Corporate Solutions

Income Protection Claim Form (Policy Owner)

Please answer every question in full.

1 Plan details

Policy number (if known)

Claim number (for office use only)

Policy Owner

Employer's name (if different to Policy Owner)

2 Life Assured

Title

Date of birth Day / Month / Year

First name(s)

Surname

Name(s) known as *(if different)*

Country of birth

Nationality

Is the Life Assured a permanent resident of New Zealand? ☐ Yes ☐ No *(**If no,** please supply evidence of Work to Reside Visa)*

3 Life Assured Employment Details

Name of Employer *(Organisation and/or trading name)*

Name of contact person

Position

Contact person's business phone ( )

Contact person's mobile ( )

Contact person's email

Physical Address *(for principal place of business)*

Unit/ apartment/ building/ floor

Street

Suburb

Town/ City

Postcode

Country

Postal Address *(if different from physical address)*

PO Box/ private bag number

Street

Suburb

Town/City

Postcode

Country

Pre-disability occupation/job title

Description of pre-disability duties *(please also attach a copy of current job description)*

Hours per duty

Hours per duty

Hours per duty

Date employment commenced / / (Day / Month / Year)

Date of entry into plan / / (Day / Month / Year)

Date last worked / / (Day / Month / Year)

Normal hours worked per week

Salary as at date last worked (gross per annum)

Sick leave balance as at date last worked

Life Assured Employment Details continued...

Confirmation — Please confirm that immediately prior to the event that result in this claim being lodged, the Life Assured met the eligibility criteria as defined in the Policy Schedule and Policy Wordings for this scheme. ☐ Yes ☐ No

Note: In some instances further qualifying evidence i.e. sick leave history, copy of employment contract or signed affidavit from the Employer, may be required.

4 Direct Credit Details *(should the claim be accepted)*

It is hereby confirmed and accepted by the Policy Owner in respect of the Benefit being claimed that:

1. AIA New Zealand requesting completion of this section is in no way an admission of liability, and that a benefit amount will only become payable under the Policy once the Life Assured claim has been assessed and accepted by AIA New Zealand; and
2. AIA New Zealand is instructed to make the benefit payment(s) directly to the party below by direct credit.

Please attach proof of the bank account name and number, such as a bank statement, a deposit slip, or a screen shot of your Internet banking page.

Name of Account Holder	Bank Name / Branch

Bank Account Number

5 Statement of Disclosure

Definition: "**AIA**" shall mean AIA New Zealand Limited, and/or any related companies and/or agents (including company officers acting in the scope of their authority) and AIA's insurance advisers or reinsurers.

This claim form collects personal information about the Life Assured which will be used to: (a) investigate and determine the validity of this claim; (b) confirm any information provided in the application for this insurance product; (c) maintain relevant statistical records. The information is collected and held by AIA at AIA House, 74 Taharato Road, Takapuna, Auckland. Personal information may be made available to our subsidiary and affiliated companies, local and overseas (and in this regard you consent to the transfer of information outside New Zealand) and to any agent, contractor or third party who provides administrative or other services to AIA or any member of the AIA Group.

You have a duty to provide AIA with all the facts material to this claim and all information, which we may reasonably require in relation to this claim. If you fail to provide this information we may not pay this claim. If you provide false information this may result in the insurance cover being voided from inception or cancelled in respect of the Life Assured.

Under the Privacy Act 2020 and Health Information Privacy Code 2020, you have the right of access to, and correction of any information held or provided.

6 Declaration

I have read and understood the information in this claim form including the section above relating to the Privacy Act 2020 and the Health Information Privacy Code 2020.

I declare that all information provided by me relating to this claim (both written and oral) is true and correct, and no material information has been withheld.

I acknowledge that if I do not meet these responsibilities, AIA may be unable to assess and pay the claim.

I acknowledge that I may have to repay any overpayments made to the nominated party by AIA New Zealand.

By signing below I warrant that I have the necessary corporate power and authority to provide the information requested in this form for and on behalf of the Policy Owner.

Full Name of Policy Owner's Representative	
Position	
Signature of Policy Owner's Representative	X — Date Day / Month / Year / /
Business phone	( )
Email	

AIA House, 74 Taharoto Road, Takapuna, Auckland 0622

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