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

Terminal Illness Claim Form

Name of Insured:	Policy No.
Address:	Date of Birth:
	Home Phone: / Work Phone:
Email Address:	Mobile Phone:

Claim Details

Describe the nature of the illness:

Date of event:	Date of diagnosis:

Name and Address of Doctor treating you (if this is not your General Practitioner, please provide his/her name also):

Have you been hospitalised for this condition? Yes ☐ No ☐

Name and Address of Hospital:

Date admitted:	Date discharged:

If Surgery was performed describe the procedure:

Name of Surgeon

How long were you unable to work following surgery:

Dates: From: / / To: / /

If you do not work, how long were you confined to bed:

Dates: From: / / To / /

Refund by Direct Credit

Claim 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:

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Account Name: ……..

Claimant Declaration

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

In respect of this claim, I request and authorise any hospital doctor or other person who had attended or examined me to furnish to Cigna Insurance Limited 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 Insurance Limited personal information held by any other person or organisation regarding or affecting this claim and authorise Cigna Insurance Limited to release to any other relevant person or organisation information regarding or affecting this claim.

Claimant Signature:

Dated:

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.