of Australasia Limited (Incorporated in Victoria, Australia), PO Box 1692, Wellington. Member of the Global AXA Group.

Be Life Confident