
# LIFE AND HEALTH APPLICATION

**Client Name**

**Date**

/ /

SOVEREIGN

## GUIDE TO COMPLETING THIS LIFE AND HEALTH APPLICATION

We understand that the questions we ask in this form may be sensitive, but it is very important that you give us all the information that may affect your application for insurance. If we find out at a later time that you have not disclosed all material information, your policy can be avoided altogether.

If you prefer, you can complete this form in private and post it directly to Sovereign Assurance Company Limited, Private Bag Sovereign, Victoria Street West, Auckland 1142.

Please complete a separate Application for each Life to be Assured, using **BLOCK LETTERS**.

| | Section 1–5 | Section 6 | Section 7 | Section 8 | Section 9 | Section 10 |
|---|---|---|---|---|---|---|
| Life | ✓ | ✗ | ✓ If YES to any health question in **Section 5** | ✓ If YES to question (m) in **Section 5** | ✗ | ✓ |
| Living Assurance<br>Early Cancer upgrade | ✓ | ✓ (optional Children's and maternity Benefit only) | ✓ If YES to any health question in **Section 5** | ✓ If YES to question (m) in **Section 5** | ✗ | ✓ |
| Business Income Support<br>Business Continuity<br>Disability Income Protection<br>Essential Disability Income Protection<br>Start-Up Income Protection<br>Total Permanent Disablement<br>Waiver of Premium<br>Mortgage Instalment Insurance<br>Redundancy<br>Retirement Protection Benefit | ✓ | ✗ | ✓ If YES to any health question in **Section 5** | ✓ If YES to question (m) in **Section 5** | ✓ | ✓ |
| Absolute Health | ✓ | ✓ Children Only | ✓ If YES to any health question in **Section 5** | ✓ If YES to question (m) in **Section 5** | ✗ | ✓ |
| Specialist and Diagnostic Testing | ✓ | ✓ Children Only | ✓ If YES to any health question in **Section 5** | ✓ If YES to question (m) in **Section 5** | ✗ | ✓ |

Please indicate how you would like us to refer to this policy in future correspondence (e.g. John's Protection Plan):

Would you like this policy to be grouped with another Sovereign policy for correspondence purposes? ☐ YES ☐ NO

If YES, please list policy numbers

(NB: Not all policies can be grouped. Contact the Operations Team for details)

Is this application part of a joint policy? ☐ YES ☐ NO If YES, please complete a separate application form for each Life to be Assured

## 1. Life to be Assured

Mr/Mrs/Miss/Ms

Last name | First names

Previous name (if changed)

Mailing address

Street

Suburb | Town/City | Postcode

Home address (if different)

Contact details

Home phone ( ) | Business phone ( ) | Mobile ( )

Email

Date of birth

Day / Month / Year | Place of birth | ☐ Male ☐ Female

Occupation | Industry

Do you smoke, or have you been a smoker in the past 12 months?

☐ YES ☐ NO If YES, for how many years have you smoked? years

If yes, please state the type and quantity smoked e.g. Cigarettes, Tobacco, Cigars.

Cigarettes (average per day) | Tobacco (average per day) | Cigars (average per day)

## 2 Policy Owner(s)

If the policy is owned by a business, a company director should complete this section and provide his/her authorisation in SECTION 10

POLICY OWNER (1)

Mr/Mrs/Miss/Ms

☐ as above, **or**

Last name | First names

**or** Company name

Mailing address

Street

Suburb | Town/City | Postcode

Home address (if different)

Contact details

Daytime phone ( ) | Email

Date of birth

Day / Month / Year

POLICY OWNER (2)

Mr/Mrs/Miss/Ms

☐ as above, **or**

Last name | First names

**or** Company name

Mailing address

Street

Suburb | Town/City | Postcode

Home address (if different)

Contact details

Daytime phone ( ) | Email

Date of birth

Day / Month / Year

< THIS SECTION MUST BE COMPLETED >

## 3. Payment Details

Premium amount $ Deposit enclosed $

Payment frequency ☐ Weekly (direct debit only) ☐ Fortnightly (direct debit/credit card only) ☐ Monthly ☐ Annual

Payment method

☐ Direct debit (please complete the attached Payment Authority)

☐ Credit/Debit card (please complete the attached Payment Authority)

☐ Annual cheque Please make cheques payable to Sovereign Services Limited. Cheques should be marked 'not transferable' or 'account payee only'

☐ Use existing Sovereign payment details Policy number

Deduction date Day / Month / Year Please specify date of first regular payment (between 1st and 28th)

## 4. Benefit Details

Please attach Illustration setting out benefits applied for.

## 5. Personal Statement

Should you need more space to provide answers to any of the questions in this form, please use the NOTES on pages 20 - 21 and write 'refer to notes' next to the original question.

(a) Do you have, or are you currently applying for, any other life, income protection, trauma or health cover with Sovereign or any other company?

☐ YES ☐ NO

If YES, please give details below

| Type of Insurance | Benefit Amount | New Cover: Applied for | Existing Cover: To remain in force | Existing Cover: To be replaced* | Company |
|---|---|---|---|---|---|
| **Life** | $ | ☐ | ☐ | ☐ | |
| | $ | ☐ | ☐ | ☐ | |
| **Total Permanent Disablement** | $ | ☐ | ☐ | ☐ | |
| | $ | ☐ | ☐ | ☐ | |
| **Disability Income** | $ | ☐ | ☐ | ☐ | |
| | $ | ☐ | ☐ | ☐ | |
| **Mortgage Instalment Insurance** | $ | ☐ | ☐ | ☐ | |
| **Redundancy** | $ | ☐ | ☐ | ☐ | |
| **Retirement Protection Benefit** | $ | ☐ | ☐ | ☐ | |
| **Living Assurance** | $ | ☐ | ☐ | ☐ | |
| | $ | ☐ | ☐ | ☐ | |
| **Health Insurance** | Excess level $ | ☐ | ☐ | ☐ | |
| **Specialist and Diagnostic Testing** | ☐ YES ☐ NO | ☐ | ☐ | ☐ | |

* If 'To be replaced' has been ticked, please complete the **Replacement Policy Advice form** at the back of this Application.

**IMPORTANT NOTES:**

- To assess your eligibility for the level of cover for which you are applying, Sovereign needs to know your level of existing cover and whether this cover is being replaced by the insurance you are applying for.
- If this application for insurance is intended to replace the existing cover listed above, you must cancel that existing cover. If you do not cancel the existing cover listed above, any claim made by you to Sovereign for the insurance applied for and accepted may not be considered.

< THIS SECTION MUST BE COMPLETED >

## 5. Personal Statement (continued)

(b) What is your height and weight?

cm/feet/inches | kg/stone/lb

(c) Has any insurance you have or applied for (e.g. life, income protection) ever been declined, deferred or modified including any loadings or exclusions?

☐ YES ☐ NO If YES, please give full details

(d) Have you ever claimed benefits from ACC or an insurer due to sickness, injury or treatment for injury (e.g. physiotherapy)?

☐ YES ☐ NO If YES, please give name of condition below, and give details in the **General Health Questionnaire** in SECTION 7

Name of condition

(e) i. Please indicate your New Zealand residency status

☐ Citizen/ Permanent resident ☐ Work permit - Please enclose a copy ☐ Long-term business visa and permit ☐ Other

ii. How long have you resided in New Zealand?

/ Years/Months

(f) Do you intend to live, work or travel overseas within the next 12 months?

☐ YES ☐ NO If YES, please tick purpose and give details below ☐ Live ☐ Work ☐ Travel

Country | Start date | Duration

(g) Do you drink alcohol?

☐ YES ☐ NO If YES, please give details below

Beer (average units per week) (300ml = 1 unit) | Wine (average units per week) (100ml = 1 unit) | Spirits (average units per week) (30ml = 1 unit)

(h) Do you participate, intend to participate, or have you participated, in any hazardous occupation or pursuit (e.g. motor racing, aviation, martial arts, parachuting, scuba diving, senior rugby or motor boat racing) in the last three years?

☐ YES ☐ NO If YES, please complete the **Hazardous Occupation or Pursuit Questionnaire** in SECTION 8

(i) i. **Family history**
Please indicate whether, **before the age of 60**, a parent, sister or brother has suffered from one of the following conditions: (Please tick YES or NO, if YES please give details)

| CONDITION | YES | NO | RELATIONSHIP TO YOU | AGE when diagnosed (if known) | Current AGE | If deceased, AGE at death |
|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | | | | |
| Stroke | ☐ | ☐ | | | | |
| Mental illness | ☐ | ☐ | | | | |
| Dementia | ☐ | ☐ | | | | |
| Kidney disease | ☐ | ☐ | | | | |
| Heart disease | ☐ | ☐ | | | | |
| High blood pressure | ☐ | ☐ | | | | |
| Cancer* | ☐ | ☐ | | | | |
| Huntington's chorea | ☐ | ☐ | | | | |
| Polycystic kidney | ☐ | ☐ | | | | |
| Multiple Sclerosis | ☐ | ☐ | | | | |
| Any hereditary or familial disease | ☐ | ☐ | | | | |

ii. If you ticked one of the above conditions, and your family member is not deceased, please give details of his/her current state of health

* For cancer please specify type

< THIS SECTION MUST BE COMPLETED >

## 5. Personal Statement (continued)

(j) Have you ever used any drug, not prescribed by a doctor, or received medical advice, counselling or treatment for the use of alcohol, drugs or gambling?

☐ YES ☐ NO If YES, please give full details

(k) In the last five years, have you had any medical examinations by a doctor or specialist, tests or X-rays?

☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 7

(l) Have you had surgery or been in hospital before?

☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 7

(m) Are you currently experiencing any health problems or are you receiving or considering seeking medical advice, counselling, tests, treatment or an operation from a health professional?

☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 7

(n) Have you ever had, or have you ever been diagnosed with or treated for, any of the following?

If YES, please complete the **General Health Questionnaire** in SECTION 7. If your symptom is underlined, please refer to the questionnaire specific to that condition.

| | | |
|---|---|---|
| Chest pain, heart complaint, high blood pressure or high cholesterol | ☐ YES | ☐ NO |
| Thyroid disorder or any other glandular condition | ☐ YES | ☐ NO |
| Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder or any other lesion | ☐ YES – please complete **questionnaire i** | ☐ NO |
| Any disease or disorder of the gastrointestinal tract or bowel e.g. irritable bowel, Crohn's disease, ulcers, colitis or reflux | ☐ YES – please complete **questionnaire ii** | ☐ NO |
| Obesity e.g. stomach stapling or liposuction | ☐ YES | ☐ NO |
| Mental, nervous or stress disorder, depression, fatigue or phobia | ☐ YES – please complete **questionnaire iii** | ☐ NO |
| Blood disorders e.g. anaemia, varicose veins, blood clots, bleeding tendencies, leukaemia | ☐ YES | ☐ NO |
| Kidney problems, endometriosis, prostate, bladder or urinary condition e.g. weakness of the bladder or kidney stone | ☐ YES | ☐ NO |
| Epilepsy, stroke or other neurological disorders e.g. motor neurone disease, multiple sclerosis, paralysis or seizures | ☐ YES | ☐ NO |
| Asthma or lung complaint e.g. bronchitis or breathing problems | ☐ YES – please complete **questionnaire iv** | ☐ NO |
| Muscle, joint or bone disorders, injury or disease e.g. arthritis, rheumatism, SLE or gout | ☐ YES – please complete **questionnaire v** | ☐ NO |
| Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis or ear infections | ☐ YES | ☐ NO |
| AIDS or HIV antibodies | ☐ YES | ☐ NO |
| Liver disease or disorder e.g. hepatitis | ☐ YES | ☐ NO |
| Disease or disorder of cervix, breast, uterus, fallopian tube, ovary, vagina or vulva | ☐ YES | ☐ NO |
| Diabetes or abnormal blood sugar level | ☐ YES – please complete **questionnaire vi** | ☐ NO |
| Any other illness, injury or condition not already stated | ☐ YES | ☐ NO |

< THIS SECTION MUST BE COMPLETED >

# 5. Personal Statement (continued)

## Health questions

If you are applying for Absolute Health in conjunction with TotalCareMax or Start-Up Income Protection, please answer the following questions. If children are to be insured as part of your Absolute Health policy, please complete SECTION 6.

(o) Do you suffer from, or have you ever suffered from, or have you ever had treatment or surgery or medical tests or prescribed medication for, any of the following?

If YES, please complete the **General Health Questionnaire** in SECTION 7

| | | |
|---|---|---|
| Oral surgery or wisdom teeth problems | ☐ YES | ☐ NO |
| Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence. | ☐ YES | ☐ NO |

## Doctors' details

(p) Please give the details of any medical professional or clinic you have consulted in the last five years

Name of medical professional or clinic

Does this professional hold your records? ☐ YES ☐ NO

Mailing address

Business phone ( )

Business fax ( )

Years attended

Last date you attended

Name of medical professional or clinic

Does this professional hold your records? ☐ YES ☐ NO

Mailing address

Business phone ( )

Business fax ( )

Years attended

Last date you attended

Name of medical professional or clinic

Does this professional hold your records? ☐ YES ☐ NO

Mailing address

Business phone ( )

Business fax ( )

Years attended

Last date you attended

I/We understand that Sovereign may require my/our medical records from the last five years or longer, depending on the information I/we have disclosed ☐ Yes ☐ No

Your consent to Sovereign accessing these records is set out in Section 10 (l).

(q) If we require that you undergo medical tests, would you use our HealthScreen® service? ☐ YES ☐ NO

HealthScreen® has been developed to provide you with an efficient, convenient and professional means of gathering medical information required for processing your Application for insurance.

Depending on your amount of cover and/or your medical history, different tests or medical questionnaires may be necessary. Usually your doctor or a specialist is responsible for providing this service and the necessary documentation. HealthScreen® provides an easier, more efficient way of gathering this information.

This is a completely confidential service provided free of charge. It enables a medical assessment to be conducted by a Registered Nurse at a time and place that is convenient for you.

(r) If we require further information to process your application quickly, can we use our Telephone Underwriting service? ☐ YES ☐ NO

Phone number ( )

Best time to call am/pm

Telephone Underwriting is a service that helps us process your Application quickly and simply. If we require further information, a Sovereign Telephone Underwriter will phone you at a time and place that is convenient for you. They may ask you questions about your health, your occupation or hazardous pursuits so we can process your Application. We use this additional information to assess the acceptance terms of your Application.

The information you provide will be taken down and a copy of the questions and your answers will be posted to you. We ask that you check that the details are correct and advise us of any amendments, if necessary, within seven days of receiving this information.

< THIS SECTION MUST BE COMPLETED >

## 6. Children To Be Assured (Absolute Health, optional Children's and Maternity Benefit and Specialist and Diagnostic Testing Benefit Only)

This section applies to Absolute Health, the optional Children's and Maternity Benefit* and the Specialist and Diagnostic Testing Benefit. If applying for Absolute Health and the Specialist and Diagnostic Testing Benefit all questions need to be completed. Answers to all questions should be given by the parent or guardian on the basis that they relate to the child to be assured. If there are more than four children to be assured please complete the Health Insurance Application.

Child one

Last name | First names

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

Child two

Last name | First names

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

Child three

Last name | First names

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

Child four

Last name | First names

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

* Please note Section 6(a) to 6 (f) is not required to be completed if only applying for the Comprehensive Living Assurance optional Children's and Maternity Benefit.

< THIS SECTION MUST BE COMPLETED >

| | Child one | Child two | Child three | Child four |
|---|---|---|---|---|
| (a) **Doctors' details**<br>i. Please give the name and mailing address of any doctors the child has consulted in the last five years | | | | |
| ii. and the doctor holding the child's records | | | | |
| (b) Does the child smoke, or have they been a smoker in the past 12 months? | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| If YES, please state the type and quantity smoked (eg Cigarettes, tobacco or cigars) | Type<br>Average per day | Type<br>Average per day | Type<br>Average per day | Type<br>Average per day |
| (c) Does the child have permanent residency status in New Zealand? | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| If NO, please give details | | | | |
| (d) Has the child had any medical examination or consultation, test, X-rays, treatment or surgery in the last five years, or is the child currently undergoing treatment, tests or observations or considering seeking advice, treatment or counselling for their health? (Disregard minor ailments such as colds or flu.) If YES, please give details in the **General Health Questionnaire** in SECTION 7 | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

## 6. Children To Be Assured (continued)

(e) Has the child ever had, or ever been diagnosed with or treated for, any of the following:

If YES, please complete the **General Health Questionnaire** in SECTION 7.

If the child's symptom is underlined, please refer to the questionnaire specific to that condition.

| | Child 1 | Child 2 | Child 3 | Child 4 |
|---|---|---|---|---|
| Chest pain, heart complaint, high blood pressure or high cholesterol | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Thyroid disorder or any other glandular condition | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder or any other lesion<br>If YES – please complete **questionnaire i** | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Any disease or disorder of the gastrointestinal tract or bowel e.g. irritable bowel, Crohn's disease, ulcers, colitis or reflux If YES – please complete **questionnaire ii** | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Obesity e.g. stomach stapling or liposuction | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Mental, nervous or stress disorder, depression, fatigue or phobia<br>If YES – please complete **questionnaire iii** | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Blood disorders e.g. anaemia, varicose veins, blood clots or bleeding tendencies or leukaemia | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Kidney problems, endometriosis, prostate, bladder or urinary condition e.g. weakness of the bladder or kidney stone | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Epilepsy, stroke or other neurological disorders e.g. motor neurone disease, multiple sclerosis, paralysis or seizures | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Asthma or lung complaint e.g. bronchitis, or breathing problems<br>If YES – please complete **questionnaire iv** | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Muscle, joint or bone disorders, injury or disease e.g. arthritis, rheumatism, SLE or gout<br>If YES – please complete **questionnaire v** | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis or ear infections | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| AIDS or HIV antibodies | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Liver disease or disorder e.g. hepatitis | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Disease or disorder of cervix, breast, uterus, fallopian tube or ovary | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Diabetes or abnormal blood sugar level<br>If YES – please complete **questionnaire vi** | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Any other illness, injury or condition not already stated | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

(f) Does the child suffer from or has the child ever suffered from or ever had treatment or surgery or medical tests or prescribed medication for, any of the following:

If YES, please complete the **General Health Questionnaire** in SECTION 7.

| | Child 1 | Child 2 | Child 3 | Child 4 |
|---|---|---|---|---|
| Oral surgery or wisdom teeth problems | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence. | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

# 7. General Health Questionnaire

Please complete this section if you answered YES to any of the selected questions in SECTIONS 5 or 6. If you need extra space to provide your response, please use the NOTES on pages 20 - 21 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name | First names

| | CONDITION | CONDITION |
|---|---|---|
| (a) Name of condition | | |
| (b) Date of first symptoms | Day / Month / Year | Day / Month / Year |
| (c) Date of last symptoms | Day / Month / Year | Day / Month / Year |
| (d) Have you ever been hospitalised or had time off work or school as a result of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (e) Have there ever been any subsequent problems, impairments or after-effects from this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (g) Have you ever had any recurrence of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above | | |

Life to be Assured / Child

Last name | First names

| | CONDITION | CONDITION |
|---|---|---|
| (a) Name of condition | | |
| (b) Date of first symptoms | Day / Month / Year | Day / Month / Year |
| (c) Date of last symptoms | Day / Month / Year | Day / Month / Year |
| (d) Have you ever been hospitalised or had time off work or school as a result of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (e) Have there ever been any subsequent problems, impairments or after-effects from this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (g) Have you ever had any recurrence of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above | | |

## 7. General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on pages 20 - 21 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name | First names

| | CONDITION | CONDITION |
|---|---|---|
| (a) Name of condition | | |
| (b) Date of first symptoms | Day / Month / Year | Day / Month / Year |
| (c) Date of last symptoms | Day / Month / Year | Day / Month / Year |
| (d) Have you ever been hospitalised or had time off work or school as a result of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (e) Have there ever been any subsequent problems, impairments or after-effects from this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (g) Have you ever had any recurrence of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above | | |

Life to be Assured / Child

Last name | First names

| | CONDITION | CONDITION |
|---|---|---|
| (a) Name of condition | | |
| (b) Date of first symptoms | Day / Month / Year | Day / Month / Year |
| (c) Date of last symptoms | Day / Month / Year | Day / Month / Year |
| (d) Have you ever been hospitalised or had time off work or school as a result of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (e) Have there ever been any subsequent problems, impairments or after-effects from this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (g) Have you ever had any recurrence of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above | | |

# 7. General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on pages 20 - 21 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name | First names

| | CONDITION | CONDITION |
|---|---|---|
| (a) Name of condition | | |
| (b) Date of first symptoms | Day / Month / Year | Day / Month / Year |
| (c) Date of last symptoms | Day / Month / Year | Day / Month / Year |
| (d) Have you ever been hospitalised or had time off work or school as a result of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (e) Have there ever been any subsequent problems, impairments or after-effects from this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (g) Have you ever had any recurrence of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above | | |

Life to be Assured / Child

Last name | First names

| | CONDITION | CONDITION |
|---|---|---|
| (a) Name of condition | | |
| (b) Date of first symptoms | Day / Month / Year | Day / Month / Year |
| (c) Date of last symptoms | Day / Month / Year | Day / Month / Year |
| (d) Have you ever been hospitalised or had time off work or school as a result of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (e) Have there ever been any subsequent problems, impairments or after-effects from this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (g) Have you ever had any recurrence of this condition? | ☐ YES – please give full details at (h) ☐ NO | ☐ YES – please give full details at (h) ☐ NO |
| (h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above | | |

# 7. General Health Questionnaire (continued)

## i. Tumour questionnaire

Please complete this section if you answered YES for **cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder, or any other lesion.**

Life to be Assured / Child

Last name | First names

(a) What was the site of the tumour?

(b) Histology of the tumour ☐ Benign ☐ Malignant or pre-malignant ☐ Unknown

(c) How long ago was the initial diagnosis made? ☐ Years ☐ Months

(d) Have you received treatment within the last three years? ☐ YES ☐ NO If YES, please give details

(e) Has there been any recurrence? ☐ YES ☐ NO If YES, please give details

(f) Are you undergoing any ongoing follow-up or have you been advised that follow-up treatment is required? ☐ YES ☐ NO If YES, please give details

## ii. Gastrointestinal tract/bowel questionnaire

Please complete this section if you answered YES for **any disease or disorder of the gastrointestinal tract or bowel e.g. irritable bowel, Crohn's disease, ulcers, colitis or reflux.**

Life to be Assured / Child

Last name | First names

(a) Do you suffer, or have you ever been advised by a medical practitioner that you suffer, from:

☐ Indigestion ☐ Heartburn ☐ Gastro-oesophageal reflux ☐ Hiatus hernia

☐ Gastritis ☐ Ulcer ☐ Ulcerative colitis ☐ Crohn's disease

☐ Irritable bowel syndrome ☐ Other

If OTHER, please give name of condition

(b) Have you ever consulted a specialist about symptoms of any of the above? ☐ YES ☐ NO

(c) Are you on continuous medication? ☐ YES ☐ NO If YES, is your medication prescribed by your GP/specialist? ☐ YES ☐ NO

(d) Have you ever had any investigations of the gastrointestinal tract? ☐ YES ☐ NO If YES, please give details below

| **Name of investigation** | **Result** Normal | Abnormal | Unknown |
|---|---|---|---|
| | ☐ | ☐ | ☐ |

| **Name of investigation** | **Result** Normal | Abnormal | Unknown |
|---|---|---|---|
| | ☐ | ☐ | ☐ |

(e) How frequently do you suffer from symptoms? times per year

# 7. General Health Questionnaire (continued)

## iii. Mental health questionnaire

Please complete this section if you answered YES for **mental, nervous or stress disorder, depression, fatigue or phobia**.

Life to be Assured / Child

Last name | First names

(a) Do you suffer, or have you ever been advised by a medical practitioner that you suffer, from:

- ☐ Anxiety
- ☐ Compulsive disorder
- ☐ Headaches
- ☐ Irritability
- ☐ Stress
- ☐ Fear or phobia
- ☐ Hyperventilation
- ☐ Depression
- ☐ Fatigue
- ☐ Sleeplessness
- ☐ Post-traumatic stress disorder
- ☐ Other

If OTHER, please give name of condition

(b) How long ago were the first symptoms? ☐ Years ☐ Months

(c) How long ago were the last symptoms? ☐ Years ☐ Months

(d) Have you had any recurrence of the symptoms? ☐ YES ☐ NO If YES, please give details

(e) Have you ever been hospitalised or had time off work or school as a result of this condition? ☐ YES ☐ NO If YES, please give details

(f) Has your condition ever led you to intentionally or unintentionally harm yourself or have suicidal thoughts? ☐ YES ☐ NO If YES, please give details

(g) Have you ever been recommended, prescribed or received treatment for any of the conditions or symptoms listed above e.g. medication or counselling? ☐ YES ☐ NO If YES, please give details

(h) Have you ever been assessed by a psychiatrist or a psychologist? ☐ YES ☐ NO If YES, please give details

## iv. Asthma questionnaire

Please complete this section if you answered YES for **asthma**.

Life to be Assured / Child

Last name | First names

(a) Frequency of symptoms in the last five years (please tick the appropriate box)

- ☐ Daily
- ☐ Weekly
- ☐ Occasionally
- ☐ One-off episode
- ☐ None – childhood only

(b) Severity of symptoms in the last five years (please tick the appropriate box)

- ☐ Nil symptoms – childhood only
- ☐ Mild, e.g. exercise-induced only, seasonal (related to hayfever allergy, colds or flu)
- ☐ Moderate, e.g. all year around, no specific triggers
- ☐ Severe, e.g. constant, reduced lung capacity, restriction of lifestyle or work duties

(c) Have you, over the last two years, required: (please tick the appropriate boxes)

- ☐ YES ☐ NO Daily preventative inhalers, e.g. ventolin
- ☐ YES ☐ NO Occasional use of a nebuliser or oral steroid medication e.g. prednisolone
- ☐ YES ☐ NO Hospitalisation/ emergency treatment

(d) Maximum number of consecutive days off work / school you have had over the last two years due to this condition ☐ Days

# 7. General Health Questionnaire (continued)

## v. Musculoskeletal questionnaire

Please complete this section if you answered YES for **muscle, joint or bone disorders, injury or disease e.g. arthritis, rheumatism, SLE or gout.**

Life to be Assured / Child

Last name | First names

| | CONDITION ONE | CONDITION TWO |
|---|---|---|
| (a) Name of condition | | |
| Areas affected | | |
| (b) How long ago did you first suffer from this condition/pain/discomfort/injury? | Years ☐ Months ☐ | Years ☐ Months ☐ |
| (c) How long did these symptoms last? | Years ☐ Months ☐ Weeks ☐ | Years ☐ Months ☐ Weeks ☐ |
| (d) Has this condition occurred more than once? | YES – please give full details at (j) ☐ NO ☐ | YES – please give full details at (j) ☐ NO ☐ |
| (e) Have you had any special investigations or surgery? | YES – please give full details at (j) ☐ NO ☐ | YES – please give full details at (j) ☐ NO ☐ |
| (f) Have you had any time off work or school as a result of this condition? | YES – please give full details at (j) ☐ NO ☐ | YES – please give full details at (j) ☐ NO ☐ |
| (g) Are you currently receiving treatment? | YES – please give full details at (j) ☐ NO ☐ | YES – please give full details at (j) ☐ NO ☐ |
| (h) Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery may be required? | YES – please give full details at (j) ☐ NO ☐ | YES – please give full details at (j) ☐ NO ☐ |
| (i) Do you have any residual, ongoing effects or restrictions as a result of this condition? | YES – please give full details at (j) ☐ NO ☐ | YES – please give full details at (j) ☐ NO ☐ |
| (j) Please give full details if you have answered YES to question (d), (e), (f), (g), (h) or (i) above | | |

# 7. General Health Questionnaire (continued)

## vi. Diabetes / Abnormal blood sugar questionnaire

Please complete this section if you answered YES for **diabetes or abnormal blood sugar level.**

Life to be Assured / Child

Last Name | First names

(a) Please tick the appropriate box

☐ Diabetes - go to (b)

☐ Abnormal blood sugar level – go to (c)

(b) Please confirm type of diabetes (please tick the appropriate box)

☐ Type 1 – Insulin dependent

☐ Type 2 – Diet controlled, oral medication

(c) When was your condition first diagnosed?

Day / Month / Year

(d) Please advise the date and result of your last blood test readings for the following:

HbA1c (Glycosylated Haemoglobin) Level
Date of last blood test — Day / Month / Year

Result of your last blood test

Blood Glucose Level
Date of last blood test — Day / Month / Year

Result of your last blood test

(e) As a result of your condition, have you ever had any of the following:

| | | |
|---|---|---|
| High blood pressure | ☐ YES | ☐ NO |
| High cholesterol | ☐ YES | ☐ NO |
| Eye problems | ☐ YES | ☐ NO |
| Kidney problems | ☐ YES | ☐ NO |
| Heart problems | ☐ YES | ☐ NO |
| Numbness or tingling in your legs or feet | ☐ YES | ☐ NO |
| Diabetic or insulin coma | ☐ YES | ☐ NO |

If YES, please provide dates and further details

## 8. Hazardous Occupation Or Pursuit

Please complete this section if you answered YES to question (h) in SECTION 5.

| | OCCUPATION / PURSUIT ONE | OCCUPATION / PURSUIT TWO |
|---|---|---|
| (a) Name of occupation or pursuit? | | |
| (b) How long have you participated in this activity? | Years Months | Years Months |
| (c) Are you a certified instructor? | YES NO | YES NO |
| (d) In the last 12 months how many events / trips / climbs / jumps did you participate in? | | |
| (e) Please advise the number of hours you engaged in this activity in the last 12 months | hours | hours |
| (f) Where do you participate in this activity (geographically)? | | |
| (g) If your occupation or pursuit is scuba diving, do you ever dive alone? | YES NO | YES NO |
| (h) Do you have any plans to become a professional? | YES NO<br>If YES, please give details | YES NO<br>If YES, please give details |
| (i) Please disclose maximum heights, speeds, depths | | |
| (j) Please give full details including the engine size for boats or other equipment used | | |
| (k) Are you involved in any record attempts? | YES NO<br>If YES, please give details | YES NO<br>If YES, please give details |

# 9. Occupation And Income Details

**Questions (a) to (r) to be completed for Business Continuity, Business Income Support, Disability Income Protection, Essential Disability Income Protection, Retirement Protection Benefit and Start-Up Income Protection.**

**Questions (a) to (m) to be completed for Total Permanent Disablement (TPD) and Waiver of Premium.** (For TPD applications Sovereign may request additional financial information as necessary.)

**Questions (a) to (n) to be completed for Mortgage Instalment Insurance and Redundancy.**

(a) What is your current main occupation?

(b) Do you hold a professional or trade qualification? ☐ YES ☐ NO If YES, please give details

(c) Is your income derived from: (select all that apply)

**i. Salaried employment**

☐ Full-time ☐ Part-time ☐ Seasonal

**ii. Self-employment**

☐ Sole proprietor — Name of business

☐ Partnership — Name of business

☐ Company (in which you have a shareholding of 25% or more) — Name of business

☐ Other (e.g. director's fees, trusts) — Please give details (e.g. name of trusts)

(d) If self-employed, please state

Number of partners/shareholders

Year your business was established

Number of part-time employees

Number of full-time employees

Profit share entitlement %

(e) Are you intending to change your occupation or duties or sell your business? ☐ YES ☐ NO If YES, please give details

(f) Are you aware of any pending redundancy or liquidation at your place of permanent employment or have you been advised that you may be made redundant? ☐ YES ☐ NO

If YES, please give details

(g) Describe your exact duties (including details as applicable of heights, depths and locations at which you work and chemicals, gases or any toxic substances used) and provide the % of time spent on each duty and the % of time that each duty requires manual or physical work, including driving

| Exact duties | % of time on each duty | % that requires manual work, including driving |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

(h) Number of hours worked per week

(i) Do you work from home? ☐ YES ☐ NO If YES, please give details

(j) Do you have any other occupation? ☐ YES ☐ NO If YES, please give details

(k) Have you ever been convicted of fraud or any offence involving dishonesty? ☐ YES ☐ NO If YES, please give details

(l) Have you ever been adjudged bankrupt, been under administration or in receivership? ☐ YES ☐ NO If YES, please give details

## 9. Occupation And Income Details (continued)

(m) Give details of your current and previous occupations during the last five years?

| From | To | Occupation | Employer |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

(n) Is the cover for a mortgage taken out in respect of an investment (e.g. a mortgage to purchase an investment property)? ☐ YES ☐ NO
**(Mortgages where the funds are to be used for investment purposes are not eligible for Mortgage Instalment Insurance or Redundancy Cover)**

(o) Annual earned income details

Have you selected the Retirement Protection Benefit

☐ YES ☐ NO

| | |
|---|---|
| Salary/wage | $ |
| Fringe benefits (e.g. company car) | $ |
| Commission income | $ |
| Bonus | $ |
| Share of profits | $ |
| Other (please specify) | $ |
| **Total earned income** | $ |
| Less business expenses | $ |
| **Net earned income – before tax** | $ |

(p) Annual unearned income details

| | |
|---|---|
| Interest | $ |
| Rental | $ |
| Dividend | $ |
| Annuity | $ |
| Other (please specify) | $ |
| **Total unearned income** | $ |
| Less related expenses | $ |
| **Net unearned income – before tax** | $ |
| | |
| **NET INCOME (earned and unearned)** | **$** |

(q) How much of your income would continue if you were disabled? How long would it continue for? What would be the source of income?
E.g. sick leave, outstanding accounts, retainers, superannuation benefits, ongoing profits or entitlements

| |
|---|
| |
| |
| |
| |

(r) Have you attached evidence of income? Please speak to your adviser for requirements ☐ YES ☐ NO

## Notes

## Notes

# WHAT YOU NEED TO TELL US

**1. ALWAYS TELL THE TRUTH.** Insurance is based on the principle of utmost good faith. Put simply you have a positive duty to provide truthful, complete and correct information about yourself, including your health and medical history. Your duty of disclosure extends to the date the contract of insurance is concluded between us. For example, you are required to tell us if you are diagnosed with a medical condition after the date of your application but before you agree to any terms of cover we may offer. If we offer to cover you, you will be insured on the basis of the information you have provided.

**2. ANSWER QUESTIONS AS FULLY AS YOU CAN.** Applying for insurance involves responding to a number of questions. Your answers need to include as much detail relating to your current and past circumstances as possible. While this may take time, it is important to ensure that we have all the information we need when we make the decision to insure you and on what terms.

**3. IF IN DOUBT, TELL US.** If you are uncertain of the relevance of any information, our advice is to include it on your form because, even if you aren't sure, it may be important to us. If someone else is completing the form on your behalf, it is important that you check that the information is correct and nothing has been left out.

**4. IF YOU DON'T KNOW SOMETHING, SAY SO.** If you say that you don't know what the answer to a question is and we think we need more information about your answer to a question so we can offer you insurance, we will need to obtain the information from somewhere else. By signing the declaration and consent, you give us your consent to get this information.

**5. KNOW WHAT YOU'RE SIGNING.** By signing the declaration on your form, you are saying that you have answered all the questions completely and to the best of your knowledge, as well as providing any other information that may influence our decision about your policy. If you are uncertain about any of your answers, ask us or your adviser before signing the declaration.

**6. HOW NON-DISCLOSURE AFFECTS CLAIMS.** When you make a claim we may look further into your personal history. If we discover that you did not provide us material information that would have changed our decision to insure you or the terms of that insurance, we may amend the terms of your insurance policy. It does not matter if the new information is about a condition unrelated to your claim. If we discover that you haven't told us something material, we may either alter the terms of your policy – which might affect your claim, or we may avoid your policy from its inception which means that you would not be able to make a claim as no policy would exist.

**7. HELP US TO HELP YOU WHEN YOU NEED TO CLAIM.** Depending on what you tell us on your claim form, we might need more information to make a decision about your claim. We may get this information by calling you, asking you to fill out another form or asking you to take a medical test. Sometimes we will need to get information from other people who may include your doctor, your employer, ACC or other government departments. By signing the consent form you give us the consent to do this.

**8. KNOW WHAT YOU ARE CONSENTING TO.** We can only request information that we need to assess your application for insurance or for payment of a claim. At all times, the information we hold about you is your information, you have the right to access and, if it is wrong, to ask us to correct it.

**9. DON'T BE AFRAID TO ASK.** If there is anything you're not sure of, don't be afraid to ask us for help. Contact your adviser, or phone Sovereign on **0800 500 108.**

# 10. Declaration and Consent

**Please read your duty of disclosure and declaration carefully and sign the bottom of the page to show your acceptance of these terms. Failure to make the following declaration truthfully may invalidate your insurance.**

**IMPORTANT NOTICE: Your Duty of Disclosure**
Before this contract of insurance ('Insurance') is issued you have a duty to disclose to Sovereign Assurance Company Limited ('Sovereign') every matter that is material to its decision whether to accept the risk of the Insurance and, if so, on what terms. If you are not sure if something is material it is best to disclose it on the application form to be safe. You have the same duty to disclose material matters to Sovereign before you apply to vary or reinstate the Insurance. If you make a claim we may request a copy of your entire medical file from your General Practitioner and other medical providers. If it becomes apparent that you have failed to comply with your duty of disclosure to us; and we would not have issued the Insurance on the same terms if disclosure had been made, we may cancel or avoid the Insurance from inception – if the insurance is avoided Sovereign will not pay your claim.

**Life assured:**

| | | |
|---|---|---|
| I understand the importance of full disclosure of all information required in this application for Insurance | ☐ YES | ☐ NO |
| I consent to Sovereign obtaining my medical records from my doctor and other medical providers and have read the "My personal information" section below. | ☐ YES | ☐ NO |

**THE BELOW NAMED LIFE TO BE ASSURED AND POLICY OWNER(S) DECLARE AND AGREE THAT:**

**Disclosure:**

(a) I/We have read the notice explaining my/our duty of disclosure and all the statements contained in this Application ('Application') are true and complete to the best of my/our knowledge.

(b) Should the Life to be Assured undergo any alteration in mental or physical health or have a change of occupation between the date of this Application and the issue of the Insurance, I/we agree to notify Sovereign immediately as this information is relevant to any decision Sovereign may make to accept this Application.

(c) I/We understand that statements made in this Application, including statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf, forms the entire basis of the Insurance contract between me/us and Sovereign.

(d) I/We acknowledge that my/our adviser receives commission from Sovereign.

(e) I/We acknowledge that I/we are signing on behalf of any children and declare that I/we have disclosed all health information, including any pre-existing conditions, for such children and ourselves.

**Underwriting:**

(f) I/We will be bound by the standard conditions applicable to the proposed Insurance upon Sovereign's acceptance of this Application. I/We understand that if my/our Application requires underwriting, then special terms (including special conditions, premium loadings, exclusions or maximums) may be applied to my/our policy. I/We understand that any special terms will apply from the risk commencement date of my/our Insurance. I/We understand that the special terms will be set out in the schedule to my/our policy document and will form part of my/our Insurance contract. I/We will accept the special terms if I/we either make a premium payment after the policy free look period or agree to the special terms in writing.

(g) I/We have read Sovereign's Telephone Underwriting information sheet and understand if additional information is required to process my/our Application for insurance, I/we may be telephoned by a Telephone Underwriter. The information that I/we provide to the Telephone Underwriter will form part of my/our Application for Insurance.

(h) I/We understand that if I/we do not consent to Sovereign collecting personal information on this Application and from the sources listed in paragraph (l) Sovereign may not be able to undertake a full underwriting assessment which may result in Sovereign declining to offer cover or offering cover on less favourable terms than I/we may otherwise be offered.

**Premiums:**

(i) I/We understand the Insurance proposed in this Application shall not commence until this Application has been accepted by Sovereign and the initial premium or a completed Direct Debit Authority or premium payment direction (such as a Credit Card) has been received by Sovereign.

(j) I/We authorise Sovereign to debit the nominated credit card account with the premiums payable for the Insurance. Sovereign may debit the credit card account with an Insurance premium even where there may be insufficient clear funds in the credit card account, but Sovereign shall not be obliged to do so. If there are insufficient funds but Sovereign debits the credit card Sovereign may also debit the credit card account with any applicable fees and charges. If the Insurance premium cannot be recovered from me/us, then Sovereign may reverse the Insurance premium payment resulting in the premiums being treated as not having been paid and Sovereign may be entitled to cancel the Insurance in accordance with the Insurance terms relating to non-payment of premiums.

**My personal information:**

(k) I/We consent to the use of the personal information provided in this Application or obtained from any source indicated in paragraph (l) by Sovereign and/or any related companies, their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application for Insurance, for the processing of this Application and administration of the Insurance and any claims, and for promotion of insurance and investment services to me/us. I/We understand that the personal information collected will be held at Sovereign's Head Office, 74 Taharoto Road, Takapuna. I/We understand access to and correction of my/our personal information may be requested by me/us.

(l) I/We consent and give authority to Sovereign and/or any of its related companies to seek from, and for all and any of the following, its officers and employees, to disclose to Sovereign and/or any of its related companies, their advisers, reinsurers, and to any legal tribunal before which any question concerning the Insurance may arise, any medical, financial or other personal information affecting such Insurance which they may hold in respect of me/us:

- Dentists • Advisers • Employers (whether current or not) • Medical laboratories • Accident Compensation Corporation • Banks and other financial institutions
- Accountants and other financial advisers • Insurers or reinsurers (whether public or private) • Counsellors, psychologists and therapists
- Government departments, agencies, organisations and enterprises • Registered medical practitioners and specialists (which may include an entire copy of my/our medical file)

(m) I/We understand that the supply of the information gathered from the above sources is voluntary and that Sovereign and/or any of its related companies may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my/our Insurance.

(n) I/We understand that in collecting information that is relevant to this application Sovereign may also receive/collect information that is not relevant to the assessment of this application for Insurance.

**Insurance Policy:**

(o) The above answers have/have not been entered by me/us in this Application but they have been checked by me/us and no statement affecting this Insurance has been made to any representative of Sovereign that is not recorded in this Application.

(p) I/We acknowledge that the Illustration attached to Section 4 of this Application forms part of the Application and sets out the insurance benefits I/we are applying for.

(q) I/We have been advised that a Specimen Policy Document and the financial statements of Sovereign are available to me/us on request from Sovereign's Head Office.

**General:**

(r) I/We understand that neither ASB Bank Limited or its subsidiaries, the Commonwealth Bank of Australia, nor any other company in the Commonwealth Bank of Australia Group, nor any of their directors, nor any other person, guarantees Sovereign Assurance Company Limited or its subsidiaries, nor any of the products issued by Sovereign Assurance Company Limited or its subsidiaries.

Please print full names of Life to be Assured

Signature of Life to be Assured

Date Day / Month / Year

## 10. Declaration and Consent (continued)

Please print full names of Child / Children to be Assured for Absolute Health

CHILD ONE

CHILD TWO

CHILD THREE

CHILD FOUR

**PLEASE COMPLETE THIS SECTION IF THE LIFE/CHILD TO BE ASSURED IS LESS THAN 16 YEARS OF AGE**

**Parent's consent where Life/Child to be Assured is less than 16 years of age**

I consent to this Application for Insurance and certify that the answers to the questions in the application are true and complete to the best of my knowledge.

Relationship (please tick) ☐ Parent ☐ Guardian

**Signature of parent or guardian of Life/ Child to be Assured**

Date Day / Month / Year

**Please note that Sections 67B and 67C of the Life Insurance Act 1908 provide the following limitations in respect of payments able to be made by Sovereign in the event of the death of a minor:**

**Where deceased minor is under the age of 10 years**
Payment is limited to a return of premiums paid plus interest thereon (compounded annually) at the rate prescribed for the purposes of Section 87 of the Judicature Act 1908 at the date of death of the minor plus the amount that, when added to any other sum permitted to be paid by any other company or friendly society, equals $2,000 (or such larger sum as may be specified by Order in Council).

**Where deceased minor is under the age of 16 years**
Sovereign is prohibited from paying on the death of a minor under the age of 16 years, any sum under any policy issued on or after the 1st day of April 1996 to any person other than:

(i) the parents or guardians of the minor, or one of them; or
(ii) a parent or guardian of the minor and the spouse of that parent or guardian jointly; or
(iii) any person who had District Court approval to effect the policy on the minor; or
(iv) an executor or administrator of any of those persons; or
(v) a person to whom payment may be made under Section 65(2) of the Administration Act 1969; or
(vi) any person who is entitled to that sum by virtue of any assignment of policy approved by the District Court.

Signature of Individual policy owner(s)
(if other than Life to be Assured and as named in SECTION 2 of this application form)

Date Day / Month / Year

Date Day / Month / Year

Date Day / Month / Year

Date Day / Month / Year

Signature of company policy owner(s)
I/We acknowledge that we are signing on behalf of the company as named in SECTION 2 of this application form and that I/we have the authority to do so.

Name (please print)

Job title

Signature

Date Day / Month / Year

Name (please print)

Job title

Signature

Date Day / Month / Year

00501-11/09

# AUTHORITY TO ACCEPT DIRECT DEBITS

SOVEREIGN
life insurance - home loans - investments

## 1. Personal Details

Title: Mr | Mrs | Miss | Ms

Other

Policy Number

First Name of policy owner

Telephone Home ( )

Surname of policy owner

Email Address (optional)

Date of first payment (between 1st and 28th of the month)

Start Date: D D M M Y Y Y Y

Frequency (please tick one): ☐ fortnightly ☐ monthly

## 2. Authority to Accept Direct Debits

Authority to Accept Direct Debits

(Not to operate as an assignment or agreement)

Name of Account

Customer (Debtor) to complete Bank/Branch number and Account Number and Suffix of Account to be debited.

Bank | Branch number | Account number | Suffix

To: The Manager (Insert name of Bank and Branch)

Start Date

Address (PO Box):

Town/City:

(Hereinafter referred to as the Bank)

Authorisation Code: 1 2 0 0 3 6 5

I/We authorise you until further notice in writing to debit my/our account with you all amounts which **Sovereign Services 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 on the reverse of this form.

Information to appear in my/our Bank Statement

Payer Particulars: S O V E R E I G N

Payer Code:

Payer Reference:

Your signature must appear here – Name of Account – Customer (Debtor) to complete

Authorised signature(s)

Authorised signature(s)

SOVEREIGN
life insurance - home loans - investments

# 1. The Initiator:

**FOR IRREGULAR PAYMENTS**

(a) Has agreed to give advance notice of the net amount of each Direct Debit and the due date of debiting at least 10 calendar days before (but not more than two calendar months) the date the Direct Debit will be initiated.

The notice will be provided either:
(i) in writing; or
(ii) by electronic mail where the Customer has provided prior written consent to the Initiator.

The advance notice will include the following message:

"Unless advice to the contrary is received from you by (*date), the amount of $_____ will be directly debited to your bank account on (initiating date)."

*This date will be at least two (2) days prior to the initiating date to allow for the amendment of Direct Debits.

**FOR REGULAR PAYMENTS**

(b) Undertakes to give notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the date the first Direct Debit is drawn, (but not more than two calendar months).

This notice will be provided either:
(i) in writing; or
(ii) by electronic mail where the Customer has provided prior written consent to the Initiator.

Where the Direct Debit system is used for the collection of payments which are regular as to frequency, but variable as to amounts, the Initiator undertakes to provide the Acceptor with a schedule detailing each payment amount and each payment date. In the event of any subsequent change to the frequency or amount of the Direct Debits, the Initiator has agreed to give advance notice of at least 30 days before changes come into effect. This notice must be provided either:

(i) in writing; or
(ii) by electronic mail where the Customer has provided prior written consent to the Initiator.

**FOR BOTH IRREGULAR AND REGULAR PAYMENTS**

(c) 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 1 (b) 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 the Direct Debit back to the Initiator through the Initiator's Bank, PROVIDED such a 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 dispute 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; and
- 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 Initiator's failure to give notice in accordance with 1(a) 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 1(b) to the debtor responsible for the payment 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 signed 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 in force from time to time.

**FOR BANK USE ONLY**

Approved
0036
02 | 02

Date Received

Recorded by

Checked by

Bank Stamp

3647-06/10

**SOVEREIGN SERVICES LIMITED, SOVEREIGN HOUSE,** 74 Taharoto Road, Takapuna, North Shore City 0622,
**PRIVATE BAG SOVEREIGN**, Victoria Street West, Auckland 1142, New Zealand. **FREEPHONE** 0800 500 108 **FREEFAX** 0800 329 768
**EMAIL** enquire@sovereign.co.nz **WEB** www.sovereign.co.nz

# CREDIT CARD / DEBIT CARD PAYMENT AUTHORITY

SOVEREIGN
life insurance - home loans - investments

| | |
|---|---|
| Full name of policy owner | |
| Residential phone number | ( ) |
| Business phone number | ( ) |
| Email | |
| For which policies do you want this authority to apply? | |
| Date of first payment (between 1st and 28th of the month) | |

## Credit card or debit card details

Card type ☐ MasterCard ☐ Visa ☐ Debit Card

Payment frequency ☐ Monthly ☐ Quarterly ☐ Half–yearly ☐ Annually

Account number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Name on card

Expiry date /

I/We declare and agree that:

I/We authorise Sovereign to debit the nominated credit card/debit card account with the premiums payable (and any increases to those premiums), for the insurance cover provided under the policies listed above. Sovereign may debit the credit card/debit card account with an insurance premium even when there may be insufficient clear funds in the credit card/debit card account, but Sovereign shall not be obliged to do so. If there are insufficient funds but Sovereign debits the credit card/debit card, Sovereign may also debit the credit card/debit card account with any applicable fees and charges. If the insurance premium cannot be recovered from me/us, then Sovereign may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and Sovereign may be entitled to cancel the Insurance in accordance with the insurance terms relating to non-payment of premiums.

Card holder's signature

Day / Month / Year

4318-06/10

4318-06/10

Investment Savings & Insurance Association (ISI)

# Replacement Policy – Adviser Advice

As an Adviser you have an important role in helping the insured be aware of the risks and advantages of changing their insurance policy. The ISI requires you to complete this declaration when a life insurance policy is being replaced, exchanged, or converted. This form relates to Term Life and Disability, Trauma, and Income Protection policies.

You need to provide a copy of this form to the new insurer who will then provide a copy to the policy owner and the old insurer.

It is important to note that this is not a cancellation request and it is the client's responsibility to cancel their existing cover once their new cover has been issued.

**Full Name of Life Insured:** **Date of Birth:**

| NEW POLICY | | |
|---|---|---|
| TYPE | POLICY NO | INSURER |
| | | |
| | | |
| | | |

| POLICY BEING REPLACED | | | |
|---|---|---|---|
| TYPE | POLICY NO | INSURER | POLICY ISSUE DATE |
| | | | |
| | | | |
| | | | |

## Statement by Adviser (please complete a, b and c in all cases)

a. Please tick the specific reason(s) for the replacement of the existing policy:

- ☐ Reduction in premium
- ☐ Change of cover amount
- ☐ Change of cover type
- ☐ Dissatisfaction with insurer/service
- ☐ Dissatisfaction with adviser/service
- ☐ Changing the premium structure
- ☐ A stronger claims paying rating
- ☐ Improved benefits coverage
- ☐ Other – please specify below

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

c. The following risks are not covered by the new policy, but were covered by the old policy:

## Adviser Declaration

I confirm that I have taken all reasonable steps to advise the policy owner of the risks and benefits of replacing the policy(ies) mentioned in this form. To the best of my knowledge and belief the information contained in this form is true and correct. I confirm that this change is in the best interests of the life insured and/or policy owner identified on this form.

NAME: SIGNATURE:

FIRM: EMAIL ADDRESS:

DATE: PHONE NUMBER:


SEE OVER

Investment Savings & Insurance Association (ISI)

# Replacement Policy – Customer Protection Advice

**Before you replace your policy make sure you understand the pros and cons.**

Life insurance provides important protection for you and your family. When you change your policy it is important that you are aware of the risks as well as the benefits.

This form helps make sure you are aware of the consequences of your decision. This completed form will be given to your old and new insurer.

Your old insurer may contact you to confirm that your old policy was not able to meet the requirements of your new policy.

It is important to note that this is not a cancellation request and it is your responsibility to cancel your existing cover once your new cover has been issued.

**Customer Acknowledgement and Declaration**

1. I/We acknowledge there may be disadvantages when replacing an existing policy such as:

   **It may cost more to retain your original benefits as you grow older:** If the policy being replaced was purchased for the life insured at a younger age, it may cost more to get the same or similar benefits in the new policy.

   **If there has been a change in your health, leisure activities or your occupation, this may influence your insurability with a new provider:** The new policy might contain restrictions on covers, plus exclusions for any developed or pre-existing medical conditions you may now have.

   **There may be longer periods without cover**: In a new policy, features like the suicide exclusion clause or the trauma benefit waiting period may recommence, and you may be without financial protection during this time.

   **Conditions or benefits may be more or less favourable:** In a new policy, the date the policy ends, its terms and conditions, and/or benefit definitions may be different from your old policy.

   **Costs to set up a new policy:** Remuneration is likely to be payable to your Adviser when you replace this policy. If you would like more information ask your Adviser.

2. I/We acknowledge that this information was provided and explained **before** I/we signed the application for the new policy.
   ☐ ***Yes*** ☐ ***No***

3. I/We acknowledge that a copy of *'Your Old Policy May Have More Life In It Than You Think'* brochure has been explained to me/us.
   ☐ ***Yes*** ☐ ***No***

4. Did you establish whether the existing/terminated policy could be amended to provide similar benefits to the replacement policy?
   ☐ ***Yes*** ☐ ***No***

   If **Yes**, can you please describe why you decided not to amend your existing policy?

   .....

5. I/We confirm that the Adviser/Intermediary has fully explained the advantages and disadvantages of the replacement of the policy(ies) mentioned in this form and I/we understand the consequences of such replacement(s).

6. I/We acknowledge that a copy of the completed form will be given to both the old and new insurer.

7. I/We acknowledge that the Adviser/Intermediary explained the amount of remuneration payable from this change.
   ☐ ***Yes*** ☐ ***No***

8. I/We agree to ISI collating information contained in this form, that does not identify the applicant/policy holder/insured, for aggregate replacement statistics purposes for participant insurer members.

9. Where the Insurer is offering a 'free look' period, I am/We are aware I/we may withdraw my application in writing at any time within that period. (*This free look period varies between Insurers but may be up to 14 business days.)*

NAME OF POLICY OWNER: ..... PLEASE PRINT

SIGNATURE OF POLICY OWNER: .....

DATE: .....

## FOR ADVISER USE ONLY special instructions

This Application form should be used for all TotalCareMax applications. This form can also be used for Start-Up Income Protection applications. If the Life to be Assured is applying for either Absolute Health or Key Health, in addition to TotalCareMax and Start-Up Income Protection, this form can be used for both products. If children are to be insured as part of Absolute Health, this form can also be used.

## Adviser Checklist

To avoid delays in processing this Application, please check the following have been received as required, before submitting the form to Sovereign:

- ☐ Personal statement complete
- ☐ Evidence of income
- ☐ Payment method identified
- ☐ Declaration signed
- ☐ Illustration attached
- ☐ Copy of any Advice on Replacement Business form (original to remain with client)
- ☐ Details of doctor holding medical records
- ☐ Payment form complete
- ☐ Commencement date identified

| | | |
|---|---|---|
| Credit this case to Sovereign adviser code | | |
| Group Voluntary Code | | |
| Percentage split | Initial | Renewal |
| Adviser's company | | |
| Adviser name | | |
| Please tick one | ☐ Variable % | ☐ Pendulum % ☐ As earned |

**SECOND ADVISER** (if applicable)

| | | |
|---|---|---|
| Credit this case to Sovereign adviser code | | |
| Group Voluntary Code | | |
| Percentage split | Initial | Renewal |
| Adviser's company | | |
| Adviser name | | |
| Please tick one | ☐ Variable % | ☐ Pendulum % ☐ As earned |

**Scanned/faxed?** ☐ YES Date Day / Month / Year

00501-06/10


## LIFE INSURANCE • HOME LOANS • INVESTMENTS

**TELEPHONE** +64 9 487 9000 **FACSIMILE** +64 9 487 8003
**FREEPHONE** 0800 500 108 **FREEFAX** 0800 329 768
**EMAIL** enquire@sovereign.co.nz **WEB** www.sovereign.co.nz

**SOVEREIGN HOUSE** 74 Taharoto Road,
Takapuna, North Shore City 0622
**PRIVATE BAG SOVEREIGN** Auckland Mail Centre 1142

00501–11/10