

Personal Statement

Subsidised Risk

1 Plan details

Plan name		
Employer name		
Adviser name		
Administrator name		Liberty Ref:
	Office Use Only	Office Use Only

2 Member details

	Last Name	First Name(s)	
Mr/Mrs/Miss/Ms			
Home Address			
Mailing Address			
Telephone	Day ()	Evening ()	Mobile
Date of Birth	/ /	Place of Birth	
Occupation		Male	Female

3 Personal statement

We understand that the medical questions that we ask in this section may be sensitive, but it is very important that you give us all the information that may affect your application for insurance. If you prefer, you can complete this form in private and post it directly to Sovereign Assurance Company Limited, PO Box 33-1004, Takapuna, North Shore City 0740.

a) Do you have or are you currently applying for any other life, income protection, trauma, health or savings policies with Sovereign or any other company? Yes No

If YES, please give details below including the name of the insurer, type of insurance and the benefit amount.

b) What is your weight and height? kgs/lbs cms/feet & inches

c) Have you smoked in the last twelve months? Yes No

If YES, please specify what substance you smoked and weekly quantity smoked.

d) Do you have permanent residency status in New Zealand? Yes No

If NO, please give full details below.

e) Has a parent, brother or sister suffered from heart disease, diabetes, stroke, mental illness, dementia, kidney disease, high blood pressure, cancer (specify type), Huntingtons chorea, polycystic kidney or any hereditary of familial disease or disorder? Yes No

If YES, please give details of the relationship to you, medical condition, age at onset or death.

f) Have you had any medical exam or consultation, test or x-rays in the last five years, or are you currently undergoing treatment, tests or observations or considering seeking advice, treatment or counselling for your health? (Disregard minor ailments such as colds or flu.)

Yes No

If YES, please give details.

g) Have you ever had any of the following:

If you answer YES to any of the questions below, please complete the questionnaire in Section 4. Please give as much detail as possible including details of any medical condition, treatment, dates and results. Use extra paper for your answers if necessary.

Kidney problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes, gout or thyroid disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy, seizures or stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer, tumour, cyst, moles or breast lump?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma/lung complaint?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis or liver problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pains, high blood pressure, heart complaint or high cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle, bone or joint disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Counselling for alcoholism, drug or gambling addiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stress, mental or nervous disorder, anxiety or fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sight or hearing problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastrointestinal tract or bowel problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

h) Have you received or are you expecting to receive any medical treatment, blood tests, medical advice or counselling in connection with AIDS or AIDS related conditions?

Yes No

If YES, please give details.

i) To the best of your knowledge would any of your sexual partners since 1980 have answered YES to question 3h)?

Yes No

If YES, please give details.

j) Doctor's details:

- (i) Please give the name and mailing address of any doctors you have consulted in the last 5 years.
- (ii) And the doctor holding your records.

k) Have you ever had an application for life, disability, trauma, sickness or accident assurance declined, postponed or not accepted on normal terms?

Yes No

If YES, please give details.

l) Have you ever received or claimed a benefit for any injury or illness whether from a government agency, ACC, an accident insurer or any other insurer?

Yes No

If YES, please give details.

m) Do you or are you likely to engage in any hazardous activity, sport or pastime? (e.g. aviation, motor racing, underwater activities, hang gliding, parachuting, mountaineering, etc.)

Yes No

If YES, please give details.

n) If we require further information to complete this application, can we use our Telephone Underwriting service?

See description on page 4 for details

Yes No

Best time to call

Phone No

o) If we require you to undergo medical tests, would you use our HeathScreen® service? See description on page 4 for details

Yes No

ONLY ANSWER THE FOLLOWING TWO QUESTIONS IF YOU ARE APPLYING FOR INCOME PROTECTION INSURANCE AND YOU EARN MORE THAN \$240,000 PER ANNUM.

p) Does your net investment income (including income from family trusts and associated business entities) exceed 10% of your gross wage/salary from your employer who is providing this insurance?

Yes No

If YES, please complete an Occupation & Income Details Questionnaire, Subsidised Risk form and attach it to this Personal Statement.

q) Does your net asset base exceed \$400,000? (Include assets in family trusts and associated business entities and exclude the family home and personal effects such as furniture, personal cars.)

Yes No

If YES, please complete an Occupation & Income Details Questionnaire, Subsidised Risk form and attach it to this Personal Statement.

4 Health Section - General Health Questionnaire

	Condition 1	Condition 2
a) Name of condition	<input type="text"/>	<input type="text"/>
b) Date of first symptoms	<input type="text"/>	<input type="text"/>
c) Date of last symptoms	<input type="text"/>	<input type="text"/>
d) Have you ever been hospitalised or had time off work as a result of this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)
e) Have there ever been any subsequent problems, impairments or after effects of this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)
f) Are you currently receiving treatment or follow up or been advised that treatment or follow up is required?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)
g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give full details below at h)
h) Please give full details if you have answered YES to questions d), e), f) or g)	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

5 Declaration & consent

Important Notice – Your Duty of Disclosure. Before you enter into a contract of insurance “insurance” you have a duty to disclose to Sovereign Assurance Company Limited “Sovereign” every matter that is material to its decision to accept the risk of the insurance and if so on what terms. You have the same duty to disclose those matters to Sovereign before you apply to vary or reinstate the insurance. If you fail to comply with your duty of disclosure Sovereign may cancel and avoid the insurance from inception.

I, the Member, declare and agree that:

- I have read the notice explaining my duty of disclosure and all of the statements contained in this personal statement are true and complete to the best of my knowledge.
- If additional information is required to process my application, I may be telephoned by a Telephone Underwriter. The information that I provide to the Telephone Underwriter will form part of this application.
- If I undergo any alteration in mental or physical health or have a change of occupation between the date of this personal statement and the acceptance of the insurance, I agree to notify Sovereign immediately as this information is relevant to any decision Sovereign may make to accept this insurance.
- I understand that the insurance in relation to this personal statement shall not commence until Sovereign has accepted my application for insurance and arrangements have been made for payment of premiums.
- Any statements made in this personal statement, and if applicable a Workplace Occupation and Income Details Questionnaire or Workplace Health Condition Questionnaire, including any statements made by me to my medical examiner or made by any medical examiner on my behalf forms the basis of the insurance between me and Sovereign. I have disclosed all health information including any pre-existing conditions I have. I will be bound by the standard conditions applicable to the proposed insurance upon Sovereign’s acceptance of the insurance.
- I consent to the use of the personal information provided in this personal statement by Sovereign and/or any related companies, their subsidiaries, their officers, their advisers, reinsurers and any third party contracted by Sovereign to administer the insurance so that they can assess my application for insurance, for the processing of the application and the ongoing administration of the insurance and any claims. I understand that the personal information collected will be held by Sovereign at 74 Taharoto Road, Takapuna, North Shore City. I understand that access to and correction of my personal information may be requested by me.
- I consent and give authority to Sovereign and any of its related companies to seek from, and for all and any of the following, their officers and employees, to disclose to the insurer and 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: • Registered Medical Practitioners and specialists • Dentists • Employers (whether current or not) • Accident Compensation Corporation • Hospitals (whether public or private) • Medical laboratories • Accountants and other financial advisers • Banks and other financial institutions • Counsellors, psychologists and therapists, Insurers • Government departments, agencies, organisations and enterprises (whether public or private).
- I agree that a photocopy of this authority will be valid as an original. I agree that this authority applies to the signature shown below.

Full Name of Member	<input type="text"/>		
Signature of Member	<input type="text"/>	Date	<input type="text"/>

Making it easy for you

Telephone Underwriting Service

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 most convenient to you. They may ask you questions about your health, your occupation or your hazardous pursuits so we can process your application. We use this additional information to assess the acceptance terms for 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 7 days of receiving this information.

HealthScreen®

HealthScreen® is a free service 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 designated specialist, is responsible for providing this service and the necessary documentation. Now, HealthScreen® provides an easier, more efficient way of gathering this information.

Key features of the service

- Confidentiality and discretion are assured
- You are notified of the required tests prior to consultation
- Tests are carried out at your convenience – at your home or office
- Service is personalised
- The processing time of your application is shortened
- Available in most areas (Whangarei, Warkworth, Auckland, Hamilton, Tauranga, Rotorua, Taupo, Turangi, Taumaranui, Gisborne, Hawke’s Bay, New Plymouth, Palmerston North, Wanganui, Wellington, Nelson, Blenheim, Christchurch, Dunedin, Invercargill, Timaru, Queenstown) and includes their immediate surrounding areas.

All HealthScreen® consultants are experienced New Zealand registered nurses and they provide the service from Monday to Friday during business hours with some flexibility. If an appointment is necessary, and depending on your availability, you will be seen within one week of the nurse receiving a referral from the underwriter.

For Office Use Only:			
Benefit Type: Death/TPD/IP/LA	Current Sum Insured: \$	_____	Total Sum Insured: \$
AAL: \$	_____	Reason for underwriting: Joined Outside Eligibility/cover exceeds AAL	
KARS Number: _____	Broker Name: _____	Broker Email: _____	