

Initial Medical Questionnaire

The below Life Assured is claiming a disability benefit from OnePath and we require the following information from you, as the Registered Medical Practitioner for the Life Assured, in order to assess the claim. The more information you are able to provide, the more accurately we will be able to assess the claim. Thank you for your assistance. Please note that this form is to be completed at the expense of the Life Assured.

1 Policy details

Policy number

Life Assured Surname First name(s)

Date of birth DD / MM / YYYY

2 Claim details

(a) What is the primary diagnosis that has caused the current disability?

(b) When did the Life Assured first consult you for the condition they are claiming for?

(c) When did the Life Assured first experience symptoms of the condition?

(d) Has the Life Assured suffered from this condition in the past? If so, please provide details.

Yes ☐ No ☐

(e) Are there any other illnesses or injuries that the Life Assured is suffering from?

Yes ☐ No ☐

(f) What treatment plan have you recommended for the current condition(s)?

(g) Is the Life Assured compliant with the treatment you have recommended?

Yes ☐ No ☐

(h) Are you aware of any rehabilitation plan that is in place for the Life Assured?

Yes ☐ No ☐

(i) When did the Life Assured last consult you for the condition they are claiming for?

3

Yes ☐ No ☐

DD / MM / YYYY

Yes ☐ No ☐

DD / MM / YYYY

Yes		No	
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Declaration

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