

Term Life Insurance Claim Form

- To help ensure you receive a prompt assessment, please complete all the required sections of this form. If you need assistance please call **0800 400 190**. Please note however, that a claim cannot be assessed until all required documents (including this original and completed claim form) are received.
- Please note that the information required to be completed in this document is in relation to the Life Insured, unless otherwise stated.
- To ensure that the claim may be fully assessed, and to avoid any delays to this process, please ensure that all the relevant items in this document are addressed and answered. Responses such as "refer to doctor", "see above", etc., are not acceptable. Failure to address and answer all items in this document may result in the refusal or delay in claim assessment.
- If for any reason there is not enough room on this document to provide the details being requested, please attach a separate piece of paper and provide the details on this, and also make reference to which item on this document you are addressing. Please ensure that you sign and date the piece of paper.

Filling in this form:

- Use a black or blue pen

Mark boxes like this with ✓ or ✗

Promoted and Distributed by

New Zealand Seniors, a trading name of
Greenstone Financial Services NZ Limited
(NZBN 9429047013582)

Issued by

Pinnacle Life Limited
(NZBN 9429030397248)
PO Box 1471
Auckland 1140

Please return this form to New Zealand Seniors by Email or Mail

Email: claims@nzseniors.co.nz

Mail: Reply Paid DX Box EP71505, Penrose, Auckland (no stamp required).

Privacy

Greenstone Financial Services NZ Limited ("Greenstone") collects personal information about you on behalf of Pinnacle Life Limited ("Pinnacle", "we", "us" or "our"). All information collected throughout the claims process by Greenstone or Pinnacle will be shared with both companies.

The information we collect will be used to assess and process your claim and any procedures associated with this. If you fail to provide us with all or part of the information we require, we will be unable to assess and process your claim. Personal information will be collected from you or, where that is not practicable, from other organisations such as Medical Practitioners and government agencies.

The information we collect may be disclosed to other organisations, including but not limited to medical and legal practitioners, health service providers, other insurance or reinsurance companies including our parent company, legal tribunals, investigation organisations, or any organisation that is duly appointed to manage the administration of such insurance policy or interpreters. Pinnacle or Greenstone will share your information with associated companies in Australia but are unlikely to send your personal information to any other foreign jurisdiction.

You can read more about how Greenstone collects, uses and discloses your personal information in its Privacy Policy, which is available on the New Zealand Seniors website or you can request a copy by contacting us. You can also obtain the Privacy Policy of Pinnacle on their website, pinnaclelife.co.nz. If you wish to access your information (including correcting or updating your information), please call **0800 400 290** Monday to Friday, 8am to 8pm.

Section A – Personal information of the Life Insured

Title	<input type="text"/>	First name	<input type="text"/>	Surname	<input type="text"/>
Policy number	<input type="text"/>				
Residential address	<input type="text"/>				
Postal address	<input type="text"/>				
Phone (home)	<input type="text"/>	(work)	<input type="text"/>	(mobile)	<input type="text"/>
Email	<input type="text"/>				

Section B - Medical Details of the Life Insured

1. Life insured details

Name of Life Insured	<input type="text"/>	Date of death	<input type="text" value="DD/MM/YYYY"/>
Cause of death	<input type="text"/>		

2. Claimant details

I am the:	<input type="checkbox"/> Nominated Beneficiary	<input type="checkbox"/> Policyowner	<input type="checkbox"/> Relative	<input type="checkbox"/> Executor	<input type="checkbox"/> Other	
First name	<input type="text"/>	Surname	<input type="text"/>			
Address	<input type="text"/>				Postcode	<input type="text"/>
Telephone number	<input type="text"/>	Relationship to Life Insured	<input type="text"/>			

SIGN HERE

X

Your signature

DD/MM/YYYY

Date

Section C – Policy Discharge

(Please note this section of the form will only be used if Pinnacle Life Limited accepts liability for the claim)

I/We hereby request payment of the benefit payable for the Life Insurance policy (details on page 2 of this document), in full satisfaction for all claims whatsoever under the policy for the Life Insured

life insured name

and do

hereby discharge Pinnacle Life Limited from all liability there under other than for payment of the benefit.

Section D – Declaration

As the nominated beneficiary/s/legal representative I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim.

I acknowledge that the making of a false statement may invalidate this claim, that if I fail to provide all or part of the information Pinnacle Life Limited requires to assess this claim it will not be assessed and processed.

SIGN HERE

X

Nominated beneficiary/s/legal representative

DD/MM/YYYY

Date

3. Authority to release information

I, , as Executor / Administrator / Guardian of hereby authorise any physician, clinic, hospital, institution or insurance company to supply upon request to Pinnacle Life Limited, on a confidential basis all details of any medical test, treatment or history that it may reasonably request.

A photocopy of this declaration shall be as valid an authority as the original.

NOTE: This authority is to be completed by the Executor / Administrator / Guardian and a copy of the relevant legal documents must be provided, (e.g. Will, Letter of Administration, Power of Attorney).

SIGN HERE

X

Your signature

DD/MM/YYYY

Date

4. Doctor's details

a. What is the name, address and telephone number of the Life Insured's usual doctor?

Name	Address	Telephone

b. For how long did the Life Insured attend this usual doctor?

Section E – Checklist

Certified copies of the relevant documentation related to this claim are attached as follows:

What is a certified copy?

This is a signed copy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, Solicitor of the High Court, Notary Public or Deputy Registrar at a court. It means you keep the original as we do not require it.

The certified copy must include a statement "I certify that this is a true copy of the original document". The certifier must include their full name, signature, date, registration number (if any) and qualification or occupation on each page of the photocopied documents.

- A CERTIFIED COPY of evidence of death (e.g. Death Certificate, Coroner's Report, Attending Medical Practitioners Report)
- A CERTIFIED COPY of the Life Insured's identity (e.g. Birth Certificate, Driver's Licence or Passport)
- A CERTIFIED COPY of proof of claimant's identity (e.g. Driver's Licence or Passport)

Section F – Direct Credit Authority*

The payout of a Life Insurance policy normally forms part of the Life Insured's Estate. It will be subject to the Life Insured's will unless there is a specific person (or persons) nominated on the policy as beneficiary. If there is a specific nomination, then the money will be paid directly to that person. If no nomination has been made, the proceeds will be paid either to a surviving Policyowner (where applicable) or legal representative.

As the nominated beneficiary, please complete:

Account number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Account name	<input type="text"/>
Name of bank/ financial institution	<input type="text"/>
Branch name/ location of financial institution	<input type="text"/>

SIGN HERE

X

Your signature

DD/MM/YYYY

Date

*If payment is to be made to more than one account, please attach supplementary schedule.