OneChoice

Total & Permanent Disability Insurance (Optional Benefit) Claim Form

- To help ensure you receive a prompt assessment, please complete all the required sections of this form. If you need assistance please call **0800 005 806**. Please note however, that a claim cannot be assessed until all required documents (including this original and completed claim form) are received.
- Please note that the information required to be completed in this document is in relation to the Life Insured, unless otherwise stated.
- To ensure that the claim may be fully assessed, and to avoid any delays to this process, please ensure that all the relevant items in this document are fully addressed and answered. Responses such as "refer to doctor", "see above", etc., are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay in claim assessment.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

Filling in this form:

- Use a black or blue pen
- Mark boxes like this ☐ with ✓ or ✗

There are 3 parts to the claim form:

- **Part A** is to be completed by the Life Insured.
- **Part B** is to be completed by the Life Insured's employer.
- **Part C** is to be completed by the registered Medical Practitioner treating the Life Insured.

Promoted and Distributed by

OneChoice, a trading name of
Greenstone Financial Services NZ Limited
(NZBN 9429047013582)

Issued by

Pinnacle Life Limited
(NZBN 9429030397248)
PO Box 1471
Auckland 1140

Please return this form to OneChoice, Reply Paid DX Box EP71505, Penrose, Auckland (no stamp required).

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PART A: Total & Permanent Disability Claim Form

Privacy

Greenstone Financial Services NZ Limited ("Greenstone") collects personal information about you on behalf of Pinnacle Life Limited ("Pinnacle", "we", "us" or "our"). All information collected throughout the claims process by Greenstone or Pinnacle will be shared with both companies.

The information we collect will be used to assess and process your claim and any procedures associated with this. If you fail to provide us with all or part of the information we require, we will be unable to assess and process your claim. Personal information will be collected from you or, where that is not practicable, from other organisations such as Medical Practitioners and government agencies.

The information we collect may be disclosed to other organisations, including but not limited to medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation organisations, or any organisation that is duly appointed to manage the administration of such insurance policy or interpreters. Pinnacle or Greenstone will share your information with associated companies in Australia but are unlikely to send your personal information to any other foreign jurisdiction.

You can read more about how Greenstone collects, uses and discloses your personal information in its Privacy Policy, which is available on the OneChoice website or you can request a copy by contacting us. You can also obtain the Privacy Policy of Pinnacle on their website, pinnaclelife.co.nz. If you wish to access your information (including correcting or updating your information), please call **0800 005 804** Monday to Friday, 8am to 8pm.

Section A – Personal information of the Life Insured

Applicable only to policies including the Total & Permanent Disability Insurance Option.

Title | First name | Surname

Policy number

Residental address

Postal address

Date of birth DD/MM/YYYY | Gender: Male ☐ Female ☐ | Height (cm) | Weight (kg)

Country of birth | Are you a New Zealand resident? Yes ☐ No ☐

Phone (home) | (work) | (mobile)

Email

Language spoken at home | Is an Interpreter required? Yes ☐ No ☐

2. Employer details

a. Name of employer/company

b. Work address

c. Commencement date DD/MM/YYYY | Telephone

3. Details of your injury or illness

a. If you are submitting this application more than 12 months after the date on which you last worked please state the reasons for the deferral or delay:

b. Please state the reasons why you ceased work:
(If you have ceased work due to Redundancy, Resignation or Termination please provide a copy of the relevant documentation)

c. Please state the exact nature of the injury or illness that caused you to cease work:

d. On what date did the injury occur or did you first become ill? DD/MM/YYYY

e. Please give details of all doctors, physiotherapists, chiropractors etc. consulted by you, including any hospital treatment you may have received in relation to your disability.

Name of doctor	Address	Date of first consultation	Date of most recent consultation
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY

f. Are any of the doctors named in (e) above the usual doctor you attend?

Yes ☐ No ☐ ▶ Please provide details of your usual doctor:

Doctor's name

Address

Phone number

g. Have you ever suffered from the same or similar illness? (please tick)

No ☐ Yes ☐ ▶ Please supply detals

Date of episode	Period off work	Name of attending doctor
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		
DD/MM/YYYY		

4. Occupational details

a. What was your job title?

b. Please describe all your work duties in detail:

c. How many hours did you normally work each week?

d. On what date did you last work? DD/MM/YYYY

e. Please list all of the work duties your disability prevents you from performing:

f. Since ceasing work with your employer have you been able to perform work of any kind?

No ☐ Yes ☐ ▶ Please supply detals

Period of work	Job title	Part time or full time	Income earned (before income tax)

g. Have you applied for any jobs since ceasing work?

No ☐ Yes ☐ ▶ Please supply details

h. Are you now able to perform any duties of your occupation?

No ☐ Yes ☐ ▶ Please list which duties you can perform

i. What level of education do you have?

Primary ☐ Secondary ☐ Tertiary ☐

j. What qualification or licencing certificates do you have? Please supply details

k. Do you have any other training or skills?

No ☐ Yes ☐ ▶ Please supply details

l. Please supply details of all previous jobs you have performed and/or enclose a copy of your resume

Employer	Description of job	Approximate dates
		DD/MM/YYYY
		DD/MM/YYYY
		DD/MM/YYYY
		DD/MM/YYYY

m. Please list any work you think you may be able to perform in the future

n. Have you received, or are you entitled to claim any benefits under any insurance policy such as income protection, lump sum total and permanent disablement or trauma, or any benefit such as ACC, Sickness Benefit, Invalid Benefit, or Unemployment Benefits?

No ☐ Yes ☐ ▶ Please supply details

Period	Type of benefit	Name and company address	Case manager and telephone number	Claim number

o. Please state your current daily activities

Please ensure that all questions have been answered before you proceed further.

5. Declaration and consent

I acknowledge;

(a) this Declaration forms part of my claim for a Total and Permanent Disability benefit;

(b) that, if I fail to provide all or part of the information Pinnacle Life Limited requires to assess this claim, it will not be assessed and processed.

I understand that, in order to assess and process my claim for a benefit, Pinnacle Life Limited may need information about me including but not limited to medical, financial, legal and employment. I consent to Pinnacle Life Limited obtaining my information about me from Medical Practitioners that I have consulted at anytime and any that Pinnacle Life Limited wishes to appoint to examine, legal practitioners, health service providers, legal tribunals and courts, investigation organisations, accountants or other consultants, other insurance or reinsurance companies, my past and present employers and interpreters.

For the purpose of this claim for a benefit and any future claim for a benefit, I also consent to Pinnacle Life Limited disclosing information about me to any of the organisations mentioned above, insofar as such disclosure is necessary for Pinnacle Life Limited to perform its functions.

SIGN HERE

X _____ DD/MM/YYYY

Life Insured's signature Date

6. Disclosure of information – doctor's authority

For the purpose of assessing my claim for a Total and Permanent Disability benefit, I authorise my current Medical Practitioner, and any other Medical Practitioner or health professional I have consulted or may consult in the future, or that Pinnacle Life Limited appoints to examine me, to disclose information about my health and related matters to Pinnacle Life Limited. A photocopy of this authorisation will be valid as the original.

SIGN HERE

X _____ DD/MM/YYYY

Life Insured's signature Date

Section C – Checklist

Certified copies of the relevant documentation related to this claim are attached as follows:

What is a certified copy?
This is a signed copy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, Solicitor of the High Court, Notary Public or Deputy Registrar at a court. It means you keep the original as we do not require it.

The certified copy must include a statement "I certify that this is a true copy of the original document". The certifier must include their full name, signature, date, registration number (if any) and qualification or occupation on each page of the photocopied documents.

☐ A CERTIFIED COPY of proof of claimant's identity (e.g. Driver's Licence or Passport)

☐ A CERTIFIED COPY of Policyowner's identity (e.g. Birth Certificate, Driver's Licence or Passport)

Section D – Policy Discharge

(Please note this section of the form will only be used if Pinnacle Life Limited accepts liability for the claim)

☐ I/We hereby request payment of the benefit payable for the insurance policy (details on page 2 of this document), in full satisfaction for all claims whatsoever under the policy for the Life Insured

Life Insured name, and do hereby discharge Pinnacle Life Limited from all liability there under other than for payment of the benefit.

Section E – Declaration

As the Policyowner/Life Insured/Claimant I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim.

I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Pinnacle Life Limited requires to assess this claim it will not be assessed and processed.

SIGN HERE

✗ _____ DD/MM/YYYY

Signature of Policyowner/Life Insured/Claimant — Date

Section F – Direct Credit Authority

Completing the details below will assist us in getting your claim payment to you as quickly as possible.

- This section of the form must be completed by the Policyowner.
- If your claim has been approved, the benefit amount payable will be credited to the account below.

Account number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account name _____

Name of bank/ financial institution _____

Branch name/ location of financial institution _____

SIGN HERE

✗ _____ DD/MM/YYYY

Policyowner's signature — Date

PART B: Employer's Statement in connection with a claim for a Disablement Benefit

To be completed by an authorised representative of the employer.

Name of employer

Full name of employee | Date of birth DD/MM/YYYY

Employee's address | Postcode

Date joined company DD/MM/YYYY

a. Date the employee was last at work.

b. Why did the employee cease work?

c. Have there been any periods of absence? If so list the periods and reasons.

d. Employee's job title?

e. Precise duties performed by the employee.

f. Number of hours normally worked each week.

g. The education, training or qualifications required to perform the job.

h. The education, training, qualifications and past experience of the employee.

i. Number of people supervised by the employee.

j. Did the employee spend any significant work on the following activities?

	Proportion of Time Spent (%)		Proportion of Time Spent (%)		Proportion of Time Spent (%)
Driving		Walking or standing		Lifting or carrying	
Climbing		Crawling or kneeling			

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k. Did the employee's duties allow him/her to move freely during work hours or was he/she confined to a set space or position?

l. Is the employee's job still open?

m. Do you have any other jobs appropriate to the employee's level of skill and experience?

n. Have any alternative jobs been offered to the employee? If so, please give details.

o. Describe any previous jobs the employee has done while employed by you. Include time spent in each job.

p. Can the employee speak, read, and write English?

Yes ☐ No ☐

q. Give details of the weekly income the employee was paid at the time of disablement.

r. Give details of the annual income the employee was paid prior to disablement.

s. Give details of any amounts you are currently paying to the employee (e.g. salary).

t. Other comments (e.g. any other comments you may have which you believe may be relevant to the assessment of the claim).

I declare that I am authorised to answer the above questions on behalf of the employer; and that the responses to the questions on this Statement are true.

SIGN HERE

✗ Signed on behalf of the employer

DD/MM/YYYY Date

PART C: Total & Permanent Disability Claim Form – Confidential Medical Report

This document is to be fully completed by the registered Medical Practitioner treating the Life Insured.

- Please note that the information required to be completed in this document is in relation to the Life Insured.
- Please note that it is the Life Insured responsibility for the payment of all fees associated in the completion of this document.
- In order to ensure that the claim may be assessed fully, and to avoid any delays to this process, please ensure that all the items in this document are fully addressed and answered.
- If for any reason there is not enough room on this document to provide the details being requested please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing.

Section A – Personal Details of the Life Insured

Title | First name | Surname

Address

Suburb | Region | Postcode

Occupation | Date of birth DD/MM/YYYY

The cost of this report is the Life Insured's responsibility.

Life Insured's family name | Given names

Date of birth DD/MM/YYYY | Occupation

Home address | Postcode

Section B – Medical Details of the Life Insured

Questions to be answered by the Life Insured's Medical Practitioner.

Please attach a separate statement if space is insufficient for any answer.

1. **a)** On what date did you first attend the Life Insured in connection with his/her illness or injuries? DD/MM/YYYY

b) On what date did the illness or accident occur? DD/MM/YYYY

c) What was the date of your last attendance? DD/MM/YYYY

d) Has the Life Insured an appointment to consult you again? No ☐ Yes ☐ ▶ Approximate date DD/MM/YYYY

2. On what date did the Life Insured become completely unable to perform all the normal duties of his/her occupation? DD/MM/YYYY

3. Please provide details of other doctors seen by the Life Insured in connection with this disability:

Name of doctor	Address	Telephone	Date of first consultation
			DD/MM/YYYY
			DD/MM/YYYY
			DD/MM/YYYY
			DD/MM/YYYY

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4. Please state the history of the illness or injury, including the exact nature and severity of the condition and give particulars of any treatment which has been necessary, including dates where relevant. Please also provide full details and results of any tests performed. Please give full details of the current condition.

5. Has hospital admission been necessary? No ☐ Yes ☐ ▶ Please give name of hospital(s) and relevant dates:

Name of hospital	Date of admission	Date of discharge
	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY	DD/MM/YYYY

6. Has surgical treatment been necessary? No ☐ Yes ☐ ▶ **a)** What operation(s) was/were performed?

Operation	Date of performed
	DD/MM/YYYY
	DD/MM/YYYY
	DD/MM/YYYY
	DD/MM/YYYY
	DD/MM/YYYY
	DD/MM/YYYY

b) Post-operative course?

7. Has the Life Insured suffered from the same or similar or related condition?

No ☐ ▶ Do you consider the disablement to be connected in any way with a previous illness or injury or unfavourable features of the Life Insured's history?

No ☐

Yes ☐ ▶ Please provide details:

Please turn over to complete this form ▶

8. In respect of the Life Insured's present illness or injury, have you given any certificate to another insurance company, or in connection with ACC, Sickness Benefit, Invalid Benefit, sick leave benefits from the Life Insured's employer or for any other reason?

No ☐

Yes ☐ ▶ To whom?

9. At the current time, can the Life Insured do his/her normal job?

No ☐ ▶ Which work duties is the Life Insured unable to perform?

Yes ☐ ▶ From what date was he/she fit to return to work? DD/MM/YYYY

10. If you do NOT expect the Life Insured to EVER return to his/her normal work do you think he/she will EVER be able to do a job for which he/she is reasonably fitted by education, training or experience?

No ☐ ▶ Please give detailed reasons:

Yes ☐ ▶ Please list examples of jobs which in your opinion would be appropriate:

Section C – Declaration

I hereby certify that I have personally attended the above named Life Insured and that all the information supplied by me in this Report is true. I agree that Pinnacle Life Limited may provide copies of this Report to any Medical Specialist from whom Pinnacle Life Limited seeks an independent report or to any other person deemed necessary to assist in the assessment of this claim, or to any other person or organisation to whom the insurer is obligated under law to give access to this Report.

Name

Qualifications

Address

SIGN HERE ▶ ✗ Signature

DD/MM/YYYY Date