Redundancy Claim Form

1 Life Assured details

Policy number

Date of birth (Day / Month / Year)

Full name

Street

Suburb

City

Postcode

Home phone

Mobile

Email address

2 Payment details

○ Please pay claim direct to bank account

Name of account

Bank | Branch number | Account number | Suffix

or ○ Attach a preprinted bank deposit slip

or ○ Pay direct into bank account premiums are being deducted from

Full name of Policy Owner

Signature of Policy Owner X

Date (DD/MM/YYYY)

Full name of Policy Owner

Signature of Policy Owner X

Date (DD/MM/YYYY)

3 Consent to disclose personal information to a third party

This section is to be used when you want AIA to give details about you to a third party.
e.g. spouse, partner, broker etc

Name of person that information is to be released to

Their address

Phone number

Email Address

Authorisation

I authorise AIA New Zealand Limited to release and/or discuss any of my personal and health information, including medical or financial details with the above-named person(s). ☐

Full name of Life Assured

Signature of Life Assured X

Date (DD/MM/YYYY)

4 Employment details (To be completed by the Life Assured)

(a) Were you employed for financial reward in a permanent position for the 6 months prior to the termination of your employment? ☐ Yes ☐ No

(b) Prior to ceasing employment, were you ☐ An employee? ☐ Self-employed?

(c) If you were an employee, state the name and address of your last employer

(d) Date you ceased employment — Day Month Year / /

(e) Are you still unemployed? ☐ Yes ☐ No If No, on what date did you begin your new job? Day Month Year / /

(f) Reason for termination of employment?

(g) Are you registered with Work and Income New Zealand or any other agency? ☐ Yes ☐ No

If Yes, please provide:

Name of agency

Name of Case Manager

Claim number

(h) How many hours did you work on average per week for the six month period immediately prior to redundancy?

(h) Have you received or are you entitled to receive, income replacement or redundancy benefits under:

	Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
☐ ACC	/ /	/ /
☐ Any other insurance policy	/ /	/ /
☐ WINZ payments (e.g. sickness or unemployment benefits)	/ /	/ /

☐ Other (e.g. medical retirement or redundancy settlement) — Please provide full details

☐ Unsure — Please provide full details

If any of the above were ticked, please provide:

(i) Name of organisation or company making payment

(ii) Amount of monthly income or compensation or lump sum payment $

(j) Were you outside of New Zealand when you were made redundant? ☐ Yes ☐ No If Yes, please advise

Date left New Zealand — Day Month Year / /

Date returned to New Zealand / /

5 Declaration and Consent

Notice under the Privacy Act 2020

This claim form collects personal information about you. This information is collected for the purpose of assessing your claim with AIA New Zealand Limited ("AIA"). Failure to provide this information may result in your claim not being processed and monthly payments not being made to you. The personal information collected will be held at AIA's Auckland office at 74 Taharoto Road, Takapuna, Auckland. You have certain rights of access and correction of personal information under the Privacy Act.

I declare that the answers on this form, made in relation to my claim with AIA are true and complete. I, the **Life Assured,** declare that all occupational and financial information pertaining to me has been provided and disclosed to AIA.

I understand that failure to provide full disclosure of all occupational and financial information that AIA would deem as relevant in the assessment of my claim under my policy(ies) would be considered to be material misrepresentation and/or material non-disclosure and as such AIA is entitled to use legal remedy, should this occur.

I further understand that the occupational and financial information provided is the basis on which AIA will base the on-going assessment of my claim under my policy(ies) and I have fully disclosed all relevant information in the utmost good faith. I understand that failure to provide this information or the provision of false information may result in my claim being declined or unable to be assessed.

I further declare that if the answers to the questions in this Redundancy Claim Form are not in my handwriting, then they have been correctly written down at my dictation.

I consent and give authority to ASB Bank Limited and/or AIA to request from AIA New Zealand Limited, or disclose to AIA, any information pertaining to me and relevant to the assessment of my insurance claim.

I consent to AIA sharing information regarding my claim with ASB Bank Limited ☐

As a part of a redundancy claim with AIA, I, the **Life Assured,** consent and give authority to AIA and any related entities to seek from and for all and any of the following, their officers and employees, to disclose to AIA and any related entities, their advisers, reinsurers and to any legal tribunal before which any questions concerning the insurance may arise, any financial, or other personal information affecting such insurance which they may hold in respect of me/us:

- Accountant and other financial advisers;
- Accident Compensation Corporation;
- Banks and other financial institutions;
- Employers (whether current or not);
- Government departments, agencies, organisations and enterprises eg: IRD;
- Insurers (whether public or private);
- Your adviser/broker/insurance agent.

I understand that AIA may share my claim details with related insurers to enable co-ordination of claims resolution.

I, the **Life Assured,** agree that a photocopy of this authority will be valid as an original.

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following :

I consent to the disclosure of my claims information to ASB Bank Limited ('ASB') for the purposes of notifying ASB of issues or disputes arising in respect of my claim ☐ Yes ☐ No

I/We, the policy owner(s), hereby claim the benefit amounts on the basis of the statements and information provided by the Life Assured in this claim form which I/we believe to be accurate and complete in every respect.

Full name of Life Assured

Signature of Life Assured X Date DD/MM/YYYY

Name of Policy Owner

Signature of Policy Owner X Date DD/MM/YYYY

Name of Policy Owner

Signature of Policy Owner X Date DD/MM/YYYY

6 Employer details (Please ask your last employer to complete this section)

(a) Name of employer

(b) Employer address

(c) Full name of employer's representative completing this form

(d) Life Assured was employed by you

From Day Month Year / /

To Day Month Year / /

(e) Have you employed anyone else to fill this Life Assured's position? ☐ Yes ☐ No

(f) Did the Life Assured receive redundancy pay? ☐ Yes ☐ No If Yes, please state the net figure received and attach a detailed breakdown of this amount $

(g) What was the Life Assured's average weekly net income in the six weeks immediately prior to redundancy? $

(h) Did the Life Assured accept voluntary redundancy? ☐ Yes ☐ No

(i) Was the Life Assured in full time employment with the employer at the date of redundancy? ☐ Yes ☐ No If No, please provide details of the basis of their employment (e.g. contract worker, seasonal worker, casual employee, etc) and hours worked on a regular basis

(j) If this person was not made redundant, what is the reason for his/her unemployment?

(k) Does the Life Assured or a relative of the Life Assured have ownership or control (e.g. a majority shareholding, ownership) of the employer from which the Life Assured has been made redundant? ☐ Yes ☐ No If Yes, please provide full details

(l) Please give the date that the Life Assured was notified that he/she would or might be made redundant Day Month Year / /

(m) What date was it generally known that redundancies were being considered by your company? Day Month Year / /

(n) How many other personnel were made redundant at the same time as the Life Assured?

7 Employer's Declaration

I hereby declare the information given is true, correct and complete and that no material information has been withheld.

Name of Employer's Representative

Title

Company name

Signature of Employer's Representative

X

Company stamp

Date DD/MM/YYYY