loan repayment insurance disability claim form

Lumley

Lumley Business Solutions, PO Box 3939, Shortland Street, Auckland 1140, New Zealand, Tel 09 308 1105, Fax 09 308 1115

Personal details

Name (in full):

Postal address: **Suburb/Town:**

Telephone no: (h) **(w)** **(mob)**

Date of birth: / / **Hire purchase contract no:**

I am currently employed: Yes ☐ No ☐

If employed, state name and address of employer:

Illness

When first contracted: / /

Nature of Illness:

Injury

State when and where the injury took place:

Time: am/pm on the: / /

What were you doing at the time?

How was it caused?

What injuries have you sustained?

Names and address of any witnesses:

Was a police report issued? (if **Yes**, please attach a copy to your claim form) Yes ☐ No ☐

General details

1 Have you ever previously met with a similar disability? Yes ☐ No ☐

If **Yes**, give particulars (date/duration, etc.):

2 Have you been able since the disability occurred, to attend in any way to your business of any portion of it? Yes ☐ No ☐

3 Have you been engaged in any other occupation? Yes ☐ No ☐

4 State the extend (extent?) and duration of your inability to attend your business or occupation:

I have been Disabled wholly for days, from / / to / /

If still disabled, state how much longer the disability is likely to continue:

5 Name and address of your current doctor:

6 If you have known him/her for less than three years, who was your previous doctor?

Declaration:

Any claim must be supported by a report on the reverse side of this form from your Medical Attendant, and any fee for the report is payable by yourself.

I hereby claim compensation for Disablement and I declare that I was in no way under the influence of intoxicating liquor or a drug when the disability occurred, and also that I will not abstain from my usual occupation, either entirely or partially for longer than absolutely necessary in consequence of the said disability, and that such disability is the sole cause of my Disablement. I do hereby warrant the truth of the foregoing Statement and particulars in every respect, and I agree that if I have made any false or fraudulent statement, or any concealment of material fact, or do so in any further Declaration other Officers of the Company may require of me, the Policy shall be null and void.

I hereby authorise any medical consultants I have consulted to provide any details regarding my medical history that may be requested by the Company. I agree that, should there be any dispute over payment of this claim, the Company shall be entitled to submit the dispute to arbitration. I/We authorise the disclosure of personal information held by any other party regarding this claim. I/We agree to Lumley General Insurance (N.Z.) Limited and their Agents and the Life Insurer releasing to other parties information regarding this claim.

Signature of Claimant: Date: / /

It is essential that this form be returned promptly to the Company with all relevant questions fully answered and the medical report on the back completed by your doctor.

Pursuant to the Privacy Act 1993

The following is brought to Your attention:

(a) This claim form collects personal information about you;

(b) The collection of this information is required pursuant to the terms of your insurance policy;

(c) The information is collected to evaluate your claim;

(d) The failure to provide this information may result in your claim being declined;

(e) The intended recipient of the information is Lumley General Insurance (N.Z.) Limited ('Lumley') (P.O. Box 2426 Auckland);

(f) Lumley may pass your personal information on to Insurance Claims Register Limited ('ICR') (C/- P.O. Box 2426 Auckland) for inclusion in the Insurance Claims Register, for general claims and underwriting purposes;

(g) You acknowledge that any ICR participant may access this personal information by way of enquiry to the ICR.

(h) You have the right of access to and correction of this information in accordance with the Privacy Act 1993.

Medical report **to be completed by your doctor**

Name of Claimant:

1 What is your name (The Medical Practitioner)?

2 What is your address?

3 What is the name of your Patient?

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

5 Are you the patient's usual medical practitioner? Yes ☐ No ☐

If **Yes**, how long have you known him/her?

6 State fully the exact nature and extent 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 disability will result in permanent disablement? Yes ☐ No ☐

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 ☐

If **Yes**, please provide name and address of the specialist:

13 To your knowledge was the disability self-inflicted? Yes ☐ No ☐

14 Is this disability directly or indirectly related to AIDS or and AIDS related condition, alcohol, drugs or poison? Yes ☐ No ☐

If **Yes**, please give details:

15 Is the Claimant suffering from any injury or illness irrespective of that stated above? Yes ☐ No ☐

If **Yes**, please please state the nature of same and to what extent recovery may be affected thereby:

16 Please give details of when the patient has been, or will be, unable to attend their usual occupation or business:

Patient **has been unable** to attend work from / / to / /

Patient **will be able** to attend work from / / to / /

17 When did, or at what date do you expect the patient will resume either all or part of their full-time duties:

Part of their work: / / Full time duties: / /

18 General remarks (please provide additional information relevant to the condition:

Medical practitioner's signature: Date: / /

Any charge by the medical practitioner for completion of this medical report and certificate must be paid by the patient. Please note, we cannot attend to your patient's claim until this section is fully completed.