BENEFICIAL INSURANCE LIMITED

CCI CLAIM FORM

Please return to
Beneficial Insurance Limited, PO Box 68 548, Newton, Auckland
Phone: 0800 438 245 Fax: 0800 329 424

Please complete **where applicable** and return within seven days

Name of Insured (in full)							
Address							
Phone	Home		Work		Insurance Policy or Cert No.		
Age Next Birthday			Occupation				

ACCIDENT *If claim is in respect of bodily injury resulting from an accident*

Nature of Injury

Name & Address of Doctor(s) in Attendance

ILLNESS *If claim is in respect of an illness*

Nature of illness

Date on which Doctor first examined you for this illness

Have you previously suffered from the illness for which you are now claiming?

If 'Yes', give details

REDUNDANCY *If claim is in respect of redundancy*

Name & Address of Employer

Position Held Date of Redundancy

Name & Address of Work & Income NZ Office where registered

Please include a copy of the Official Notice of Redundancy and a letter from Work & Income NZ that you are actively seeking employment

PAYMENT PROTECTION PLAN CLAIM

Are the goods, the subject of the Finance Agreement, still in your possession?

If 'No', where are they located

I the undersigned declare that I am the person referred to in the above statements which are true in every respect and made without reservation

Signature	Date	

IMPORTANT Your Medical Attendant must complete the Accident or Illness section of the report on the reverse of this form

MEDICAL REPORT

Name of Claimant

ACCIDENT

1.	Nature of Injury	
2.	Are the appearances of the injuries consistent therewith and do you believe they were so caused?	
3.	On what date did the claimant first consult you in connection with this accident?	
4.	Are you the claimant's usual medical attendant? If so, how long have you known him/her?	
5.	Is the claimant suffering from any injury or illness irrespective of that stated above? If so, please state its nature and to what extent it may affect recovery?	
6.	In our opinion, is the injury attributable to or a result of any physical defects or illness existing at a prior date? If 'Yes', please give details	
7.	Would the claimant have been aware of this condition?	
8.	Anticipated length of TOTAL DISABLEMENT?	**From** **To**
9.	Date claimant released to work (if known)	

ILLNESS

1.	Nature of illness?	
2.	Date illness commenced?	
3.	Present condition? State as clearly as possible	
4.	Has the claimant previously suffered from this illness?	
5.	On what date did the claimant first consult you about this illness?	
6.	Are you the claimant's usual medical attendant? If so, how long have you known him/her?	
7.	Is the claimant suffering from any injury or illness irrespective of that stated above? If so, please state its nature and to what extent it may affect recovery?	
8.	In your opinion, is the illness attributable to or a result of any physical defects or illness existing at a prior date? If 'Yes' please give details	
9.	Would claimant have been aware of this condition?	
10.	Anticipated length of TOTAL DISABLEMENT?	**From** **To**
11.	Date claimant released to work (if known)	

GENERAL COMMENTS

I certify that, to the best of my belief, the foregoing statements are correct

Name		Qualifications		Phone	
Signed		Date		Address	