



Client Name

Date

LIFE AND HEALTH APPLICATION



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 given correct answers to our questions, your policy can be avoided altogether.

If you prefer, you can complete this form in private and post it directly to Sovereign Services 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	✓	✗	✓ If YES to any health question in Section 5	✓ If YES to question (m) in Section 5	✗	✓
Business Income Support Business Continuity Disability Income Protection Essential Disability Income Protection Start-Up Income Protection Total Permanent Disablement Waiver of Premium	✓	✗	✓ 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	✗	✓
Key Health	✓	✗	✓ 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	/ /	Place of birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Occupation			Industry	
Do you smoke, or have you been a smoker in the past 12 months?	<input type="checkbox"/> YES	<input type="checkbox"/> 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	<input type="checkbox"/> as above, or	Last name		First names	
		Company name			
Mailing address	Street				
	Suburb	Town/City	Postcode		
Home address (if different)					
Contact details	Daytime phone ()	Email			
Date of birth	/ /				

POLICY OWNER (2)

Mr/Mrs/Miss/Ms	<input type="checkbox"/> as above, or	Last name		First names	
		Company name			
Mailing address	Street				
	Suburb	Town/City	Postcode		
Home address (if different)					
Contact details	Daytime phone ()	Email			
Date of birth	/ /				

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 Section)

Credit/Debit card (please complete the attached Payment Section)

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 / / 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 - 22 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 (including this Application)? YES NO
- If YES, please give details below

THIS SECTION MUST BE COMPLETED

Type of Insurance	Benefit Amount	New Cover		Existing Cover		Company
		Applied for	To remain in force	To be replaced*		
Life	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Total Permanent Disablement	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Disability Income	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Living Assurance	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Health Insurance	Excess level \$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	Specialist and tests <input type="checkbox"/> YES <input type="checkbox"/> NO					

* If 'To be replaced' has been ticked, please complete the **Advice on Replacement Business 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.

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 NZ? / 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) i. **Family history**
 Please indicate whether, before the age of 60, a parent, sister or brother has suffered from one of the following conditions: (If YES please give details)

CONDITION	YES	NO	RELATIONSHIP TO YOU	AGE when diagnosed (if known)	Current AGE	If deceased, AGE at death
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cancer*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polycystic kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Any hereditary or familial disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

(i) 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



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) 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

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

THIS SECTION MUST BE COMPLETED >



5. Personal Statement (continued)

Health questions

If you are applying for Absolute Health or Key Health, in conjunction with TotalCareMax or Start-Up Income Protection, please answer the following question. 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence.	<input type="checkbox"/> YES	<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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
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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 Only)

This section applies only for Absolute Health cover. 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 Supplementary Child's application for Absolute Health.

Child one

Last name	First names		
Date of birth	/ /	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

Child two

Last name	First names		
Date of birth	/ /	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

Child three

Last name	First names		
Date of birth	/ /	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

Child four

Last name	First names		
Date of birth	/ /	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

(a) **Doctors' details**

	Child one	Child two	Child three	Child four
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				
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(b) Does the child smoke, or have they been a smoker in the past 12 months?

	Child one	Child two	Child three	Child four
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type				
Average per day				

If YES, please state the type and quantity smoked (eg Cigarettes, tobacco or cigars)

(c) Does the child have permanent residency status in New Zealand?

	Child one	Child two	Child three	Child four
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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.)

	Child one	Child two	Child three	Child four
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

< THIS SECTION MUST BE COMPLETED >

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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Thyroid disorder or any other glandular condition	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder or any other lesion</u> If YES – please complete questionnaire i	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Any disease or disorder of the gastrointestinal tract or bowel</u> e.g. <u>irritable bowel, Crohn's disease, ulcers, colitis or reflux</u> If YES – please complete questionnaire ii	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Obesity e.g. stomach stapling or liposuction	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Mental, nervous or stress disorder, depression, fatigue or phobia</u> If YES – please complete questionnaire iii	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood disorders e.g. anaemia, varicose veins, blood clots or bleeding tendencies	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney problems, endometriosis, prostate, bladder or urinary condition e.g. weakness of the bladder or kidney stone	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epilepsy, stroke or other neurological disorders e.g. motor neurone disease, multiple sclerosis, paralysis or seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Asthma or lung complaint e.g. bronchitis, or breathing problems</u> If YES – please complete questionnaire iv	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Muscle, joint or bone disorders, injury or disease</u> e.g. <u>arthritis, rheumatism, SLE or gout</u> If YES – please complete questionnaire v	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis or ear infections	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
AIDS or HIV antibodies	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver disease or disorder e.g. hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Disease or disorder of cervix, breast, uterus, fallopian tube or ovary	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Diabetes or abnormal blood sugar level</u> If YES – please complete questionnaire vi	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any other illness, injury or condition not already stated	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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 - 22 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	/ /		/ /	
(c) Date of last symptoms	/ /		/ /	
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> 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	/ /		/ /	
(c) Date of last symptoms	/ /		/ /	
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> 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 - 22 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	/ /		/ /	
(c) Date of last symptoms	/ /		/ /	
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> 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	/ /		/ /	
(c) Date of last symptoms	/ /		/ /	
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h)	<input type="checkbox"/> 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 - 22 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name	First names
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	CONDITION	CONDITION	
(a) Name of condition			
(b) Date of first symptoms	/ /	/ /	
(c) Date of last symptoms	/ /	/ /	
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> 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
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	CONDITION	CONDITION	
(a) Name of condition			
(b) Date of first symptoms	/ /	/ /	
(c) Date of last symptoms	/ /	/ /	
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> NO	<input type="checkbox"/> YES – please give full details at (h) <input type="checkbox"/> 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

(a) What was the site of the tumour?

--

(b) Histology of the tumour

<input type="checkbox"/> Benign	<input type="checkbox"/> Malignant or pre-malignant	<input type="checkbox"/> Unknown
---------------------------------	---	----------------------------------

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

<input type="text"/> Years	<input type="text"/> Months	
----------------------------	-----------------------------	--

(d) Have you received treatment within the last three years?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="text"/> If YES, please give details

(e) Has there been any recurrence?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="text"/> If YES, please give details

(f) Are you undergoing any ongoing follow-up or have you been advised that follow-up treatment is required?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="text"/> 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

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

<input type="checkbox"/> Indigestion	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Gastro-oesophageal reflux	<input type="checkbox"/> Hiatus hernia
<input type="checkbox"/> Gastritis	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Other		

If OTHER, please give name of condition

(b) Have you ever consulted a specialist about symptoms of any of the above?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
------------------------------	-----------------------------

(c) Are you on continuous medication?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, is your medication prescribed by your GP/specialist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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(d) Have you ever had any investigations of the gastrointestinal tract?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> If YES, please give details below
------------------------------	-----------------------------	--

	Result		
Name of investigation	Normal	Abnormal	Unknown
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Result		
Name of investigation	Normal	Abnormal	Unknown
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(e) How frequently do you suffer from symptoms?

<input type="text"/>	times per year
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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
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(a) Do you suffer, or have you ever been advised by a medical practitioner that you suffer, from:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Compulsive disorder	<input type="checkbox"/> Headaches	<input type="checkbox"/> Irritability
<input type="checkbox"/> Stress	<input type="checkbox"/> Fear or phobia	<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Depression
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleeplessness	<input type="checkbox"/> Post-traumatic stress disorder	<input type="checkbox"/> 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
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(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)

<input type="checkbox"/> YES Daily preventative inhalers, e.g. ventolin	<input type="checkbox"/> YES Occasional use of a nebuliser or oral steroid medication e.g. prednisolone	<input type="checkbox"/> YES Hospitalisation/emergency treatment	
<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	

(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)

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
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(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?

/	/
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(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

Result of your last blood test

Blood Glucose Level / /
 Date of last blood test

Result of your last blood test

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

- | | | | | |
|---|--------------------------|-----|--------------------------|----|
| High blood pressure | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| High cholesterol | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Eye problems | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Kidney problems | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Heart problems | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Numbness or tingling in your legs or feet | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Diabetic or insulin coma | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

If YES, please provide dates and further details



8. Hazardous Occupation Or Pursuit

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

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

9. Occupation And Income Details

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

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

(a) What is your current main occupation?

(b) Do you hold a professional or trade qualification? YES NO

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

i. Salaried employment
 Full-time Part-time Seasonal

ii. Self-employment

Sole proprietor

Partnership

Company (in which you have a shareholding of 25% or more)

Other (e.g. director's fees, trusts)

(d) If self-employed, please state

Number of partners/shareholders	<input type="text"/>	Year your business was established	<input type="text"/>
Number of part-time employees	<input type="text"/>	Number of full-time employees	<input type="text"/>
Profit share entitlement	<input type="text"/> %		

(e) Are you intending to change your occupation or duties or sell your business? YES NO

Exact duties	% of time on each duty	% that requires manual work, including driving
<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"/>	<input type="text"/>

(f) 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

(g) Number of hours worked per week

(h) Do you work from home? YES NO

(i) Do you have any other occupation? YES NO

(j) Have you ever been convicted of fraud or any offence involving dishonesty? YES NO

(k) Have you ever been adjudged bankrupt, been under administration or in receivership? YES NO

9. Occupation And Income Details (continued)

	From	To	Occupation	Employer
(l) Give details of your current and previous occupations during the last five years?				

(m) Annual earned income details	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	\$

(n) 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)	\$

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

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

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 the life assured understand the importance of full disclosure of all information required in this application for insurance

 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 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.
- (h) 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.
- (i) I/We understand that if I/We do not consent to Sovereign collecting personal information from the Application and 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:

- (j) 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.
- (k) I/We authorise Sovereign to debit the nominated credit card account with the premiums payable pursuant to the Insurance premium. 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:

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

 / / 

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 / /

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)

<input type="text"/>	Date	<input type="text"/>	<input type="text"/>
<input type="text"/>	Date	<input type="text"/>	<input type="text"/>
<input type="text"/>	Date	<input type="text"/>	<input type="text"/>
<input type="text"/>	Date	<input type="text"/>	<input type="text"/>

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 / /

Name (please print)

Job title

Signature

Date / /



00501-11/09

THIS SECTION MUST BE COMPLETED



Payment (Direct Debit; Credit Card; Debit Card)

Direct debit details I have read and understand the Terms and Conditions (see below).
 I am the account holder (if not, please complete separate Direct Debit form). Authorisation code

1	2	0	0	3	6	5
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Account details
Name of account

<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Bank Branch number Account number Suffix

Credit card/Debit card details
 Visa Mastercard
Account number

<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Name on card Expiry date /

Authorised signature Date / /

Conditions of the Direct Debit authority

1. The Initiator:

10-day advance notice of each Direct Debit

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

Regular payments

- (b) Undertakes to give written notice to the Customer of the commencement date, frequency and amount at least 10 calendar days before the date the first Direct Debit is initiated (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 customer 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 (email) where the Customer has provided prior written consent to the Initiator.

- (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(a) and (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 the Customers account.

This page is held securely within Sovereign. No other payment forms are required.



Conditions of this authority (continued)

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) The Bank accepts no responsibility or liability for the accuracy of information about payments on bank statements.
- (e) The Bank is not responsible for, or under any liability in respect of
 - any variations between notices given by the Initiator and the amounts of Direct Debits.
 - the Initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.
- (f) Notice given by the Initiator in terms of 1(b) above 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 payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.
- (b) At any time, terminate this Authority as to future payments by notice in writing to the Customer.
- (c) Charge its current fees for this service in force from time to time.



00483-11/09



Advice on Replacement Business

A separate form is to be completed for each existing contract/policy/plan to be replaced.

The original of this form should be held by the policy owner and a copy sent to the company issuing the new contract, policy or plan.

Details of new contract/policy/plan

Name(s) of policy owner(s)

Type of contract/policy/plan Annual premium or contribution \$

Is initial commission being received in relation to the new contract? YES NO

Is renewal commission being taken as an alternative form? YES NO

Details of contract/policy/plan being replaced

Name(s) of policy owner(s)

Name of insurer

Type of contract/policy/plan Annual premium or contribution \$

Details of replacement – statement by adviser/intermediary

(a) The specific reasons for the replacement of the existing contract/policy/plan are:

(b) The policy to be replaced cannot adequately fulfil the owner's objectives because:

(c) The following death/disability risks/medical costs or procedures are NOT covered by the new contract/policy/plan which WERE covered by the old contract/policy/plan:

Name of adviser/intermediary

Address of adviser/intermediary

Sovereign adviser code Telephone ()

Adviser's signature Date / /

Advice to policy owner(s)

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

1. the Lives Assured (or one of the lives Assured) is the same; or
2. the policy owner (or one of the policy owners) is known to be the same; or
3. the premium payer (or one of the premium payers) is known to be the same.

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

1. There are sometimes establishment costs in setting up a contract/policy/plan. Replacing it with a new contract/policy/plan may involve further establishment costs.
2. If the policy which is being replaced was purchased on the Life to be Assured at a younger age, the same or similar benefits in the new policy may now cost more.
3. A change in health, pastimes or occupation of the Life to be Assured may affect insurability and the new policy may contain restriction limitations, and/or be more costly.
4. In a new policy, the Suicide Exclusion Clause may recommence.
5. Conditions or benefits may be more (or less) favourable under the contract/policy/plan which is being replaced; for example, the contract duration, wording and/or benefit definitions may differ.
6. If the purchase of the new contract/policy/plan involved using or borrowing against cash values of any existing policy(ies) or plan(s), these monies may be beyond the policy owner's future ability or intention to repay. This may mean a loss or reduction of the benefits under the policy(ies) or plan(s).

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

I/We am aware I/we may cancel this Application, in writing, within the 'free look' period of 15 days from the date the new contract/policy/plan is received. In this event, Sovereign Assurance Company Limited will refund any premium, deposit or other payment made in respect of the new contract/policy/plan.

Name(s) of policy owner(s)
(please print)

Signature(s) of policy owner(s)

Date / /



4032



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	<input type="checkbox"/> Variable %	<input type="checkbox"/> Pendulum % <input type="checkbox"/> 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	<input type="checkbox"/> Variable %	<input type="checkbox"/> Pendulum % <input type="checkbox"/> As earned

Scanned/faxed?

YES

Date





LIFE INSURANCE • HOME LOANS • INVESTMENTS

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EMAIL enquire@sovereign.co.nz **WEB** www.sovereign.co.nz

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