



**Claimant Declaration**

I declare that to the best of my knowledge that the particulars provided are true and correct and that I have not withheld any information that is relevant to this claim.

In respect of Accident or Illness claim, I request and authorise any hospital doctor or other person who had attended or examined me to furnish to Cigna Life Insurance NZ Ltd or its representative any and all information concerning any illness or injury suffered, medical history, consultations, prescriptions or treatments and all hospital or medical records that may be included as part of the proofs of the claim submitted. A photocopy of this authorisation will be considered as effective and valid as the original.

I authorise the disclosure to Cigna Life Insurance NZ Ltd personal information held by any other person or organisation regarding or affecting this claim and authorise Cigna Life Insurance NZ Ltd to release to any other relevant person or organisation information regarding or affecting this claim.

**Claimant Signature:** ..... **Date:** ...../...../.....

**TO FACILITATE PROMPT ASSESSMENT OF YOUR CLAIM PLEASE ENSURE THAT:**

- This Claim Form has been fully completed
- The Initial Medical Attendants Statement has been completed
- Hospital admission and discharge forms
- Hospital and/or Specialist Reports are attached

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