

# 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 original documents 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 X

There are 3 parts to the claim form:

- **Part A** is to be completed by the claimant.
- **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).

# 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](http://pinnaclelife.co.nz). If you wish to access your information (including correcting or updating your information), please call **0800 005 806** Monday to Friday, 8am to 8pm.

## Section A – Policy Information

Policyowner

Policy number

## Section B – Details of Insured

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

### 1. Personal information of the Life Insured

Title

First name

Surname

Residential 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

- 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 details

Date of episode	Period off work	Name of attending doctor

## 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 details

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

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	<input type="text" value="X"/>	<input type="text" value="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	<input type="text" value="X"/>	<input type="text" value="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)

## 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

, 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

X

Signature of Policyowner / Life Insured / Claimant

DD/MM/YYYY

Date

## Section F – Direct Credit Authority

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

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

X

Your signature

DD/MM/YYYY

Date

If you don't have a bank account, we will make any claim payment by cheque.

# 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

Employee's address  Postcode

Date joined company

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			



**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

X

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.

**The cost of this report is the claimant's responsibility.**

Claimant's family name  Given names

Date of birth  Occupation

Home address  Postcode

**Questions to be answered by the claimant'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 claimant in connection with his/her illness or injuries?
- b) On what date did the illness or accident occur?
- c) What was the date of your last attendance?
- d) Has the claimant an appointment to consult you again? No  Yes   Approximate date
2. On what date did the claimant become completely unable to perform all the normal duties of his/her occupation?
3. Please provide details of other doctors seen by the claimant in connection with this disability:

Name of doctor	Address	Telephone	Date of first consultation

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

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

Operation	Date of performed

**b)** Post-operative course?

7. Has the claimant 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 patient's history?

No

Yes  Please provide details:

8. In respect of the claimant'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 claimant's employer or for any other reason?

No

Yes  ► To whom?

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

No  ►

Which work duties is the claimant 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 claimant 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:

## Declaration

I hereby certify that I have personally attended the above named patient 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 ►

X

Signature

DD/MM/YYYY

Date