first insurance LIMITED

LOAN PROTECTION INSURANCE CLAIM FORM

PART 1: DETAILS OF THE INSURED

Full name of MEMBER: ____

Date of Birth: ________________________

Postal Address: ____

Telephone Nos: ____________**Hme** ____________**Wrk** ____________**Mobile**

Name of Member: (if different from above)

____

Type of Claim presented:
Disability (complete parts 2 & 7)
Critical Illness (complete parts 3 & 7)
Redundancy (complete parts 4 & 7)
Bankruptcy (complete parts 5 & 7)
Hosp. Cash (complete parts 6 & 7)

PART 2: DISABILITY

1. What date did the disability occur? ________________ am/pm
2. Where were you at the time?

   ____

3. State what you were doing at the time and describe fully the cause of the disability.

   ____

   ____

4. Name and address of Employer:

   ____

   ____

5. What is your occupation?

   ____

6. How many hours per week did you work prior to the disability?

____

7. Are you a seasonal worker? (please circle) **Yes/No**

8. If you are entitled to any other compensation as a result of this disability, please give details:

____

____

____

9. State briefly but fully the nature and extent of the disability:

____

____

10. State name and postal address of your GP.

Name:

____

Address:

____

11. Have you suffered previously from this disability? (please circle) **Yes/No**

If yes, please provide details:

____

____

____

PART 3: CRITICAL ILLNESS

1. Type of Illness Event: ***Heart attack***

   Coronary Artery Surgery

   Stroke

   Cancer

2. Date of Illness Event: ____/____/____
3. Name and postal address of GP?

Name____

Address____

4. If you are entitled to any other compensation as a result of the Illness, please give details:

____

____

5. Have you suffered previously from this condition? (please circle) **Yes/No**

If yes, please provide details;

____

____

____

PART 4: REDUNDANCY

1. Name and postal address of Employer:____

____

2. Employer Contact Name and Telephone Number

____

____

3. Effective date of Redundancy:

____

PART 5: BANKRUPTCY

1. Date file for Bankruptcy lodged:

____

2. Date adjudicated Bankrupt by High Court of New Zealand:

____

3. Current status

____

PART 6: HOSPITAL CASH

1. Name of Hospital / Medical Clinic:

____

2. Date of admission: ________________

3. Date of discharge: ________________

PART 6: DECLARATION

I/We declare the information provided on this claim form to be true and correct, and will assist First Insurance Ltd in dealing with the claim. Further, I/we understand that this claim is subject to the terms and conditions of the policy.

I/we authorise the disclosure of personal information held by any other party regarding this claim.

I/We agree to First Insurance Ltd releasing to the other parties - including Asteron Life Insurance - information regarding this claim. Please note the following:

1. This claim form collects personal information about you.
2. The information is collected to evaluate your claim.
3. The information collected is intended for and held by First Insurance Ltd.
4. The collection of this information is required as per your insurance policy.
5. You have rights of access and correction of personal information concerning you, held by First Insurance Ltd pursuant to the Privacy Act 1993.

Signature of Insured:

________________________________**Date:**____________________________

Print Insured's name:

____

Please scan and email completed form to: insuranceLPI@firstcu.co.nz
(Please include any medical certificates or reports if these are already available)