

loan repayment insurance policy: accident & sickness claim form

Southbury Insurance, PO Box 1970, Christchurch, New Zealand, Telephone 0508 southbury (768 842), Facsimile (03) 962 1849

Personal Details

Full name:	Date of birth: / /
Residential address:	Suburb/Town:
Contact address (if different):	
Telephone No: (hm) () (wk) () (mob) ()	
Name of employer:	Contact Person:
Financier:	Contact Person:

Illness Details

Date first contracted: / /	Date you first sought medical advice: / /
Description of illness:	
Date illness diagnosed: / /	By whom:

Injury Details

Place where the injury was suffered:	
Time am/pm date / /	Date you first sought medical advice: / /
What were you doing at the time?	
How was it caused?	
What injuries have you suffered?	
Name and address of any witness:	

Hospitalisation Details

Date and Place admitted to hospital:	Medical practitioner consulted:
Date discharged: / /	
Hospital contact details: Phone: ()	Postal address:

General Details

I have been able to do limited work duties: Yes <input type="checkbox"/> No <input type="checkbox"/> Details:
Have you been engaged in any other occupation? Yes <input type="checkbox"/> No <input type="checkbox"/> Details:
Have you ever previously met with a similar injury or illness? Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, give particulars (date/duration etc):
I have been unable to work at all for days, from / / to / /
If still disabled, state how much longer the disability is likely to continue:
Name and address of your doctor:
If you have known him/her for less than three years, who was your previous doctor?

Privacy Act 1993

This claim form collects personal information about you for the purpose of evaluation of your claim. The intended recipients of the information are **Southbury Insurance Limited, Lumley Life (N.Z.) Limited and Lumley General Insurance (N.Z.) Limited**. This information is collected pursuant to the terms of your insurance policy and your authorised use and disclosure of the information to other persons for the purposes of assessment of your claim. You have the right to access and to correct this information subject to the provisions of the Privacy Act 1993.

Policy number:

Claim number:

Declaration

I declare that all statements made in this form are true and correct and that no material information has been withheld. I acknowledge that if I have not answered any question correctly, completely or faithfully my claim may be declined and/or my policy may not operate. I understand that any benefits payable under this claim will be paid to the Financier to my credit.	
I authorise any medical practitioner(s) I have consulted to provide information and documents recording my medical condition and medical history.	
Signature of Claimant/Customer:	Date: / /
It is essential that this form be returned promptly to Southbury with all questions fully answered and the medical report on the reverse side of this form completed by your medical practitioner.	

Medical Report

to be completed by your Medical Practitioner – please print clearly

Name of Claimant/Patient:

1. Medical Practitioner's full name:

2. Contact details: Phone: ()

Fax: ()

Postal address:

Address:

3. What is your patient's occupation, business or profession?

4. Are you the patient's usual medical practitioner?

Yes

No

If so, how long has he/she been a patient?

5. State the nature and extent of the injuries or illness:

6. What do you believe is the cause of the injuries or illness:

7. Please give details of the treatment given:

8. Is the patient (to your knowledge) complying with your treatment instructions:

Yes

No

9. On what date did you first attend the patient in connection with this condition? / /

10. To your knowledge, has the patient previously suffered from this condition?

Yes

No

If yes, please provide full details including when the condition was first diagnosed?

11. Do you consider this injury or illness is terminal or will result in permanent disablement?

If yes, Please give details:

12. Has the patient been referred to a specialist or do you intend to refer the patient to a specialist?

Yes

No

Name and address of specialist (if applicable):

13. To your knowledge, was the injury self-inflicted (if applicable)?

14. Is this condition directly or indirectly related to AIDS or an AIDS related condition, alcohol, drugs or poison? Yes No

Please give details:

15. Is the Claimant suffering from any other conditions (additional to that described in question 6 above)?

Yes

No

If so, please state the nature of the condition and to what extent recovery may be affected:

16. Please confirm:

Patient has been unable to attend work from / /

17. When do you expect the patient will resume work:

Part of their work / /

Full time duties / /

18. General remarks:

Signature of Medical Practitioner:

Date: / /