

# Life & Accidental Death

## Privacy Statement

### Notice under the Privacy Act 1993 and The Health Information Privacy Code 1994

'We', 'us' and 'our' refers to WeProtect Limited (WeProtect) and Fidelity Life Assurance Company Limited (Fidelity Life) and 'you' and 'your' refers to the Policy Owner and the Life Insured.

We collect personal information about you. The personal information and any additional information obtained, (including medical information or financial information if required) will be used by us and our officers to assess and administer the claim. The information may also be used for statistical purposes provided you are not identified.

WeProtect and Fidelity Life, their subsidiaries, advisers, reinsurers and any agents appointed by us collect from, use, and disclose to any third party, your information that is reasonably necessary to assess, administer and manage the claim. Those third parties include (but are 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 individual organisation where the collection/disclosure is required or permitted by law.

The information may also be disclosed between us, outside of WeProtect or Fidelity Life where the disclosure is necessary for one or more purposes for which the personal information was collected, to agents, representatives, organisations, or contractors who provide services to us in connection with the administration of products or services, for the purpose of customer satisfaction surveys, or where permitted by law.

We will take all reasonable steps to keep the information secure and ensure it is accurate, complete and up to date.

Under the Privacy Act 1993 you have the right of access to and correction of the information that we hold about you. We will rely on you to keep us informed of any changes to your information.

The NZ Cover Direct Privacy Policy is available at [www.nzcoverdirect.co.nz](http://www.nzcoverdirect.co.nz). If you have any query in relation to your privacy please contact NZ Cover Direct:

**Phone:** 0800 894 504 (Mon to Fri, 9am - 8pm NZST)

**Email:** [customerservice@nzcoverdirect.co.nz](mailto:customerservice@nzcoverdirect.co.nz)

**Mail:** Claims Manager, NZ Cover Direct, PO Box 99892, Newmarket, 1149

## Completion instructions

**Step 1:** As Policy Owner (or Claimant if the Policy Owner is deceased), you should first check your most recent policy schedule to make sure that the Funeral cover is in place and current for the deceased Life Insured.

**Step 2:** Then complete **Parts A to F**. If you cannot locate the most recent policy schedule and/or are unsure who the nominated beneficiaries are, please call us for assistance.

**Step 3:** Then send the completed form back to NZ Cover Direct, together with the documentation listed in **Part D**.

## Part A: Policy Owner's details

Policy Owner:		Policy number:
Address:		
Suburb:	City:	Postcode:
Phone (H):	Phone (W):	Phone (M):
Email:		

## Part B: Claimant's details

Please tick the relevant box. I am the:  Policy Owner  Nominated beneficiary  Relative  Executor  Other

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

## Part C: Deceased's details

First name:	Surname:
Date of birth: <input type="text"/> / <input type="text"/> / <input type="text"/>	Date of death: <input type="text"/> / <input type="text"/> / <input type="text"/>
Cause of death:	

## Part D: Executor of the Estate's details (not applicable if 'Executor' is already selected in Part B)

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

## Part E: Required documentation

Please tick the boxes to confirm you have submitted all the required documents to us.

- A CERTIFIED COPY of evidence of death (eg. Death Certificate or Coroner's Report)
- A CERTIFIED COPY of evidence of the Deceased's age (eg. Birth Certificate or Driver's Licence)
- A CERTIFIED COPY of proof of your identity (eg. Birth Certificate or Driver's Licence)
- A CERTIFIED COPY of your relationship to the deceased
- A CERTIFIED COPY of legal authority

### What is a certified copy?

This is a signed photocopy of an original document. The person signing it must see the original and the photocopy. It can be signed by a Justice of the Peace, accountant, solicitor, doctor, bank officer or police officer. It means you keep the original as we do not require it.

## Part F: Authority to Release Information

I, (insert your full name)

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

of (insert the deceased's name)

hereby authorise any physician, clinic, hospital, institution or Insurance Company to supply upon request to Fidelity Life, on a confidential basis all details of any medical test, treatment or history that it may reasonably request.

A photocopy of this declaration shall be as valid an authority as 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, (eg. Will, Letter of Administration or Power of Attorney).

Claimant's signature:

Date:

 /  / 

## Part G: Beneficiary payment authority

This section must be completed by the Policy Owner or, where the Policy Owner is deceased, by the claimant. Once the claim has been accepted the benefit will be paid to the Policy Owner. If the Policy Owner is deceased, payment will be to the nominated beneficiaries. If there are no nominated beneficiaries, payment will be made to the estate of the Policy Owner. If unsure, please contact us for assistance.

### Policy Owner if alive, or first nominated beneficiary:

First name:

Surname:

Name of bank:

Name of account holder:

Account number:  -  -

### Other nominated beneficiary/ies:

First name:

Surname:

Name of bank:

Name of account holder:

Account number:

First name:

Surname:

Name of bank:

Name of account holder:

Account number:  -  -

First name:

Surname:

Name of bank:

Name of account holder:

Account number:  -  -

First name:

Surname:

Name of bank:

Name of account holder:

Account number:  -  -

## Part H: Details of the Life Insured's doctor (s)

Doctor's name:

Address:

Suburb:

Postcode:

Phone:

Period of time when attending this doctor:

From:

 /  / 

To:

 /  /

## Part H: Details of the Life Insured's doctor (s) (continued)

Doctor's name:

Address:

Suburb:

Postcode:

Phone:

Period of time when attending this doctor:

From:

/  /

To:

/  /

Doctor's name:

Address:

Suburb:

Postcode:

Phone:

Period of time when attending this doctor:

From:

/  /

To:

/  /

## Part I: Declaration

As the Claimant I have read and carefully considered the questions on this document and all the responses are true and correct in relation to the claim. By completing this form I acknowledge I have a duty to provide WeProtect and Fidelity Life with all the facts material to my claim and all information they may reasonably require in relation to my claim.

I acknowledge that the making of a false statement may invalidate this claim, and that if I fail to provide all or part of the information Fidelity Life requires to assess this claim, it will not be assessed and processed.

I have read and consent to the Privacy Statement on page 1.

Claimant's signature:

Date:

/  /

### Please return the completed form to NZ Cover Direct. You can either:

1. Scan and email to [customerservice@nzcoverdirect.co.nz](mailto:customerservice@nzcoverdirect.co.nz) (please put 'CONFIDENTIAL, Policy Owner's surname, Policy Number' in the subject line); or
2. Mail to Claims, NZ Cover Direct, PO Box 99892, Newmarket, 1149 (please mark the envelope as CONFIDENTIAL).

This cover is insured by Fidelity Life Assurance Company Limited NZBN 9429040548623 and is subject to the terms and conditions as set out in the Policy Wording which was current at the Acceptance Date.