

Policy number

1 Life Assured details to be completed for all claims

Mr/Mrs/Miss/Ms

Last name

First name(s)

Mailing address

Residential address
(if different from above)

Telephone

Home ()

Mobile ()

Business ()

Date of birth

/ /

2 Payment detailsPlease pay claim direct
to bank account☐

Name of account

orAttach a preprinted
bank deposit slip☐

Bank

Branch number

Account number

Suffix

orPay direct into bank
account premiums are
being deducted from☐Name(s) and
signature(s) of
Policy Owner(s)

Name

Signature

Name

Signature

Date

/ /

Date

/ /

3 Authority for Adviser/Broker/Insurance Manager involvement

I authorise Sovereign to release any of my personal information and to discuss any details of my claim, including medical or financial details, with my Adviser/Broker/Insurance Manager.

Name of Adviser/Broker/
Insurance Manager

Signature of Life Assured

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?

Employment details continued

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

(d) Date you ceased employment

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

(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?

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

	Start date	End date
<input type="checkbox"/> ACC	/ /	/ /
<input type="checkbox"/> Any other insurance policy	/ /	/ /
<input type="checkbox"/> WINZ payments (e.g. sickness or unemployment benefits)	/ /	/ /
<input type="checkbox"/> Other (e.g. medical retirement or redundancy settlement)	Please provide full details	
<input type="checkbox"/> 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 / /
Date returned to New Zealand / /

5 Declaration and Consent

Notice under the Privacy Act 1993

This claim form collects personal information about you. This information is collected for the purpose of assessing your claim with The Colonial Mutual Life Assurance Society Limited, and/or Sovereign Assurance Company Limited ("the Companies"). 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 the Head Office of the Companies 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 any of the Companies are true and complete. **I, the Life Assured**, declare that all occupational and financial information pertaining to me has been provided and disclosed to Sovereign.

I understand that failure to provide full disclosure of all occupational and financial information that Sovereign 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 Sovereign is entitled to use legal remedy, should this occur.

I further understand that the occupational and financial information provided is the basis on which Sovereign 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 and approved by me.

As a part of a redundancy claim with one of the Companies, **I, the Life Assured**, consent and give authority to the Companies and any related companies to seek from and for all and any of the following, their officers and employees, to disclose to the Companies and any related companies, 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, the Life Assured, agree that a photocopy of this authority will be valid as an original.

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.

Please print full name of
Life Assured

Signature of Life Assured

Date	/	/
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Signature(s) of Policy Owner(s)

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

(a) Name of employer	<input type="text"/>		
(b) Employer address	<input type="text"/> <input type="text"/>		
(c) Full name of employer's representative completing this form	<input type="text"/>		
(d) Life assured was employed by you	From	<input type="text"/> / <input type="text"/> / <input type="text"/>	To <input type="text"/> / <input type="text"/> / <input type="text"/>
(e) Have you employed anyone else to fill this Life Assured's position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
(f) Did the Life Assured receive redundancy pay?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, please state the net figure received and attach a detailed breakdown of this amount <input type="text"/>
(g) What was the Life Assured's average weekly net income in the six weeks immediately prior to redundancy?	<input type="text"/>		
(h) Did the Life Assured accept voluntary redundancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
(i) Was the Life Assured in full time employment with the employer at the date of redundancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 <input type="text"/> <input type="text"/> <input type="text"/>
(j) If this person was not made redundant, what is the reason for his/her unemployment?	<input type="text"/> <input type="text"/>		
(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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, please provide full details <input type="text"/> <input type="text"/> <input type="text"/>
(l) Please give the date that the Life Assured was notified that he/she would or might be made redundant	Date <input type="text"/> / <input type="text"/> / <input type="text"/>		
(m) What date was it generally known that redundancies were being considered by your company?	Date <input type="text"/> / <input type="text"/> / <input type="text"/>		
(n) How many other personnel were made redundant at the same time as the Life Assured?	<input type="text"/>		

7 Declaration (To be signed by Employer)

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

Signature			
Name		Date	/ /
Title		Company stamp	
Company name			

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