Fidelity Life

THE NEW ZEALAND LIFE COMPANY

APPLICATION FORM

FIDELITY LIFE ASSURANCE COMPANY LIMITED

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE APPLICATION . . .

This application is scanned and data is input electronically. Please follow these instructions carefully so there are no delays in processing . . .

Please do not write on this page or inside the perforated section of the spine, as the front page and spine are detached and discarded for processing purposes when received by Fidelity.

Any notes should be included on the "Notes" page (refer 100 – 03).

Use a black pen where possible printing in BLOCK CAPITALS within the spaces provided, e.g.

J	O	N	E	S			

Do not leave empty boxes at the start of lines containing words, but leave a space between words.

Always attach a quote.

Remember to complete all questions in the required sections. Any alterations made must be initialled by the life to be insured and proposer where applicable.

Ensure the following sections are completed:

For all applications, please complete Sections 1 to 4 (Section 3 not required if no credit card payment).

If any of the benefits listed below are included, please complete . . .

Sections 5 to 12 for	Life Assurance Family Income Plan/Survivor's Income Critical Care/LifeCare/Trauma
Sections 5 to 13 for	Income Protection/Disability Income Total & Permanent Disability Waiver of Premium Accidental Death Benefit
Sections 5 to 14 for	Business Overheads/Business Expense Locum Cover
Section 15. if the	total Sum Assured exceeds $1,500,000 with all companies or Income Protection Benefit including any Business Overheads, exceeds $8,000 per month with all companies

Please provide any additional details relating to this Product Application in the Notes section on page 100 – 03.

1. LIFE TO BE INSURED or MEMBER FOR PERSONAL SUPERANNUATION

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

Surname

First name

Middle name

Residential address

Postcode

Marital status _____ Male ☐ Female ☐ Date of birth ___/___/___ (Day / Month / Year)

Previous surname (if applicable) _____

Telephone Home _____ Work _____ Mobile _____

Email address _____

Occupation _____ Industry _____

Average Gross Annual Earnings (net of expenses) $ _____

2.1 CONTACT PROPOSER (not applicable for Personal Superannuation)

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

Surname (or Company)

First name

Middle name

Relationship to life insured _____ Male ☐ Female ☐ Date of birth ___/___/___ (Day / Month / Year)

Telephone Home _____ Work _____ Mobile _____

Email address _____

2.2 OTHER PROPOSER (not applicable for Personal Superannuation)

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

Surname (or Company)

First name

Middle name

Relationship to life insured _____ Male ☐ Female ☐ Date of birth ___/___/___ (Day / Month / Year)

2.3 OTHER PROPOSER (not applicable for Personal Superannuation)

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

Surname (or Company)

First name

Middle name

Relationship to life insured _____ Male ☐ Female ☐ Date of birth ___/___/___ (Day / Month / Year)

2.4 MAILING ADDRESS of Contact Proposer or Member for Personal Superannuation

Postcode

3. ADVISER/BROKER TO COMPLETE

	Broker number	I/C % split	R/C % split
Broker 1 _____		%	%
Broker 2 _____		%	%

See attached quote

Amount collected $ _____ . _____

Commencement date for Direct Debits only – monthly 1st to 28th _____

– fortnightly 1st to 31st _____ Day of week _____ Month _____ Year _____

To speed up the acceptance of this application, if we need further information we will contact your client directly (e.g. via email or telephone) unless you indicate otherwise. No, please do not contact my client ☐ If 'Yes', when is the best time? am / pm

Is this application to amend an existing policy? Yes ☐ No ☐

If 'Yes', please give policy number and complete Policy Alteration Form (available from the Fidelity Adviser website)

Is this application dependent on completion of any other arrangement? Yes ☐ No ☐

If 'Yes' please give details in Notes Section Page 3.

Does this application include Family Income Plan with Annuity/Survivor's Income option? Yes ☐ No ☐

If 'Yes', please give details below of beneficiary

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐

Surname

First name

Middle name

Male ☐ Female ☐ Date of birth Day / Month / Year

3.1. CREDIT CARD PAYMENT

Name of cardholder Amount $

Credit Card number Card type Visa ☐ Mastercard ☐

Expiry date

Signature Date Day / Month / Year

Please note:

1. Credit card payments will be accepted for all annual, bi-annual, initial monthly premiums and advance payment of risk premiums only.
2. Fidelity Life does not accept credit card payments for regular monthly premiums, overdue premiums, savings or investment premiums (including annual or bi-annual).

4. PURPOSE OF THIS APPLICATION

Family Protection ☐ Retirement Provision ☐ Income Protection ☐

Business/Loan Guarantee Insurance ☐ Mortgage Protection ☐ Key Person Insurance ☐

Partnership/Share Protection ☐ Other, give details please ☐ _____

ADVISER/BROKER NOTES

Section number	

DUTY OF DISCLOSURE – please read BEFORE completing application

Your Duty of Disclosure for the life to be insured/member and proposer(s)

Before you enter a contract of insurance you have a duty to disclose to Fidelity Life every matter that you know or could reasonably be expected to know is relevant to its decision whether to accept the risk of insurance and if so on what terms. You have the same duty to disclose those matters to Fidelity Life that occur after signing this application and before your contract of insurance commences. If you fail to comply with your duty of disclosure, Fidelity Life may cancel your policy from inception. In that event, all premiums paid may be forfeited.

5. OTHER INSURANCE ARRANGEMENTS

Note: Please complete the "Advice on Replacement Business" if this application replaces any of the insurances listed here, or any insurance cancelled within the last six months.

		Yes	No
a.	Are you currently proposing to any other company?	☐	☐
b.	Has an application ever been declined, deferred, withdrawn or loaded, or had an exclusion?	☐	☐
c.	Do you have any life or critical care insurance?	☐	☐
d.	Do you have any disability insurance?	☐	☐
e.	Is this application replacing an existing policy, or a policy discontinued within the last 6 months, with Fidelity Life or any other company?	☐	☐

If 'Yes', please give details here.

Company	Year issued	Type	Sum Insured	Indicate Normal terms, Declined, Deferred, Loaded

6. RESIDENCE AND TRAVEL

		Yes	No
a.	Are you a citizen or permanent resident of New Zealand?*	☐	☐

If 'No', please give details here.

* Please note for persons without permanent residence life cover only will be available.

		Yes	No
b.	Do you intend to travel to (other than on holidays) or live in another country?	☐	☐

If 'Yes', please give details here.

Destination	Purpose	Duration

7. HAZARDOUS ACTIVITIES/OCCUPATIONS

If answer to any of these questions is 'Yes', please go to and complete the section noted.

Do you participate or intend to participate in any of the following:		Section	Yes	No
a.	Flying (other than as a fare-paying passenger)	(16.1)	☐	☐
b.	Hang-gliding	(16.2)	☐	☐
c.	Motor racing, motor boat racing	(16.3)	☐	☐
d.	Scuba diving	(16.4)	☐	☐
e.	Parachuting	(16.5)	☐	☐
f.	Any other hazardous sports/pastimes/activities (e.g. martial arts, rock climbing, mountaineering, working at heights, etc.)	(16.5)	☐	☐

8. DOCTOR, LIFE TEST

Please give details of your usual doctor below

Name		**Telephone**
Address		

How long have you been with your usual doctor? ☐

Please advise date ☐ / ☐ / ☐ reason and outcome for your last consultation

Reason:
Outcome:

	Yes	No
Are your medical records held under the same name as shown in Section 1 of this application?	☐	☐

If 'No', please give details here.

Please give details of the doctor who holds your records, if different from above

Name		**Telephone**
Address		

Life Test (a medical service company) provides a convenient way for you to supply Fidelity Life with personal medical information sometimes required for insurance cover. The service uses qualified nurses to conduct medical assessments and/or blood tests for Fidelity Life. It is available for applications which are over non-medical limits, but not Income Protection cover, or applicants outside our normal build range.

	Yes	No
Are you happy for Life Test to contact you if we need more information?	☐	☐

9. PERSONAL INFORMATION

Name

Date of birth / / Place of Birth

a. What is your height? cm ft ins What is your weight? kg lbs

b. Has your weight changed in the last year? Yes ☐ No ☐

If 'Yes', did your weight increase by kg/lbs or decrease by kg/lbs

If any weight change, please provide reason

c. Do you smoke tobacco or any other substance? Yes ☐ No ☐

If 'Yes', what? how much?

d. Have you ever smoked? Yes ☐ No ☐ If 'Yes', date last smoked / /

Reason for stopping

e. Have you used marijuana, heroin, cocaine, narcotics, barbiturates, or any other recreational, non-prescription drugs, or psychoactive drugs? Yes ☐ No ☐

If 'Yes', please give details.

f. Do you drink alcohol? Yes ☐ No ☐

If 'Yes', number of standard drinks* per day week month

*a standard drink = 1 nip of spirits or 1 glass of wine or 1 glass of beer.

g. Have you ever been advised by a medical practioner to reduce your alcohol consumption? Yes ☐ No ☐

If 'Yes', please give details.

10. MEDICAL INFORMATION

	Yes	No
a. Are you now under medical observation or undergoing treatment for any medical condition? (a)	☐	☐
b. Have you been advised to have any tests, treatment or operation? (b)	☐	☐
c. Are you considering seeking advice or treatment for your health? (c)	☐	☐
d. Have you ever taken medication or sedatives, prescribed or otherwise (apart from for colds, flu or contraception)? (d)	☐	☐
e. Have you ever had any operation? (e)	☐	☐
f. Do you suffer from any disabilities e.g. deafness, blindness (total or partial)? (f)	☐	☐
g. Have you had any medical exam, tests (including blood tests) or X-rays in the last 5 years? (g)	☐	☐
h. Have you consulted a doctor, been admitted to a hospital or visited a clinic in the last five years? (Disregard minor ailments such as colds or flu) (h)	☐	☐
i. Have you consulted any other health providers or advisers (e.g. acupuncturist, naturopath, chiropractor, physiotherapist, counsellor, etc) in the last five years? (i)	☐	☐
j. In the past 5 years have you ever had more than 7 consecutive days off work due to any illness or injury? (j)	☐	☐
k. Have you or your sexual partner(s):		
i) Received or expect to receive any medical treatment, advice, counselling or blood tests in connection with AIDS or an AIDS related condition? (i)	☐	☐
ii) Engaged in sexual activity with person(s) whose previous or current sexual behaviour involves homosexual activity or puts them at risk of HIV? (ii)	☐	☐
l. For females –		
i) Are you pregnant? (i)	☐	☐
ii) If 'Yes', please give estimated date of delivery / /		
iii) If currently pregnant, have you had any complications with this or past pregnancies? (iii)	☐	☐
iv) Have you had an abnormal pap smear or mammogram or any breast lump (even if you have not seen a doctor about it)? (iv)	☐	☐

If 'Yes', to any of questions a. to l. please give details here. EXAMPLE ONLY

Question	Reason	Date first started	Duration	Time off work	Full details of treatment including degree of recovery	Doctor or Hospital
d, f, j	*Pneumonia*	*3/02*	*2 weeks*	*3 weeks*	*Antibiotics, 100% recovery*	*Dr Jones/Auckland Hospital*
f, h	*Deafness*	*1/00*	*Ongoing*	*Nil*	*Hearing aid, 60% hearing loss in right ear*	*Dr Jones*

If you prefer not to disclose any **particular** medical condition on this application due to its personal or sensitive nature and you wish Fidelity Life to contact your doctor who has the information, please indicate here ☐

11. HEALTH HISTORY

If the answer to any of these questions is 'Yes', please go to and complete the section noted.

Are you currently being treated for, or have you ever been treated for, or diagnosed with any of the following?

		Section		Yes	No
a.	Asthma	*(17)*	(a)	☐	☐
b.	Bronchitis, tuberculosis, or any other lung complaint		(b)	☐	☐
c.	High blood pressure or high cholesterol		(c)	☐	☐
d.	Chest pains, any heart complaint, or stroke		(d)	☐	☐
e.	Gastric or duodenal ulcer, dysentery, or frequent indigestion		(e)	☐	☐
f.	Epilepsy	*(19)*	(f)	☐	☐
g.	Depression, breakdown, stress or anxiety disorder, sleeplessness, or any other mental health disorder	*(21)*	(g)	☐	☐
h.	Liver disease e.g. hepatitis, disorder of bowel, colitis or any other internal organ		(h)	☐	☐
i.	Kidney, bladder disease		(i)	☐	☐
j.	Bleeding from lung, bowel or kidney		(j)	☐	☐
k.	Sexually transmitted disease or virus		(k)	☐	☐
l.	Diabetes	*(18)*	(l)	☐	☐
m.	Back or neck problems	*(20)*	(m)	☐	☐
n.	Recurrent or chronic allergy, skin disease		(n)	☐	☐
o.	Cancer or tumour of any kind including skin growth		(o)	☐	☐
p.	Arthritis, gout or any kind of joint problem, including previous surgery (state which limb, "r" or "l")	*(20)*	(p)	☐	☐
q.	Disorder of the reproductive or genito-urinary system including prostate or gynaecological disorders		(q)	☐	☐
r.	Any neurological disorder, e.g. dizziness, migraines, paralysis, multiple sclerosis		(r)	☐	☐

If 'Yes', to any of these questions, please give details here.

Please use notes page (page 03) if you require more space.

EXAMPLE ONLY

Question	Condition	Date first started	Duration	Full details of investigations/treatment	Degree of recovery	Full name & address of doctor or hospital
d	chest pain	5/97	1 day	Blood tests, ECG. No treatment given	100%	Akl Hosp
					%	
					%	
					%	
					%	
					%	
					%	
					%	
					%	

12. FAMILY HISTORY

Has any blood-related immediate family member (father, mother, brother, sister) had or been diagnosed with:

a. Diabetes, heart disease, stroke, high cholesterol, kidney disease, mental health condition (including depression), breast, cervical, ovarian, colon or other cancer? Yes ☐ No ☐

b. Multiple Sclerosis, muscular dystrophy, motor neurone disease, cystic fibrosis, familial polyposis, haemochromatosis, Huntington's chorea or any familial disease or inherited disorder? Yes ☐ No ☐

If 'Yes', to either a or b above, please complete the table below.

Relation	List ALL conditions and cause of death if applicable (if cancer, please give type and site)	Age at diagnosis	Current age	OR	Age at death (if applicable)
Mother					
Father					
Brothers					
Sisters					

NOTE: Where Medical Examination is required the following Declaration is to be completed by the examining Doctor.

Declaration by Doctor – I have sighted this person's medical file and confirm the information on the Personal Statement section (pages 05 and 06) of this application is complete and accurate. (Please delete if not applicable.)

Name:	
Signed:	Date: / /

13. OCCUPATION

For Income Protection/ Disability Income and Business Overheads/ Business Expense complete questions 13a. to 13w.

For Total and Permanent Disablement and Waiver of Premium, complete questions 13a to 13r.

For Accidental Death Benefit complete questions 13a to 13l.

a. What is your main income-earning occupation?

b. What is your position?

c. Are you self-employed? Yes ☐ No ☐ or a shareholder-employee? Yes ☐ No ☐

If a shareholder-employee, % of shares owned %

d. What is the name of your employer?

e. What is the nature of the business?

f. How long have you been with this employer or in your current self-employment? (if self-employed less than 12 months, adviser to contact Underwriting Dept)

g. Please give details of your major duties (including details as applicable of heights, depth and locations at which you work, and chemicals, gases or any toxic substances used)

h. Please provide percentage of time on each major duty

Major Duty	%	Major Duty	%

i. What percentage of these duties require manual or physical work? (i.e. non-clerical or desk-based work)

Major Duty	%	Major Duty	%

j. Is your income derived from

salaried employment		**self-employment**		**if partnership**	
Full-time	☐	Sole proprietor	☐	Number of partners	
Part-time	☐	Partnership	☐	Profit Share entitlement	%
Seasonal	☐	Other	☐	If other please specify e.g. Trust, Directors fees	

k. If self-employed, total number of employees? Full-time Part-time

l. How many hours per week do you work to earn your income?

m. How long would your income (other than investment income) continue if you become disabled?

n. What qualifications or training do you hold for your present occupation?

If 'Yes', please give full details of work activities performed away from home and average weekly hours of such activities.

o. Do you work from your home? (see Note) Yes ☐ No ☐

p. Do you have any other occupation? (including hobby farming) *If 'Yes', please give full details.* Yes ☐ No ☐

q. Give details of your occupations during the past 5 years (attach separate sheet if necessary)

From (mm/yy)	To (mm/yy)	Occupation	Employer
/	/		
/	/		

r. Do you intend to change your occupation or duties? *If 'Yes', please give full details.* Yes ☐ No ☐

Note:
For all Agreed Value, and any Indemnity Value policies with a benefit in excess of $8,000 per month, evidence of income is required as follows.
1) For self-employed persons please provide evidence of the last 3 years income e.g. copy of accounts.
2) For wage or salary earners please provide a copy of a recent wage/salary advice.
3) Bonus - to ascertain whether eligible for inclusion please refer to Underwriting Dept.

s. Annual Income details (from personal exertion in primary occupation only) - see Note

Salary/Wages (excluding Fringe Benefits)	$	Bonus (see Note)	$
Fringe Benefits (itemise) e.g. Company Car	$	Share of Profits (Losses)	$
	$	Other *(please specify)*	$
	$	Total Gross Income	$
	$	Less Business Expenses	$
Commission Income	$	Net Income – Before Tax	$

t. Is your income split for tax purposes with your spouse or partner? Yes ☐ No ☐
If 'Yes', please advise the percentage split and the hours and nature of work they do in the business.

u. Do you receive other income which is not produced from personal exertion (not included in "s.") and would continue if you became disabled? Yes ☐ No ☐

If 'Yes', please give details (i.e. rental income, share dividends, investment income, royalties, etc.)

v. Have you previously made any claim under Accident Compensation, sickness or accident policies or any other disability policies for a period of more than two weeks? Yes ☐ No ☐

If 'Yes', please give details.

w. Have you ever been convicted of fraud or any criminal offence? Yes ☐ No ☐

If 'Yes', please give details here.

14. BUSINESS OVERHEAD PROTECTION OR LOCUM COVER/BUSINESS EXPENSES

*Note: In the event of a claim, **either** the Expenses **or** the Locum cover shall be paid, but not both.*

Name of business

When did the business commence? / /

How many people are employed in the business? Full-time Part-time

Business Expense Analysis (for 12-month period)	$
a. Rent or mortgage interest payments	
b. Rates, taxes and other government levies	
c. Electricity, gas, water, heating, telephone, cleaning and security	
d. Depreciation of plant and business equipment	
e. Non-income producing employees – position:	
f. Interest on Business Loans	
g. Lease payments on business vehicles and equipment	
h. Accountants and legal fees	
i. Insurance premiums	
j. Other fixed costs usually incurred in your business (please detail)	
k. Total business expenses	
l. Percentage of total business expense for which you are responsible	%
m. Estimated cost of locum $	

Approved Business Expenses do not include personal income, repayments of mortgage principal, cost of goods or merchandise, cost of implements of profession and salaries of employees who would continue to produce revenue during the disability of the life assured or cost of goods, merchandise, furniture or depreciation of items acquired after commencement of disability.

15. FINANCIAL INFORMATION

Note: Required for all cases with new and existing sums insured between $1,500,000 and $1,999,999 with all companies or monthly Income Protection, Business Overheads and Business Expense benefits in excess of $8,000 with all companies.

*For **total** sums insured of $2,000,000 or more a Confidential Financial Questionnaire must be completed by the person to be insured and counter signed by the accountant or solicitor.*

Personal Estate

Assets	$	Liabilities	$
Dwelling, farm, other property		Amount owing on all property	
Motor vehicles, boat, etc.		Amount owing on vehicles, etc.	
Investments		Other liabilities (specify)	
Other assets (specify)			
TOTAL		TOTAL	

Note: Please attach this information in as much detail as possible to this application:

- Provide details of company, name, nature of business
- Provide copies of accounts for last three years
- Explain reason for insurance, i.e. partnership, keyman, loan protection
- Provide details of how required cover is calculated

16. PURSUITS and HOBBIES INFORMATION

16.1 FLYING

a. What type of licence do you hold?

b. What type of aircraft do you fly?

c. Please indicate number of hours flown — This year / Last year / Expected next year

d. What is the purpose of the flights?

e. Please give details of routes/areas flown?

f. Number of years flying? Total hours flown?

g. Do you have any definite plans to upgrade or change your licence or the nature of your present flying? Yes ☐ No ☐

If 'Yes', please give details.

h. Have you had any previous flying accident/s and/or charges relating to violating Aviation Regulations? Yes ☐ No ☐

If 'Yes', please give details.

16.2 HANG-GLIDING/KITING

a. What heights do you attain?

b. Are you towed? Yes ☐ No ☐

c. How often do you participate in this activity?

d. Do you go over water? Yes ☐ No ☐

16.3 MOTOR RACING, POWER BOAT RACING

a. What classification of motorsport do you participate in?

b. What type of vehicle do you race?

c. What is the engine capacity?

d. What is the maximum speed attained?

e. Give details of your present and future racing activities (number of events per year)

16.4 SCUBA DIVING

a. How long have you been scuba diving?

b. Number of dives per year?

c. Average depth of dives?

d. Maximum depth of dives?

How many times have you dived to this depth?

e. Where do you dive?

f. What qualifications do you hold?

g. Do you dive alone or in company?

Yes ☐ No ☐

h. Have you ever required medical attention following a dive?

If 'Yes', please give details.

16.5 OTHER SPORTS, PASTIMES (including parachuting)

Describe activity (please give full details)

a. How long have you been doing this?

b. How many times a year do you do this activity?

c. How often do you intend to participate in the future?

d. Where do you participate in this activity and what equipment is used?

Yes ☐ No ☐

e. Are you, or do you intend to become a professional?

If 'Yes', please give details.

f. If heights are involved, please advise details.

Yes ☐ No ☐

g. Do you travel outside New Zealand for this activity?

If 'Yes', please give details.

17. ASTHMA

a. When did you first develop asthma?

b. When did you last experience symptoms?

c. How frequently did those symptoms occur in the last 2 years?

d. What is your present treatment (please give names of inhalers and/or tablets and dosage)?

e. How many inhalers do you use in a year?

	Yes	No
f. Have you ever been admitted to a hospital for asthma treatment?	☐	☐
g. Have you had treatment with cortisone or prednisone in the last 5 years?	☐	☐

If 'Yes', to f. and/or g., please give details.

h. How much time have you lost from work in the last 5 years due to asthma?

18. DIABETES

a. When was diabetes diagnosed?

b. How often do you see your doctor for diabetic supervision?

c. State date of last visit / /

d. How often does your doctor carry out blood tests for control of diabetes?

e. If taking insulin or tablets, please give name, dose and frequency

	Yes	No
f. Do you take your own blood sugar readings?	☐	☐

g. If 'Yes', how often, and what is the usual range?

	Yes	No
h. Have you suffered a diabetic or insulin coma?	☐	☐
i. Have you suffered any complication of diabetes affecting your circulation, heart, vision or kidney function?	☐	☐

If 'Yes', to h. or i., please give details.

19. EPILEPSY

a. When did you have your first attack?

b. How many attacks did you have before treatment? ☐ after treatment? ☐

c. How many attacks did you have last year?

d. When was the last attack?

	Yes	No
e. Are you able to work without discomfort or distress?	☐	☐
f. Do you drive a vehicle?	☐	☐
g. During an attack - are you unconscious?	☐	☐
If 'Yes', for how long?		
- have you ever passed urine?	☐	☐
- have you ever bitten your tongue?	☐	☐
h. Have you had an EEG?	☐	☐

If 'Yes', please give details and doctor consulted.

20. MUSCULOSKELETAL QUESTIONNAIRE

(Please complete this section for disorder, disease or injury to muscles, bones or joints, including hips, shoulders, back, neck, knees, wrists or arthritis, gout, rheumatism, OOS)

a. When did you first suffer from any of the above problems? Date / /

b. Please state – i) the cause

ii) the symptoms/exact nature of the problems

c. Please indicate the area or joint involved and specify which side (if applicable)

cervical spine (neck) ☐ knee joint R ☐ L ☐ other specify below

lumbar spine (low back) ☐ hip joint R ☐ L ☐ R ☐ L ☐

thoracic spine (mid back) ☐

d. What was the severity of the pain? Mild ☐ Moderate ☐ Severe ☐

e. How many recurrences have you had of the problems? when?

Yes No

f. Are you now free of all symptoms? (e.g. no pain or stiffness) ☐ ☐

i) If 'Yes', for how long?

ii) If 'No', what is the current severity of pain?

g. How much time have you lost from work as a result of the above problems?

h. Please describe the treatment(s) received

i. If you are still undergoing treatment, please give details

j. If treatment has ceased, please give date / /

k. Please advise diagnosis (e.g. slipped disc, arthritis, etc.)

l. Please give the dates, names and address of doctors or other health providers or advisers consulted for these problems

21. MENTAL HEALTH QUESTIONNAIRE

a. Please indicate the nature of the complaint.

a. Depression ☐ b. Stress ☐ c. Anxiety disorder ☐

d. Other ☐ (please specify)

b. Date of onset or dates if you have suffered more than one episode.

Yes No

c. Did this complaint arise as a result of particular circumstances? ☐ ☐

If 'Yes', please outline those circumstances.

d. Has your condition ever led you to intentionally or unintentionally consider harming yourself or have you ever had suicidal thoughts? Yes ☐ No ☐

If 'Yes', please provide details.

e. Please provide the name of any doctor(s) or health provider you have consulted regarding your symptoms.

f. Please give details of any drugs prescribed and dates.

Yes No

g. Are you still on treatment for this complaint? ☐ ☐

If 'Yes', please give details.

h. How much time have you had off work for this complaint?

i. Date(s) of recovery (if applicable)

22. SPECIFIC HEALTH QUESTIONNAIRE for completion by life to be insured

1. Please describe your particular health condition:

2. When did this condition first occur?

3. Please describe the location on the body and the severity and nature of symptoms, eg. left leg.

4. When were the most recent symptoms?

5. Have you had time off work as a result? Yes ☐ No ☐

   If 'Yes', when and for how long?

6. Have you ever been hospitalised or attended a clinic as a result of this condition? Yes ☐ No ☐

   If 'Yes', when and for how long?

7. Please advise full details of treatment, medication, tests, investigations and advice you have had for this condition, eg. x-rays, ECGs, physio, etc.

   Please name any drugs and dosage.

8. Which doctors or health professional(s) did you consult and on what dates?

9. On what date did you last receive treatment/ medication for this condition? / /

10. Has further treatment been recommended? Yes ☐ No ☐

11. Have you fully recovered from this condition? Yes ☐ No ☐

    If 'Yes', please advise date. / /

    If 'No', please give details below of ongoing issues.

DECLARATION

Your Duty of Disclosure for the life to be insured/member and proposer(s)

Before you enter a contract of insurance you have a duty to disclose to Fidelity Life every matter that you know or could reasonably be expected to know is relevant to its decision whether to accept the risk of insurance and if so on what terms. You have the same duty to disclose those matters to Fidelity Life that occur after signing this application and before your contract of insurance commences. If you fail to comply with your duty of disclosure, Fidelity Life may cancel your policy from inception. In that event, all premiums paid may be forfeited.

Privacy Act 1993 and The Health Information Privacy Code 1994

- This application collects personal information about you, the life to be insured/member and proposer(s).
- You have the right of access to, and correction of, this information.
- The information will be used by Fidelity Life, its subsidiaries, its officers, its advisers and reinsurers to calculate and administer the insurance you apply for and for the purposes and promotion of insurance and investment services to you.
- The information is held by Fidelity Life Assurance Company Limited at 81 Carlton Gore Rd, Newmarket, Auckland.

Declaration and Authority by life to be insured/member and proposer(s)

- I have completed the sections in this application that I was required to complete. If I have not done this, I declare that I have read the application and the information given is true, accurate and complete.
- No statement affecting this insurance has been made to any representative of Fidelity Life that is not recorded in this application.
- The information I have provided and the information provided by anyone else on my behalf in this application will form the basis of the contract of insurance between me and Fidelity Life.
- I understand if additional information is required to process my application for insurance, I may be telephoned by an underwriter. The information that I provide to the underwriter will form part of my application for insurance.
- I will immediately notify Fidelity Life of any circumstances affecting the risk that may occur after signing this application and before the contract of insurance commences.
- The contract of insurance with Fidelity Life will not commence until this application has been accepted by Fidelity Life, acceptance terms have been agreed to by the proposer(s) and received by Fidelity Life and until payment of the premium is received, or receipt of a valid direct debit, to operate within 30 days.
- I shall be bound by the standard terms and conditions in the policy to be issued to me by Fidelity Life.

Statement of Consent by life to be insured/member

- I authorise Fidelity Life to obtain any information about me from any person and/or entity including, but not limited to, any medical practitioner, specialist, hospital, clinic, counsellor, psychologist, therapist, dentist, insurer, Accident Compensation Corporation, employer, accountant, consultant, financial adviser, bank, financial institution and public authority.
- I authorise any person and/or entity, including any of those listed above, to give any information about me to Fidelity Life.
- I agree that a photocopy of this statement of consent shall be as valid as an original and is sufficient evidence of my consent and authority to the disclosure of my information.

14 day free look

I/we understand that my/our contract of insurance can be cancelled during the 14-day free look period and all premiums refunded to me/us.

Signature of life to be insured/member

Date / /

Signature of parent/guardian/employer for person under age 18

Date / /

Signature of proposer(s), if not the life to be insured/member (If Company owned, authorised signatory must sign and indicate they are signing on behalf of the Company and their position in the Company.)

(1)

Date / /

(2)

Date / /

(3)

Date / /

ADVICE ON REPLACEMENT BUSINESS

The completion of this form is a requirement of the ISI Standard for Term Life and Disability Products. (A separate form is to be completed for each existing contract or policy to be replaced.) A copy of this form will be given to the Applicant(s) by the Adviser and the original held by the Company issuing the new contract or policy.

Details of new Contract/Policy

Name of Client

Name of Company: **Fidelity Life Assurance Company Limited**

Type of Contract/Policy | **Annual Premium** | **$**

	Yes	No
Is initial commission being received in relation to the new contract?	☐	☐
Is instalment commission being taken as an alternative form?	☐	☐

Details of Contract/ Policy being replaced

Name of Client

Name of Company

Contract/Policy No(s).	Annual Premium
	$
	$
	$
	$

Details of Replacement – Statement by Adviser/Broker

a. The specific reasons for the replacement of the existing contract/policy are

b. The policy to be replaced cannot adequately fulfil the owner's objectives because

c. The following risks are not covered by the new contract/policy which were covered by the old contract/policy

Name of Adviser/Broker

Address of Adviser/Broker

Telephone number:

Adviser/Broker's signature

Date: / /

ADVICE TO APPLICANTS

You might find this advice helpful in deciding whether to replace an existing contract or policy. This includes all situations where a new contract or policy is being issued within a period of six (6) months after an existing one has been discontinued, or six (6) months before an existing contract or policy is planned to be discontinued; and

1. the insured (or one of the insureds) is the same, or
2. the applicant (or one of the applicants) is known to be the same, or
3. the premium payer (or one of the premium payers) is known to be the same.

APPLICANT ACKNOWLEDGEMENT

I/We acknowledge there may be advantages and disadvantages involved in replacing an existing contract/policy such as:

1. there are sometimes establishment costs (including commission) in setting up a contract/policy. Replacing it with a new contract/policy may involve further establishment costs;
2. if the policy which is being replaced was purchased on the life assured at a younger age, the same or similar benefits in the new policy may now cost more;
3. a change in health, pastimes or occupation of the life assured may affect insurability and the new policy may contain restrictions, limitations, and/or be more costly;
4. in a new policy the Suicide Exclusion clause will recommence;
5. conditions or benefits may be more (or less) favourable under the contract/policy which is being replaced, for example, the contract duration, wordings, and/or benefit definitions may differ.

I/We also acknowledge that this information was provided and explained before I/we signed the application for the new contract/policy.

I am/We are aware I/we may withdraw this application in writing within the "free look" period of fourteen (14) days from the date the new contract/policy is received.

Name of the Applicant(s) (please print)	
	(1)
	(2)
	(3)

Signature of Applicant(s):

(1)	Date / /
(2)	Date / /
(3)	Date / /

FIDELITY LIFE
THE NEW ZEALAND LIFE COMPANY

FIDELITY LIFE ASSURANCE COMPANY LIMITED
81 CARLTON GORE ROAD, NEWMARKET.
PO BOX 37-275 PARNELL, AUCKLAND, NEW ZEALAND.

TELEPHONE: 64 9 373 4914
FACSIMILE: 64 9 308 9953
WEBSITE: www.fidelitylife.co.nz

BANK INSTRUCTIONS

NAME:
(Of Bank Account)

AUTHORITY TO ACCEPT DIRECT DEBITS
(Not to operate as an assignment or agreement)

AUTHORISATION CODE
0 6 0 4 9 0 2

BANK ACCOUNT FROM WHICH PAYMENTS TO BE MADE:

Bank | Branch | Account Number | Suffix

(Please attach an encoded deposit slip to ensure your number is loaded correctly)

To: The Bank Manager,

BANK:
BRANCH:
TOWN/CITY:

I/We authorise you until further notice, to debit my/our account with all amounts which

FIDELITY LIFE ASSURANCE COMPANY LIMITED

(hereinafter referred to as the Initiator)

the registered Initiator of the above Authorisation Code, may initiate by Direct Debit.

I/We acknowledge and accept that the bank accepts this authority only upon the conditions listed below.

INFORMATION TO APPEAR ON MY/OUR BANK STATEMENT:

PAYER PARTICULARS | PAYER CODE | PAYER REFERENCE

YOUR SIGNATURE(S)

DATE: / /

Approved
0490
11 | 1999

For Bank Use Only
Original - Retain at Branch

Date Received:	Recorded by:	Checked by:

BANK STAMP

CONDITIONS OF THIS AUTHORITY

1. The Initiator:

(a) The Initiator undertakes to given written notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the first Direct Debit is drawn (but not more than 2 calendar months).

In the event of any subsequent change to the frequency or amount of the Direct Debits, the initiator has agreed to give written advance notice at least 30 days before the change comes into effect.

(b) May, upon the relationship which gave rise to this Authority being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Authority. Upon receipt of such notice the Bank may terminate this Authority as to future payments by notice in writing to me/us.

2. The Customer may:

(a) At any time, terminate this Authority as to future payments by giving written notice of termination to the Bank and to the initiator.

(b) Stop payment of any Direct Debit to be initiated under this Authority by the initiator by giving written notice to the Bank prior to the Direct Debit being paid by the Bank.

(c) Where a variation to the amount agreed between the initiator and the Customer from time to time to be direct debited has been made without notice being given in terms of clause 1(a) above, request the Bank to reverse or alter any such Direct Debit initiated by the Initiator by debiting the amount of the reversal or alteration of a Direct Debit back to the Initiator through the Initiator's Bank. PROVIDED such request is made not more than 120 days from the date when the Direct Debit was debited to my/our account.

3. The Customer acknowledges that:

(a) This Authority will remain in full force and effect in respect of all Direct Debits passed to my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this Authority until actual notice of such event is received by the Bank.

(b) In any event this Authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.

(c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the Direct Debit has not been paid in accordance with this Authority. Any other disputes lies between me/us and the Initiator.

(d) Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility or liability in respect of:

- the accuracy of information about Direct Debits on Bank statements.
- any variations between notices given by the Initiator and the amounts of Direct Debits.

(e) The Bank is not responsible for, or under any liability in respect of the Initiators failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.

(f) Notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payments shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.

4. The Bank may:

(a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other Authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.

(b) At any time terminate this Authority as to future payments by notice in writing to me/us.

(c) Charge its current fees for this service on force from time-to-time.

FIDELITY LIFE
THE NEW ZEALAND LIFE COMPANY

WELCOME TO FIDELITY LIFE

Free Accidental Death Cover and Our Commitment of Service

Life/Lives to be insured _____

_____

We welcome your application and will endeavour to give you quality service. As our client we intend to give you the service expected for the length of your contract. Please contact us if you have any questions.

Introduction to Fidelity Life

Fidelity Life is a New Zealand-owned life assurance company and a member of the Investment Savings and Insurance Association of New Zealand Inc.

Being one of the few life assurance companies making use of independent investment managers, we are able to secure the best available investment advice on behalf of our policyholders. Our protection benefits are enhanced through an international network of leading reinsurance companies, securing a top-ranking risk management programme where most of the insurance risk is shared by the reinsurers.

Importance of Proposal

The application and accompanying documents form an integral part of the contract between you and Fidelity Life. As soon as the application is received by us we will check all the information.

If the application is approved on the terms requested by you, we will advise you in writing that the application is accepted and when the Direct Debit Order (if any) is due to start. The resulting contract (policy document) will be sent to you 7 to 10 days following the above letter.

Insurance

Life and disability cover requested under the application needs to be assessed carefully to determine the terms on which it can be provided. By completing a full assessment at this stage, delays can be avoided when a claim is made. We ask your co-operation in providing us with as much information as possible. We will contact your adviser/broker if further information is required.

If your application is acceptable on terms that differ from those originally requested by you, your adviser/broker will contact you for approval of any changes.

You will be notified in writing when the application is accepted. The insurance for which you applied will take effect from that day or the date of commencement, whichever is the later. Please notify us if anything happens which may have an effect on your application for insurance before your policy is issued. Any failure to inform us may jeopardise a claim at a later stage.

Fidelity Life

CERTIFICATE

of

FREE ACCIDENTAL DEATH COVER
(to be kept by Proposer)

Fidelity Life grants free Accidental Death Cover on the Life to be Insured at no additional cost while this application is being assessed, provided the first premium has been paid or a valid payment instruction has been received. The Accidental Death Cover under this application is payable, upon submission of this duly completed Certificate, if the Life to be Insured under this application dies as a result of accidental death, prior to the earliest of:

- the expiry of 60 days from the date you signed the application
- the date on which you are notified that the insurance in terms of this application is accepted, rejected or accepted subject to modification of the terms of acceptance
- the date the policy applied for under this application is issued
- the date of cancellation of this application at your request
- the date on which Fidelity Life seeks facultative reinsurance in respect of the life assurance applied for in order to secure better terms for the Life to be Insured. A minimum sum of $5,000 is payable even if facultative terms are sought.

BENEFIT

Irrespective of the number of Certificates issued for any one Life to be Insured, the Accidental Death Cover is equal to the sums insured proposed with a maximum of $500,000. If there was no application for life insurance, the Accidental Death Cover is $5,000 for any one Life to be Insured. In terms of this Certificate and other concurrent Certificates, no benefit is payable if any proposed life insurance becomes payable.

ACCIDENTAL DEATH

Accidental death in terms of this Certificate means death which is the result of external or internal bodily injury caused directly or solely by violent external and visible means, not attributable to any other event. It excludes death caused by or resulting from

- Suicide, whether sane or insane
- Aviation other than as a fare paying passenger on a recognised airline
- Any accident which took place before or on the date of this application

Signature of Adviser/Broker

Date / /

FIDELITY LIFE ASSURANCE COMPANY LIMITED
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