LIFESTYLE PROTECTION INSURANCE
TERMINAL ILLNESS CLAIM FORM

MARAC INSURANCE LIMITED

MARAC Insurance, Box 9919, Newmarket, Auckland 1149. Ph 0800 45 10 10 Fax 09 927 9318

Personal Details - INSURED

Mr/Mrs/Miss/Ms/Dr (please circle) First Names Surname

Address

Suburb City Postcode

Phone No. (hm) Phone No. (wk) Phone No. (mobile)

Email address Date of Birth / /

Nominee

Postal address

Illness details

Name of General Practitioner Phone No. (wk)

Address

Suburb City Postcode

Name of Consultant/Surgeon Phone No. (wk)

Address

Suburb City Postcode

Date of Original Diagnosis: / /

Brief details of ongoing treatment

Please arrange for the attached Medical Report to be completed and lodged with this claim.

Proceeds of Claim

Please confirm (tick a box) where you would like the claim proceeds (if accepted) to be paid:

☐ Pay the full claim onto my MARAC loan

☐ Pay the full claim into the following bank account ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

☐ Pay the full claim to another finance company named here:

Policy No.

Claim No.

About protecting your privacy

This claim collects personal information about you to evaluate the claim you are making.

The recipient and holder of the information is MARAC Insurance Limited, 35 Teed Street, Newmarket, Auckland 1023. The collection of this information is required pursuant to the common law duty to disclose all material facts relevant to the claim and is mandatory. The failure to provide this information may result in your claim being declined or your insurance being void.

You have right of access to, and correction of, this information subject to the provisions of the Privacy Act 2020.

Insured signature

Signed

Date / /

Declaration

I/we declare that the statements contained in this claim are true, and I/we have not suppressed or misstated any facts that are relevant to this claim.

AFM1722G 08/15

MEDICAL REPORT

TO BE COMPLETED BY YOUR MEDICAL PRACTITIONER

Name of Claimant/Patient First Names _____ Surname _____

1. Medical Practitioner's Full Name _____

2. Phone No. (hm) _____ Phone No. (wk) _____ Fax _____

Address _____

Suburb _____ City _____ Postcode _____

3. What is your patient's occupation, business or profession? _____

4. Are you the patent's usual medical practitioner? ☐ Yes ☐ No If so, how long has he/she been a patient? _____

5. State the nature and extent of the injuries or illness _____

6. What do you believe is the cause of the injuries or illness _____

7. Please give details of the treatment given _____

8. Is the patient (to your knowledge) complying with your treatment instructions? ☐ Yes ☐ No

9. On what date did you first attend the patient in connection with this condition? / / _____

10. To your knowledge, has the patient previously suffered from this condition? ☐ Yes ☐ No

If Yes, please provide full details including when the condition was first diagnosed _____

11. Do you consider this injury or illness is terminal or will result in permanent disablement? ☐ Yes ☐ No

If Yes, please give details _____

12. Has the patient been referred to a specialist or do you intend to refer the patient to a specialist? ☐ Yes ☐ No

Name and address of specialist (if applicable) _____

13. To your knowledge, was the injury self-inflicted? (if applicable) ☐ Yes ☐ No

14. Is this condition directly or indirectly related to AIDS or an AIDS related condition, alcohol, drugs or poison? ☐ Yes ☐ No

Please give details _____

15. Is the Claimant suffering from any other conditions (additional to that described in question 6 above)? ☐ Yes ☐ No

If so, please state the nature of the condition and to what extent recovery may be affected _____

16. Please confirm the patient has been unable to attend work from / / _____

17. When do you expect the patient will resume work / / Part of their work / / Full time duties / / _____

18. General remarks _____

Signature of Medical Practitioner _____ Date / / _____