

You can enter and save data directly into this form, or you can print out and complete by hand.

**1 Plan details**

Name of plan

Employer name

**2 Applicant details** (please complete a separate form per applicant - employee or spouse)

First name and surname

Date of birth    Sex  Male  Female

Do you smoke or have you smoked in the last 12 months, including e-cigarettes?  Yes  No

Email address

Home address

Street

Suburb  City  Postcode

Telephone Day  Mobile  Evening

**Employee applicant**  Yes  No Occupation

Are you actively at work or available for work and not restricted by illness or injury from performing part or all of your normal hours and/or normal duties of your paid permanent employment?  Yes  No

**Spouse applicant**  Yes  No If Yes, please advise your spouse's (the Employees) name

Depending on your answers to the questions below, we may need more information.

If we require further information to process your application quickly, can we contact you directly?  Yes  No

Preferred contact method  Telephone underwriting  Email  Through Adviser

**Please provide your regular doctor's details.**

Name

Medical practice

Address

Street

Suburb  City  Postcode

### 3 Benefits being applied for

Note: Accelerated benefits cannot exceed the amount of Life cover selected

Sum Assured (cover amount)	Benefit Expiry age (years)	Details
Life \$ <input type="text"/>	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	n/a
Total Permanent Disablement \$ <input type="text"/> Accelerated	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	<input type="checkbox"/> Any occupation or <input type="checkbox"/> Own occupation
Income Protection \$ <input type="text"/> p.a.	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	<input type="checkbox"/> Own occupation or <input type="checkbox"/> 2 Step occupation Benefit Payment Period (years) <input type="text"/> Waiting period (weeks) <input type="text"/>
Living Assurance \$ <input type="text"/>	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	<input type="checkbox"/> Essential or <input type="checkbox"/> Comprehensive <input type="checkbox"/> Accelerated or <input type="checkbox"/> Standalone

### 4 Personal Statement

Should you need more space to provide answers to any of the questions in this form, please use the **NOTES** on page 6 and write 'refer to notes' next to original question.

- What is your height?  cm/ft And your weight?  kgs/st
- Have you been absent from work, or unable to manage your household (if your principal occupation is homemaker) due to injury or illness, for 10 or more consecutive days in the 90 days immediately before the date of signing this form?  Yes  No  
If Yes, please give details
- Within the last 5 years, have you been prescribed medication (other than the contraceptive pill) for more than 10 days, or been hospitalised for more than 2 days or had a day stay procedure?  Yes  No  
If Yes, please give details
- Have you ever used any drug, not prescribed by a doctor, or received, or are considering seeking medical advice, counselling or treatment for the use of alcohol, drugs or gambling?  Yes  No  
If Yes, please give details
- Have you ever had any signs or symptoms of, been tested for, treated for, or diagnosed with (whether you have consulted a health professional or not):
  - Mental illness, nervous disorder, stress, depression, insomnia, fatigue or phobia?  Yes  No  
If Yes, please give details Condition   
Date of Diagnosis / first symptoms  /  /  Date of last symptoms  /  /   
Extent of Recovery (see examples below 5c)
  - An injury, disease or disorder of your muscle, joint or bone or neurological condition (eg arthritis, rheumatism, SLE, gout, multiple sclerosis, motor neurone disease)?  Yes  No  
If Yes, please give details Condition   
Date of Diagnosis / first symptoms  /  /  Date of last symptoms  /  /   
Extent of Recovery (see examples below 5c)

**Personal Statement continued...**

c. Any heart complaint, high blood pressure, bowel disease, chest pain, high cholesterol, asthma or lung complaint, epilepsy, stroke, kidney disease, diabetes, cancer, liver disease, disease or disorder of the eyes or ears, Hepatitis B or C or HIV/AIDS or related condition?  Yes  No

If Yes, please give details

Condition		
Date of Diagnosis / first symptoms	/ /	Date of last symptoms / /
Extent of Recovery (see examples below 5c)		

**Extent of recovery examples**

1. Current condition receiving treatment or follow-up
2. Advised treatment and/or follow-up will be required
3. Symptomatic - advised no treatment required
4. Partially recovered
5. Full recovery, with no symptoms, no treatment required
6. Had investigations - results were normal
7. Had investigations - results were abnormal

6. Have you ever been diagnosed with, had treatment for, consulted a medical or health practitioner, or had signs or symptoms of:  Yes  No

a. a serious illness (other than any illness listed in 5 above), or

b. a terminal illness that is likely to result in your death within 12 months of the date of this application (with or without treatment)?

If Yes, please give details

Condition	
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7. Have you ever claimed a benefit under a private insurance policy or a government benefits scheme (such as ACC or sickness benefit)?  Yes  No

If Yes, please give details

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8. Has any insurance you have applied for ever been declined, deferred or offered on modified terms (including loadings or exclusions)?  Yes  No

If Yes, please give details

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9. In the last three years have you participated in, or do you currently or are you intending to participate in, any high risk or hazardous pastime or pursuit (e.g. diving, motor sport, motorboat racing, aviation, mountaineering, abseiling, rock climbing, parachuting, hang gliding, martial arts)?  Yes  No

If Yes, please give details

Pastime/pursuit	No. of years participated and detail of experience	Frequency of participation per annum	Maximum height, depth, speed, record attempts	Geographic location	Equipment details

**10. Family History**

Has any parent, brother or sister (blood relative) before the age of 60, received treatment for, or been diagnosed with, one of the following conditions: diabetes, stroke, mental illness, dementia, kidney disease, heart disease, high blood pressure, cancer (specify type), huntington's chorea, polycystic kidney, multiple sclerosis, or any hereditary or familial disease or disorder?

If Yes, please give details

Relationship to you	Condition	Age at diagnosis	Age now	Current state of health

## 5 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

When you apply for this insurance, and whenever you apply to vary or reinstate it, you have a duty to disclose to Sovereign Assurance Company Limited (“Sovereign”) all information you know (or could reasonably be expected to know) that would influence the judgment of a prudent underwriter in deciding whether or not to insure you, and if so, on what terms and at what cost. If you fail to comply with your duty of disclosure, Sovereign may avoid this insurance from the beginning, which means any claim will not be paid.

Please note, Sovereign may request a copy of all or part of your medical file from your General Practitioner and other medical providers if we consider it necessary to properly assess your application or claim.

### If in doubt - disclose. We treat all information confidentially.

#### Life assured:

I understand the importance of full disclosure of all information required in this application for Insurance

 Yes

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

I authorize Sovereign to disclose all personal information relating to this application for insurance, pursuant to clause (k) under the “My personal information” section below.

 Yes

### The below named life assured declare and agree as follows:

#### Disclosure:

- a. I have read the notice explaining my duty of disclosure and all the statements contained in this application for insurance (‘Application’) are true and complete to the best of my knowledge.
- b. Should I 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 agree to notify Sovereign immediately as this information is relevant to any decision Sovereign may make to accept this Application.
- c. I understand that statements made in this Application and any other application relating to the Plan, including statements made by me to any medical examiner or made by any medical examiner on my behalf, forms the entire basis of the insurance contract with Sovereign.
- d. I understand that irrespective of whether I have been insured with Sovereign before, that Sovereign will rely on the accuracy and completeness of my answers given in this Application and I must not assume Sovereign has any prior knowledge of my history.

#### Underwriting:

- e. I will be bound by the standard conditions applicable to the proposed insurance upon Sovereign’s acceptance of this Application. I understand that if my Application requires underwriting, then special terms (including special conditions, premium loadings, exclusions or maximums) may be applied to my policy. I understand that any special terms will apply from the risk commencement date of my insurance.
- f. I understand 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 my Application.
- g. I understand that if I 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 may otherwise be offered.
- h. I understand that financial information may be required as part of the underwriting process, and that if requested, any such information will form part of my Application.

#### Premiums

- i. I understand the insurance proposed in this Application shall not commence until this Application has been accepted by Sovereign and the initial premium has been received by Sovereign.

#### My personal information:

- j. I 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 (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application, for the processing of this Application and administration of my insurance cover and any claims including assessing if I have met my duty of disclosure under this Application or any prior applications, for promotion of insurance

## Declaration and consent continued...

and investment services to me and for market research purposes (whether or not I choose to proceed with this Application). I consent to my name, phone number and address being given to research/direct marketing firms engaged by Sovereign or its related companies to seek my views on products or services offered by Sovereign or its related companies. I understand that my personal information will be stored at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I understand that Sovereign will take reasonable steps to keep such information secure. I understand that Sovereign may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of my personal information may be requested by me.

- k. I authorise Sovereign to disclose all personal information relating to this Application to the Plan's financial adviser. The information is to be provided for the purposes of the Plan's financial adviser providing me with advice regarding the underwriting of this Application by Sovereign. This authority is limited to this Application, and is only valid for the period of the assessment of this Application until an outcome on this Application is reached. I acknowledge that the personal information which may be disclosed includes, but is not limited to, medical, vocational, occupational and financial information relevant to the assessment of this Application.
- l. I consent and give authority to Sovereign and/or any of its related companies to seek from, and for all and any of the following, their 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:
  - > any doctor or other registered medical practitioner or specialist, counsellor, psychologist, therapist, dentist, clinic, hospital or medical laboratory;
  - > the Accident Compensation Corporation;
  - > any bank, financial institution, accountant or financial adviser;
  - > any of your current or former employers;
  - > insurers or reinsurers (whether public or private); and
  - > any government department, agency, organisation or enterprise.
- m. I 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 insurance.
- n. I 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, or the assessment and administration of my claim and Sovereign will not use this non-relevant information for any purpose other than as permitted under the Privacy Act 1993.

## Correspondence by Email:

- o. Where I have provided my email address(es) in Section 2, I consent to Sovereign corresponding with me by email regarding this application and any changes or additions in respect of this application listed in Section 2.
- p. Such correspondence can be sent to the email address(es) detailed in Section 2 or subsequent email addresses I provide to Sovereign.
- q. I am responsible for advising Sovereign if my email address(es) change.
- r. I am responsible for the security of the information sent to and held in my email account(s) and the access that others have to this account/ these accounts e.g. the access other family members/colleagues may have to my emails.

## Insurance policy:

- s. The above answers have been entered by me in this Application and have been checked by me and no statement affecting this insurance has been made to any representative of Sovereign that is not recorded in this Application.
- t. I am aware that a copy of the Plan's Policy Document is available from the Employer and the financial statements of Sovereign are available to me on request from Sovereign's Head Office.

Full names of Life to be Assured

Signature of Life to be Assured

Date



## Notes

Use this section as extra space for your answers. Please make sure you have written 'refer to notes' next to original question.