Email completed form to nz.corporatesolutions@aia.com

Corporate Solutions

Lump Sum Claim Form (Policy Owner)

1 Plan details

Policy number (if known)

Claim number (for office use only)

Plan name

Employer's name

2 Member details

Full name

Date of birth (dd/mm/yyyy) / /

Residential Address

Street

Suburb | Town/City | Postcode

Mailing Address (if different to Residential)

Street

Suburb | Town/City | Postcode

Phone No.

Home ( ) | Mobile ( ) | Work ( )

Email address

Country of residence

NZ citizen / resident? ☐ Yes ☐ No *(If no, please supply evidence of citizenship/Work to Reside Visa)*

3 Claim type

☐ **Life** ☐ **Terminal Illness** ☐ **Critical Illness** ☐ **Total & Permanent Disability**

For Life claims, please also include a certified copy of the members Death Certificate.

4 Member's Employment Details

Employer's name

Job Title

(For Total & Permanent Disability attach a copy of job description if available)

Description of duties performed *(required for Total & Permanent Disability Claims only)*

Duty % of time spent

Duty % of time spent

Duty % of time spent

Date employment commenced Day / Month / Year

Date of entry into plan Day / Month / Year

Date last worked Day / Month / Year

Salary as at date last worked $

Normal hours worked (per week)

(Base salary - exclude bonuses, overtime etc. This is not required for fixed sum benefits)

Confirmation

Please confirm that immediately prior to the event that resulted in this claim being lodged, the Member 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.

5 Member Payment Surrender Discharge 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 Member's claim has been assessed and accepted by AIA New Zealand; and
2. Payment by AIA New Zealand of the claimed benefit shall constitute full and final discharge of AIA New Zealand's liability in respect of the Member; and
3. AIA New Zealand is instructed to make the benefit payment directly to the Policy Owner by direct credit, as below or as directed by the Policy Owner, to the below bank account

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

If making payment to a party other than the policy owner or the member, please provide the full name(s), date(s) of birth and current address(es) of the account holders(s) you would like payment to be made to

Full name(s)

Date(s) of birth
(dd/mm/yyyy)

Address(es)

6 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 Member 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 Member.

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

1. 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.
2. I declare that all information provided by me relating to this claim (both written and oral) including the answers provided in this form is true and correct, and no material information has been withheld.
3. I acknowledge that if I do not meet this responsibility, AIA may be unable to assess and pay the claim.
4. I acknowledge that I may have to repay any overpayments made to the Policy Owner by AIA.
5. By signing below I warrant that I have the necessary corporate power and authority to provide the information requested in this form and to enter in the Payment Surrender Discharge for and behalf of the Policy Owner.

Name of Policy Owner's representative

Signature of Policy Owner's representative

X

Date Day / Month / Year

Position held

Business phone number ( )

Mobile phone number ( )

Email