Cigna Life Insurance New Zealand Limited
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100 Willis Street
PO Box 24 031, Wellington 6142
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Cancer or Major Illness Claim Form

Policy Number: ……

Name of the Policy Holder: ……..

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

Residential Address: .....

Email: .....

Home Phone: ..... Mobile Phone: .....

Employment Details – complete only in the respect of Cancer

Employer/Company Name: .....

Contact Person: .....

Address: .....

Phone No: ( )..... Number of hours worked per week? .....

Occupation and duties performed: .....

.....

Period of employment: From: ...../...../..... To: ...../...../.....

What date did you cease all forms of work: ...../...../.....

If you have recommenced work, what date did you resume: ...../...../.....

Is your job available on recovery? ☐ Yes ☐ No

Cancer or Major Illness Details

Describe the nature of the illness: .....

.....

Date of onset: ...../...../..... 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 of Hospital: ..... Address: .....

Admitted on: ...../...../..... at .....am / pm. Discharged on: ...../...../..... at .....am / pm.

If Surgery was performed describe the procedure.....

.....

Name of Surgeon: .....

How long were you unable to work following surgery: From: ...../...../..... To: ...../...../.....

If you do not work, how long were you confined to bed: From: ...../...../..... To: ...../...../.....

Please ensure you have had a Cigna Initial Medical Attendant's Statement Form completed.

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

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:

☐☐☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

Account Name: ……

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.

☐ Histology Reports and any other information that is relevant and which may assist in the assessment of your claim are attached.

☐ 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.