

# personal accident and illness claim form



Echelon New Zealand, PO Box 11440, Wellington 6142, Tel 0800 00 41 43, Fax 04 495 8176

## Insured details please ensure all questions are answered

Name of the Insured person:	
Address:	
Daytime phone number:	Evening phone number:
Present occupation:	Date of birth: / /
Name of Insured (if different from above):	

## Accident details

Location:	
Time: am/pm	Date: / /
What was the insured person doing at the time of the accident?	
How was it caused?	
What injuries have been sustained?	
Was the Insured Person under the influence of intoxicating liquor, drugs and/or a controlled substance at the time of the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, please give details:	
Name and address of any witnesses:	

## Illness details

When first contracted: / /
Nature of illness:

## Further details

1	Is the accident or illness the sole cause of the Insured Person's Disablement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If No, please give details:			
2	Has the Insured Person ever previously met with a similar accident or ever suffered from a similar illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, please give details (date, duration etc):			
3	What has been the Insured Person's occupation since the policy was issued?		
4	Is the Insured Person insured against accident or illness with any other company or Friendly Society?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Is the Insured Person receiving or entitled to receive benefits under the Accident Compensation Act or any sickness benefit?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6	Has the Insured Person been able, since the accident/illness occurred, to attend in any way to any portion of their business?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7	Has the Insured Person been able to engage in any other paid employment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8	State the extent and duration of their inability to attend to their business or occupation:		
	Disabled wholly for	days,	from / / to / /
	Disabled partially for	days,	from / / to / /
	I am now (insert "wholly," or "not at all" as the case may be) disabled		
	If still disabled, state how much longer the disability is likely to continue:		
9	Name and address of the Insured Person's usual medical attendant:		
10	If current medical attendant had been known for less than three years, please state name and address of previous medical attendant:		

Any claims must be supported by a report on the reverse of this form from your medical attendant, and any fee for the report is payable by yourself.  
**Please ensure declaration and medical certificate overleaf are completed.**



**Pursuant to the Privacy Act**

The following is brought to your attention.

- (a) This proposal form collects personal information in order to evaluate your application for insurance;
- (b) Failure to provide this information may result in your application being declined;
- (c) Information will be held by JLT Transport, PO Box 6743, Auckland and/or Lumley General Insurance (NZ) Limited, PO Box 2426, Auckland ("Lumley");
- (d) Individuals have the right to request access to, and correction of, personal information held by JLT Transport and Lumley.

**Declaration**

- (a) I/We declare that all information provided is correct and complete in every respect and all information material to this claim has been disclosed to Lumley;
- (b) I/We agree to provide Lumley with any assistance or further information that Lumley may require;
- (c) I/We authorise Lumley to give to, and/or obtain from, third parties including but not limited to the Insurance Claims Register, advisors, medical practitioners and other insurers, information about me/us, this claim or any insurance held by me/us.

Insured person's signature: _____	Date:    /    / _____
Insured's signature (if different): _____	Date:    /    / _____

**Please return all forms to Echelon New Zealand.**