Death Claim Form

Cigna Life Insurance New Zealand Limited
Majestic Centre, Level 24
100 Willis Street
PO Box 24 031, Wellington 6142
Tel: 0800 244 623
Fax: 04 470 9151
Email: claims.nz@cigna.com

Policy Number: …….....

Name of the Deceased: …….....

Date of Birth: ..... / ..... /.....

Date of Death: ..... / ..... /.....

Name of the Person handling the Estate: .....

Postal Address: .....

.....

Contact Number: ..... Email: .....

Claim Requirements

☐ Proof of Age for the insured – a copy of the birth certificate, driver's licence, or passport

☐ Copy of the Death Certificate (This must state cause of death. A copy of Coroner's or Pathologist's report may suffice)

☐ Copy of Probate or Letters of Administration

☐ Name and Address of General Practitioner who holds the insured's medical records: ….....

.....

Refund by Direct Credit

In the event this claim is accepted proceeds will be credited directly into your bank account. Direct crediting enables almost immediate access to funds and removes the risk associated with mailing cheques, clearance delays and mail problems. Insert account details below:

☐☐☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐

Account Name: ……..

Declaration

(To be completed by the Executor/s of the Estate.)

I declare that to the best of my knowledge the foregoing particulars are true and correct, and that I have not withheld any information that is relevant to this claim.
I request and authorise any hospital, doctor, or other person who has attended or examined the deceased to furnish to Cigna Life Insurance New Zealand Limited or its representative any and all information concerning any sickness or injury suffered, medical history, consultations, prescriptions, or treatment including X-ray plates and copies of all hospital or medical records, that they may be included as a part of the proofs of the claim submitted. A photocopy of this authorisation shall be considered as effective and valid as the original.
I authorise the disclosure to Cigna Life Insurance New Zealand Limited of personal information held by any other person or organisation (including ACC, the Ministry of Health – General Medical Subsidy) regarding or affecting this claim and authorise Cigna Life Insurance New Zealand Limited to release to any other person or organisation information regarding or affecting this claim.

Name: ..... Name: .....

Signature: ..... Signature: .....

Witness: ..... Witness: .....

Signature: ..... Signature..... Date: ...../...../.....

The personal information collected on this Claim Form will be held by Cigna Life Insurance New Zealand Limited and you have rights of access to and correction of this information under the Privacy Act.

FOR OFFICE USE ONLY	DATE REQUESTED: 18/11/2020	DATE SENT: 18/11/2020	DATE RECEIVED: