dollar
INSURANCE®

life cover benefit

Need some help completing this form? Call us on **0800 226 223** (9am – 8pm NZST).

At Dollar Insurance, we want to get your claim underway as quickly as possible. To help us do this:

1. Check the latest policy schedule to make sure that the $1 a Day Life Cover for the deceased Policy Owner is in place and up to date.
2. Fill out this form in black or blue pen. Make sure all answers are clear and easy to read.
3. **Complete parts A to H**. If you can't find the latest policy schedule and/or aren't sure who the nominated beneficiaries are, please call us and we can help.
4. Attach these 6 documents (we need all of these to review your claim):
   - ☐ A **certified copy** of evidence of death (e.g. Death Certificate or Coroner's Report).
   - ☐ A **certified copy** of evidence of the **deceased's** age (e.g. Birth Certificate, current Passport or Driver's Licence).
   - ☐ A **certified copy** of **your** identity as the person making the claim (Claimant) e.g. photo identification containing your signature.
   - ☐ A **certified copy** of your relationship to the deceased (e.g. Marriage or Birth Certificate).
   - ☐ A **certified copy** of legal authority (e.g. Will, Probate, Power of Attorney or Letter of Administration).
   - ☐ A **certified copy** of each beneficiary's bank account (e.g. a recent bank statement with their account name and number).

A **certified copy** is a signed photocopy of an original document. It can be signed by a Justice of the Peace, accountant, solicitor, doctor, bank officer or police officer. The person signing it must see the original and the photocopy. Please keep the original documents for your own records, we only need copies.

5. Email or post this completed form and all the required documents back to us.

Part A: Policy Owner's details	
Policy number:	
First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	
Date of birth: ☐☐ / ☐☐ / ☐☐☐☐	Date of death: ☐☐ / ☐☐ / ☐☐☐☐
Cause of death:	

Part B: Your details

How I know the Policy Owner:	☐ Executor	☐ Nominated beneficiary	☐ Relative	☐ Other

Title:	First name:	Surname:
Address:		
Suburb:		Town/City:
Postcode:		Phone (H):
Phone (W):		Phone (M):
Email:		

Part C: Executor of the estate's details

Ignore this if you chose 'Executor' in Part B.

Title:	First name:	Surname:
Address:		
Suburb:		Town/City:
Postcode:		Phone (H):
Phone (W):		Phone (M):
Email:		

Part D: Authority to release information

I, (your full name)

as Executor / Administrator / Guardian / Other (if other please state)

of (the deceased's name)

give permission for any physician, clinic, hospital, institution or Insurance Company to share with Momentum Life Limited, confidentially, all details of any medical tests, treatment or history that they may reasonably ask for.

We will accept a photocopy of this declaration as an authority of the original.

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

Claimant's signature:	Date: ☐☐ / ☐☐ / ☐☐☐☐

Part E: Beneficiary payment authority

After a claim is approved, we'll pay the benefit to the nominated beneficiary/ies, usually within 2 business days. If the deceased named more than one beneficiary, the benefit will be paid to these beneficiaries based on the percentages that they gave us.

If the beneficiary is under 18 years of age, the benefit will be paid to that person's legal guardian or to any trust that may have been created under the deceased's will.

If the deceased didn't name any beneficiary/ies, payment will be made to their Executor.

If you aren't sure who is a beneficiary on this policy, please contact us and we can help.

Beneficiary 1

First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	Phone (H):
Phone (W):	Phone (M):
Name of bank:	
Name of account holder:	
Account number: ☐☐ – ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐☐	

☐ I have attached a certified copy of proof of ownership of this bank account.

Beneficiary 2

First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	Phone (H):
Phone (W):	Phone (M):
Name of bank:	
Name of account holder:	
Account number: ☐☐ – ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐☐	

☐ I have attached a certified copy of proof of ownership of this bank account.

Beneficiary 3

First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	Phone (H):
Phone (W):	Phone (M):
Name of bank:	
Name of account holder:	
Account number: ☐☐ – ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐☐	

☐ I have attached a certified copy of proof of ownership of this bank account.

Part E: Beneficiary payment authority (continued)

Beneficiary 4

First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	Phone (H):
Phone (W):	Phone (M):
Name of bank:	
Name of account holder:	
Account number: – – –	

☐ I have attached a certified copy of proof of ownership of this bank account.

Beneficiary 5

First name:	Surname:
Address:	
Suburb:	Town/City:
Postcode:	Phone (H):
Phone (W):	Phone (M):
Name of bank:	
Name of account holder:	
Account number: – – –	

☐ I have attached a certified copy of proof of ownership of this bank account.

Part F: Details of the Policy Owner's doctor(s)

Doctor 1

Doctor's name:	
Address:	
Suburb:	Town/City:
Postcode:	
Phone (W):	Phone (M):
Dates when attending this doctor: From / /	To: / /

Doctor 2

Doctor's name:	
Address:	
Suburb:	Town/City:
Postcode:	
Phone (W):	Phone (M):
Dates when attending this doctor: From / /	To: / /

Part F: Details of the Policy Owner's doctor(s)

Doctor 3

Doctor's name:	
Address:	
Suburb:	Town/City:
Postcode:	
Phone (W):	Phone (M):
Dates when attending this doctor: From __ __ / __ __ / __ __ __ __	To: __ __ / __ __ / __ __ __ __

Part G: Consent statement

'Them', 'they' and 'their' refers to Momentum Life Limited ("the Insurer") and 'I', 'my', 'you' and 'your' refers to the Policy Owner and the Claimant.

As part of this insurance claim with the Insurer, I give permission and authority for them to collect and use any personal information (including medical or financial information) they might need to manage and make a decision about this claim. This includes their subsidiaries, advisers, reinsurers and any agents they choose to use. They might also use this information for data reports, so long as they don't use my name nor the deceased's name. I also give permission for my information to be shared with relevant third parties including (but not limited to): advisers, agents, health service providers (including recognised private and public hospitals, registered medical practitioners and specialists, medical authorities, Accident Compensation Corporation, therapists, insurers and reinsurers), and any other single organisation where the collection and sharing of my information is legally allowed.

I also understand my personal information may be shared with agents, representatives, organisations or contractors working with the Insurer if it's necessary. They might use this information when they provide services to the Insurer, or for customer satisfaction surveys, or simply where it's allowed by law.

I understand that under the Privacy Act 1993 and The Health Information Privacy Code 1994, I have the right of access to, and correction of, any information provided.

Part H: Declaration

As the person making the claim, I have carefully read and thought about all the questions in this form. All my answers are truthful and correct. By completing this form, I understand I'm responsible for providing the Insurer with all the facts and information they may need to make a decision about this claim.

I understand that lying about anything may cancel this claim. Also, if I don't provide all the information the Insurer needs, this claim can't be assessed at and no benefit will be paid.

I agree that a photocopy of this form will be thought of and accepted as an original.

I have read and agree to the statement in Part G.

Claimant's signature:	Date: __ __ / __ __ / __ __ __ __

Please return the completed form to Dollar Insurance. You can either:

Scan & email to claims@dollarinsurance.co.nz (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); **OR**

Mail to The Claims Manager, Dollar Insurance, PO Box 99892, Newmarket, 1149 (mark the envelope as CONFIDENTIAL).

Policies and claims are managed and paid by Momentum Life Limited NZBN 9429041981658 (trading as Dollar Insurance) and are subject to the terms, conditions, limitations and exclusions as set out in the Policy Wording which was current at the acceptance date.