

Application/Policy No.

Superior Health Cover Application



AIA.CO.NZ

Submitted by

Agency Name

IFA Name

IFA Number

Commission Split

Commission Code

For more than two people, please complete an additional application form.

Please ensure that you have completed the following (please tick):

☐

Applicant details.

☐

Details for all children to be covered under the policy.

☐

Medical details (Questions 1 - 3 and Sections A - H)

Please refer to the guidelines on page 2 before completing these sections.

☐

Details of other insurance (Questions 4 - 6).

☐

Declaration - Must be signed by every person over the age of 16 to be covered by this insurance and all Policy Owners.

☐

Illustration - Please attach this to the application form.

☐

Direct Debit Authority Form and/or

☐

Cheque enclosed

☐

Credit Card Details

☐

Advice on Replacement Business Form - Must be completed if this application is intended to replace existing insurance with another insurer on any person named on this application form.

Thank you for selecting an AIA New Zealand Superior Health Cover policy

Before you complete this application form please refer to the guidelines below.

Please complete all questions on the application form with as much detail as possible, including dates, treatment undertaken or planned, and details of any ongoing symptoms, complications or other medical issues. Completing the application form correctly is an important part of the insurance process. The information that you supply helps us in determining the terms and conditions of your policy.

General guidelines

- **If you are replacing an existing policy, please do not cancel the original policy until you are aware of the terms that we can offer you.**
- Please use black or blue ballpoint pen when completing the application form, and please write clearly.
- If there is insufficient space on the application form, please feel free to attach additional sheets. Please ensure that you clearly state which person and question number this additional information relates to. If each applicant has a different GP – please ensure that you advise us of the correct GP for each respective applicant.
- Please ensure that all names are printed clearly on the application form.
- If you use a 'nickname' or you abbreviate your name, please ensure that the application is completed with your full legal name throughout.

Children to be covered under this policy

- If you are completing the application on behalf of children please list all of their past and current ailments and medical conditions. It is important to tell us if they have had ear infections, tonsillitis, and other common medical conditions. Even if you consider them to have only had 'normal' childhood complaints, please provide all the details.
- All children aged 16 and over to be covered by the policy must sign the application themselves.
- Remember to supply height and weight details for all children you wish to cover and let us know which child it relates to – there is space to provide these details on page 3 of the application form.

Health and medical information

- Please provide us with dates of when you last experienced symptoms. Ensure that you include the date (year) and duration of the symptoms.
- Please ensure that you clearly identify which applicant has the medical problem, for example: if you are giving details for asthma then please state the name of applicant affected beside the details.

Superior Health Cover

Life Assured (1)

Title	Surname				
<input type="text"/>	<input type="text"/>				
First Names					
<input type="text"/>					
Date of Birth	Male/Female	Height (cm/in)	Weight (kg/st/lbs)	Smoker?	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Y	<input type="text"/> N
Email					
<input type="text"/>					
Applicant's Occupation		Phone (Home)		(Work)	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Are you a Permanent Resident of New Zealand? YES <input type="checkbox"/> NO <input type="checkbox"/>					
If no, please select one: Work Permit <input type="checkbox"/> Student <input type="checkbox"/>					
Visitor <input type="checkbox"/> Other <input type="checkbox"/>					
Other (Please state) <input type="text"/>					
Do you have any intention of travelling or residing overseas? YES <input type="checkbox"/> NO <input type="checkbox"/>					
If yes, please provide details. <input type="text"/>					
Name, address, phone and fax number for your current doctor. <input type="text"/>					
<input type="text"/>					
<input type="text"/>					

Life Assured (2)*

Title	Surname				
<input type="text"/>	<input type="text"/>				
First Names					
<input type="text"/>					
Date of Birth	Male/Female	Height (cm/in)	Weight (kg/st/lbs)	Smoker?	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Y	<input type="text"/> N
Email					
<input type="text"/>					
Applicant's Occupation		Phone (Home)		(Work)	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Are you a Permanent Resident of New Zealand? YES <input type="checkbox"/> NO <input type="checkbox"/>					
If no, please select one: Work Permit <input type="checkbox"/> Student <input type="checkbox"/>					
Visitor <input type="checkbox"/> Other <input type="checkbox"/>					
Other (Please state) <input type="text"/>					
Do you have any intention of travelling or residing overseas? YES <input type="checkbox"/> NO <input type="checkbox"/>					
If yes, please provide details. <input type="text"/>					
Name, address, phone and fax number for your current doctor. <input type="text"/>					
<input type="text"/>					
<input type="text"/>					

* Note: Where there are two Lives Assured applying for cover, if a policy is issued by AIA New Zealand, the adult Lives Assured will own their own cover and jointly own any children's cover.

Contact Address For This Application

<input type="text"/>	Postcode
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Details of Children Covered Under Policy

Surname	First Name	Date of Birth	Male/Female	Height (cm/ft/in)	Weight (kg/st/lbs)
<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name of current doctor (For each child)	<input type="text"/>
Address, phone and fax numbers	<input type="text"/>

Plan Option

Optional Benefits	Additional specialist visits and diagnostic procedures	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Single Parent Family <input type="checkbox"/>	Family <input type="checkbox"/>
Excess	Note: A \$100 excess per claim form submitted in respect of each Life Assured applies to the additional Specialist Visits and Diagnostic Procedures Benefit.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NIL <input type="checkbox"/>	\$250 <input type="checkbox"/>
				\$500 <input type="checkbox"/>	\$1,000 <input type="checkbox"/>
					\$2,000 <input type="checkbox"/>
Waiver of Premium		YES <input type="checkbox"/>	NO <input type="checkbox"/>		

Payment Details

Premium Frequency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Half Yearly	<input type="checkbox"/> Annually
First Premium	<input type="checkbox"/> Cheque	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Direct Debit	
Regular Premium	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Direct Debit		

Where the payer is neither the Life Assured or Policy Owner, what is the relationship?

Where the payer is neither the Life Assured or Policy Owner, what is their name?

Credit Card	Please debit my
<input type="checkbox"/> Visa	<input type="checkbox"/> Mastercard

Card No.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Expiry Date	<input type="text"/>
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This authority enables AIA New Zealand to debit your credit card as above until you advise AIA New Zealand in writing to cancel this authority. The amount debited may vary from time to time as a result of contractual increases or decreases which apply to your policy.

Card Holder's Name	<input type="text"/>	Policy Commencement Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Card Holder's Signature	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>

Full Declaration Must Be Given Below

THIS IS A MATERIAL PART OF THE INSURANCE CONTRACT

To help us to process your application form as quickly as possible, please answer each question fully. Because the information in this application will be used to decide the terms and conditions of your policy, it is important that you answer all the questions completely and correctly. You have a legal duty to disclose to us any matter that you know, or could reasonably be expected to know, which is relevant to our decision on the terms and conditions of acceptance of this insurance.

Please note you are required to complete all questions.

1. Have any of the people named on this application ever suffered from, been diagnosed with and/or had symptoms of, been investigated for, are currently being treated for or receiving medical advice for, or expect to receive treatment and/or medical advice in the future, or consulted a health professional, for any of the following?
- (a) High blood pressure (if "yes" complete section A), any disease or disorder of the heart (including any rhythm disorder or heart murmur) or circulatory system (If "Yes" complete Section B), stroke, high cholesterol, hepatitis or any liver condition or disorder? Yes ☐ No ☐
- (b) Any disease, disorder or injury of the joints? (if "yes" complete section H.) Yes ☐ No ☐
- (c) Back pain or neck pain (if "yes" complete section H), or rheumatoid arthritis or osteoarthritis? (if "Yes" complete section F.) Yes ☐ No ☐
- (d) Any health condition/symptoms that could require hospitalisation and/or medical treatment in the future? Yes ☐ No ☐
- (e) Indigestion/chest pain? (if "yes" complete section B.) Yes ☐ No ☐
- (f) Asthma, including any other respiratory disease? (if "yes" complete section C.) Yes ☐ No ☐
- (g) Neurological disorders, including epilepsy any migraine or frequent headaches? (if "yes" complete section D.) Yes ☐ No ☐
- (h) Diabetes (including raised blood sugar levels)? (if "yes" complete section E.) Yes ☐ No ☐
- (i) Rheumatic disorders, including heart murmur, rheumatism and gout? (if "yes" complete section F.) Yes ☐ No ☐
- (j) Cancer, skin lesions, tumours, malignancy or growth of any kind? (if "yes" complete section G.) Yes ☐ No ☐
- (k) Musculo-skeletal disorders, injury or disease of the spine, joints, muscles, bones? (if "yes" complete section H.) Yes ☐ No ☐
- (l) Deafness, eye or vision disabilities, (including wearing glasses), ear, nose or throat disorders or teeth or gum problems? Yes ☐ No ☐
- (m) Nervous or mental disorders, kidney, bladder or prostate disorders, hernia (inguinal, hiatus or umbilical), stomach, bowel or gall bladder disease or disorders, peptic ulcer or haemorrhoids, colitis or any other disease or disorder of the gastrointestinal tract? Yes ☐ No ☐
- (n) Varicose veins or disorders of the blood? Yes ☐ No ☐
- (o) Recurring ailments, or congenital conditions not already disclosed? Yes ☐ No ☐
- (p) Or ever been hospitalised as an emergency or for special treatment or surgery, or suffered any other problems which required or may require further investigation, treatment or medication whether or not a doctor/dentist or specialist has been consulted? Yes ☐ No ☐
- (q) **To be answered by females only** - disease or disorder of the gynaecological tract, including the cervix, uterus, fallopian tube(s), ovary, vulva and vagina, abnormal smear test(s), fibroids, irregular or heavy menstrual bleeding or mid cycle pain, breast lumps, thickenings, cancer or abnormal mammogram(s) and ultrasound(s)? Yes ☐ No ☐
2. Within the past five years, have any of the people named on this application:
- (a) Been off work and/or confined to bed on account of illness or injury for a period of two weeks or more? Yes ☐ No ☐
- (b) Been admitted to hospital as a day-patient or in-patient, or undergone a surgical procedure in specialist's rooms? Yes ☐ No ☐

If you answered "yes" to any of the questions above, apart from where additional information has already been given, please give details below.

Given name	Reason for treatment	Details of operation / medication	Date / year and duration	Result and name of doctor consulted

Family History

3. Has any near relative, father, mother, brother or sister of any of the people named on this application ever suffered from high blood pressure, stroke, cancer (specify type), heart disease/disorder, diabetes (including raised blood sugar levels), epilepsy, nervous disorder or any hereditary or familial disease or disorder?

Yes ☐ No ☐

If yes, please give details.

Life Assured	Relationship to the Life Assured	Details of condition suffered and current state of health	Age when condition diagnosed (if known)	Current age	Age at death

Other Insurance Details

4. Have any proposed Health Insurance or Life, Health, Disability or Trauma Insurance policies relating to any of the people named on this application ever been declined, deferred or accepted on special terms?

Yes ☐ No ☐

If yes, please give details.

5. Have any of the people named on this application ever had a Health Insurance, Disability or Trauma Insurance claim?

Yes ☐ No ☐

If yes, please give details.

6. Is this application intended to replace any existing insurance on any of the people named on this application?

Yes ☐ No ☐

If yes, an Advice on Replacement Business form must be completed for each policy to be replaced.

Client Contact

Please state a convenient time for our underwriter to contact you if necessary. Information you provide to our underwriter will form part of your application for insurance.

Time Contact No.

SECTION A - Blood Pressure

	Name <input type="text"/>	Name <input type="text"/>
(a) Please state the date and reading when it was first noted that you had high blood pressure.	<input type="text"/>	<input type="text"/>
(b) Please state date when blood pressure treatment commenced and medication being taken currently.	<input type="text"/>	<input type="text"/>
(c) Has your treatment changed recently?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(d) If yes, please give details.	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
(e) Please state date and reading of your last ECG.	<input type="text"/>	<input type="text"/>
(f) Have you been referred to a specialist for treatment or investigation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(g) If yes, please provide dates, treatment and result.	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
(h) What is your current status? (including details of any ongoing symptoms and/or complications)	<input type="text"/>	<input type="text"/>

SECTION B - Indigestion / Chest Pain or Heart Disease

	Name <input type="text"/>	Name <input type="text"/>
(a) Please state exact diagnosis if known.	<input type="text"/>	<input type="text"/>
(b) Please give the date symptoms first occurred.	<input type="text"/>	<input type="text"/>
(c) How frequently do you suffer from these symptoms?	<input type="text"/>	<input type="text"/>
(d) Please describe nature and severity of symptoms, including location of pain and does this radiate to any other part of your body?	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
(e) What treatment are you receiving?	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
(f) Have any specialist investigations been carried out?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(g) If yes, please give details.	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
(h) What is your current status? (including details of any ongoing symptoms and/or complications)	<input type="text"/>	<input type="text"/>

SECTION C - Asthma and other respiratory disorders

	Name <input type="text"/>	Name <input type="text"/>
(a) What is the nature of your disorder?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(b) How old were you when you first developed symptoms?	<input type="text"/>	<input type="text"/>
(c) What is the frequency, severity (mild, moderate, severe) and duration of attacks?	<input type="text"/>	<input type="text"/>
(d) Please provide the date of your last symptoms.	<input type="text"/>	<input type="text"/>
(e) What treatment are you receiving and how frequently has it been modified or changed significantly in the last 12 months?	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
(f) Have you required any time off work in the past five years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(g) If yes, please provide details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(h) Have you ever been hospitalised because of this condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(i) If yes, please provide details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(j) Have you ever required a course of oral steroids?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(k) If yes, please provide details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(l) Has your doctor measured your peak flow in the past two years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(m) If yes, please provide results if known.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(n) If no, what was your last peak flow measurement?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

SECTION D - Neurological Disorders

	Name <input type="text"/>	Name <input type="text"/>
(a) Please state the exact diagnosis.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(b) Please state when symptoms first occurred.	<input type="text"/>	<input type="text"/>
(c) Please give the date of last episode, frequency and duration of attacks each year.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(d) What treatment or medication is being prescribed?	<input type="text"/>	<input type="text"/>
(e) Has this condition been investigated (or due to be) by any specialist?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(f) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(g) What is your current status? (including details of any ongoing symptoms and/or complications)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

SECTION E - Diabetes

	Name <input type="text"/>	Name <input type="text"/>
(a) Please state the date of diagnosis.	<input type="text"/>	<input type="text"/>
(b) Are you on oral drug treatment or insulin? Please state the medication and dosage.	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
(c) Has the intake of insulin or oral drugs varied during the past two years?	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
(d) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(e) Have you ever had a diabetic coma?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(f) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(g) What is your current status? (including details of any ongoing symptoms and/or complications)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

SECTION F - Rheumatic Disorders, Heart Murmurs, Arthritis, Rheumatism or Gout

	Name <input type="text"/>	Name <input type="text"/>
(a) Please state exact diagnosis, and date of diagnosis. If unknown, please describe symptoms.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(b) Are you currently receiving treatment of any kind?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(d) Has this condition been investigated (or due to be) by any specialist?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(e) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(f) What is your current status? (including details of any ongoing symptoms and/or complications)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

SECTION G - Skin Lesions, Tumours, Malignancy or Growth of any kind or Cancer

	Name <input type="text"/>	Name <input type="text"/>
(a) Please state the nature of lesion, location and date(s) diagnosed.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(b) If lesion(s) has been treated, please state diagnosis and treatment.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(c) Was lesion benign or malignant?	<input type="text"/>	<input type="text"/>
(d) Have any follow up checks been required?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(e) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

SECTION H - Musculo-Skeletal Disorders

	Name <input type="text"/>	Name <input type="text"/>
(a) Please state date and exact diagnosis of injury or disorder. If unknown, please describe symptoms.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(b) Did you take time off work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) If yes, how much time?	<input type="text"/>	<input type="text"/>
(d) Type of treatment received.	<input type="text"/>	<input type="text"/>
(e) Are you still receiving medical treatment for injury or disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(f) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
(g) When did you last experience symptoms?	<input type="text"/>	<input type="text"/>
(h) Do you need to use any mobility aids or is your mobility affected in any way?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(i) Does this injury or disorder cause a degree of disability in your occupation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(j) If yes, please give details.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

Disclosure Information to AIA New Zealand

Definition: AIA New Zealand shall mean American International Assurance Company (Bermuda) Limited (New Zealand Branch), and/or any related companies and/or agents (including company officers acting in the scope of their authority) and AIA New Zealand's Insurance Advisers or reinsurers.

You are not insured:

- until this application has been accepted by AIA New Zealand; and
- you have paid the first month's premium.

AIA New Zealand may decline this application, or may accept this application subject to certain conditions and exclusions.

Your duty of disclosure: When you apply for insurance with AIA New Zealand, you have a legal duty of disclosure to AIA New Zealand.

This means that:

1. All the statements you make to AIA New Zealand (both written and oral) including the answers in this application, must be true and correct.
2. You must disclose everything that you know, or could reasonably be expected to know, that is relevant to AIA New Zealand's decision whether:
 - to accept your application for insurance; and
 - if AIA New Zealand accepts your application, then on what terms AIA New Zealand will accept it and how much it will cost.
3. This duty of disclosure continues from the time you complete this application until either:
 - the commencement date of this policy or the date AIA New Zealand accepts your application for insurance, whichever is the later; or
 - AIA New Zealand declines your application for insurance.
4. You also have the same duty of disclosure to AIA New Zealand at the time you extend, vary or reinstate your insurance.

Important

If you do not comply with your duty of disclosure, and AIA New Zealand would not have accepted your application for insurance on the same terms or at the same premium if you had made full disclosure, then legally AIA New Zealand may:

- decline any claim that you make; and/or
- retain all premiums paid and recover any benefits paid; and/or
- alter the terms of any benefits under the policy; and/or
- remove any benefits under the policy; and/or
- void your insurance from inception.

IF YOU ARE NOT SURE WHETHER YOU NEED TO DISCLOSE A PARTICULAR FACT, PLEASE ASK AIA NEW ZEALAND OR YOUR INSURANCE ADVISER.

NOTE - U.S. Citizens: By purchasing this policy and signing below, I/we represent that I/we are not a U.S. person for the purpose of U.S. federal income tax and I/we are not acting on behalf of a U.S. person.

Declaration to AIA New Zealand

It is important for you to read and understand this declaration before signing the application, as there are terms and conditions that you may not be aware of and that will form part of your insurance if AIA New Zealand accepts your application.

1. I/We declare that the statements made in this application are true and complete and that I/we have disclosed all information material to this insurance for myself/ourselves and on behalf of family members.
2. I/We agree that this application and any other written statements made in connection with the proposed insurance shall form the basis of the contract between myself/ourselves and AIA New Zealand.
3. I/We understand that AIA New Zealand reserves the right to recover any medical costs incurred in assessing this application should I/we decide to cancel this application.
4. I/We further declare that if the answers to the questions in this application are not in my/our writing, that they have been correctly written down at my/our dictation and read and approved by me/us.
5. I/We acknowledge that the illustration attached to this application forms part of the application and sets out the insurance benefits I/we are applying for.
6. I/We acknowledge that if I/we undergo any alteration in my/our mental or physical health or have a change of occupation between the date of this application and the commencement date of this policy, or the date AIA New Zealand accepts this application for insurance, whichever is later, I/we agree to notify AIA New Zealand immediately.
7. I/We acknowledge that I/we are signing on behalf of any children under the age of 16 and declare that I/we have disclosed all health information, including any pre-existing conditions, for such children as well as myself/ourselves.
8. I/We authorise AIA New Zealand to debit my/our nominated credit card account with the premiums payable pursuant to the insurance. AIA New Zealand may debit the credit card account with an insurance premium even where there may be insufficient clear funds in the credit card account, but AIA New Zealand should not be obliged to do so. If there are insufficient funds but AIA New Zealand debits the credit card account, AIA New Zealand may also debit the credit card account with any applicable fees and charges. If the insurance premium cannot be recovered from me/us, then AIA New Zealand may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and AIA New Zealand may be entitled to cancel the insurance in accordance with the insurance terms relating to non-payment of premiums.
9. I/We acknowledge that personal information collected or held by AIA New Zealand (whether contained in this application or otherwise obtained) is provided and may be held, used, and disclosed by AIA New Zealand to:
 - process this application; and
 - any other application for insurance I/we make to AIA New Zealand; and
 - for the purpose of assessing any claim I/we may make should this or any other application be accepted by AIA New Zealand; and
 - for the purposes of any legal proceedings before a Court, or review or arbitration before a statutory or independent body.
10. I/We authorise AIA New Zealand to obtain my full medical history where the application form contains:
 - on-going medical conditions
 - partial or incomplete medical history
 - multiple medical conditions
 - a referral to a medical provider
11. I/We acknowledge that if I/we fail to provide any information requested in this application, AIA New Zealand may be unable to process the application for insurance.
12. I/We understand that access to my/our personal information is available to me/us under the Privacy Act 1993 by writing to AIA New Zealand.
13. I/We authorise AIA New Zealand to obtain personal information held about me/us relevant to my/our application, my/our insurance, or any claim that I/we may make. This declaration shall constitute sufficient authority to the party that AIA New Zealand requests the information from and extends to personal information held about me/us by any government department, incorporated body or person, including (but not limited to) information held by:
 - Accident Compensation Corporation
 - accountants and other financial advisers
 - banks and insurers
 - counsellors, psychologists and therapists
 - dentists
 - employers
 - government departments and bodies
 - medical laboratories
 - private and public hospitals
 - registered medical practitioners and specialists
14. I/We agree that a photocopy of this authority shall be treated as an original.
15. If this application is to replace existing cover with another insurer, I/we have read, understood and signed an Advice on Replacement Business form.
16. I/we have been advised that specimen policy wordings are available from my/our Insurance Adviser and that AIA New Zealand's financial statements are available from AIA New Zealand's head office.

I/We declare that I/we have read and understood the above declaration and agree to be bound by these terms and conditions.

To be signed below by every person to be covered by this insurance and all Policy Owners.

(To be signed by the parent/legal guardian if the Life Assured is a child under 16 years.)

Full Name of Life Assured (1)

--

Signature of Life Assured (1)

	Date	/	/
--	-------------	---	---

Full Name of Life Assured (2)

--

Signature of Life Assured (2)

	Date	/	/
--	-------------	---	---

Full Name of Life Assured (3)

--

Signature of Life Assured (3)

	Date	/	/
--	-------------	---	---

Full Name of Life Assured (4)

--

Signature of Life Assured (4)

	Date	/	/
--	-------------	---	---

Authority to Accept Direct Debits



Daytime contact no: ()

Name of Account

Customer (Acceptor) to complete Bank / Branch number &
Account number & Suffix of account to be debited

--	--	--	--	--	--

Bank

Branch Number

--	--	--	--	--	--	--	--

Account Number

--	--	--

Suffix

**AUTHORITY TO ACCEPT
DIRECT DEBITS**

(Not to operate as an
assignment or agreement)

To: The Manager

Bank

--

Branch

--

Address
(PO Box)

--

Town/City

--

AUTHORISATION CODE

0	3	1	8	8	2	7
---	---	---	---	---	---	---

(User Number)

Date: / /

I/We authorise you until further notice in writing, to debit my/our account with all amounts which
AIA New Zealand

(hereinafter referred to as the Initiator)

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

I/We acknowledge and accept that the bank accepts this authority only upon the conditions
listed on the reverse of this form.

Information to appear on my/our Bank Statement (to be completed by the Initiator)

Payer Particulars

Payer Code - Type of Cover

Payer Reference - Policy No.

A	I	A		I	N	S	U	R	E		
---	---	---	--	---	---	---	---	---	---	--	--

--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--

Authorised Signature/s:

--

APPROVED

1882
07/10

FOR BANK USE ONLY

Date
Received:Recorded
by:Checked
by:

Original - Retain at Branch
Copy - Forward to initiator if requested

BANK STAMP

CONDITIONS OF THIS AUTHORITY TO ACCEPT DIRECT DEBITS

1. The Initiator:

- (a) Will not initiate a direct debit on my/our account unless authorisation is received from me/us in accordance with the terms and conditions agreed between me/us and the Initiator of each amount to be debited from my/our account.
- (b) Has agreed to send notice of the net amount of each Direct Debit and the due date of debiting after receiving authorisation from me/us under clause 1 (a) but no later than the date the Direct Debit will be initiated. This notice must be provided either:
 - (i) in writing; or
 - (ii) by electronic mail where the Customer has provided prior written consent to the InitiatorThe notice will include the following message:- "The amount \$....., was direct debited to your Bank account on (initiating date)."
- (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) 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 request is made not more than 120 days from the date when the Direct Debit was debited to my/our account.

3. The Customer acknowledges that:-

- (a) This authority will remain in full force and effect in respect of all Direct Debits passed to my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the Bank.
- (b) In any event this authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.
- (c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the Direct Debit has not been paid in accordance with this authority. Any other disputes lies between me/us and the Initiator.
- (d) Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility in respect of:
 - the accuracy of information about Direct Debits on Bank statements
 - any variations between notices given by the Initiator and the amounts of Direct Debits
- (e) The Bank is not responsible for, or under any liability in respect of the 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.

4. The Bank may:-

- (a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.
- (b) At any time terminate this authority as to future payments by notice in writing to me/us.
- (c) Charge its current fees for this service in force from time-to-time.

Application/Policy No.

Advice on Replacement Business



The completion of this form is required if this application is to replace existing cover with another insurer. A separate form is to be completed for each existing policy to be replaced. The original of this form will be held by the applicant, and a copy sent to AIA New Zealand.

Details of new Policy

Name of Client

Name of Company

Type of Policy

Annual Premium
or Contribution

\$

Is initial commission being received in relation to the new policy?

Yes ☐

No ☐

Is instalment commission being taken as an alternative form?

Yes ☐

No ☐

Details of Policy being Replaced

Name of Client

Name of Company

Policy No.(s)

Annual Premium
or Contribution

\$

Details of Replacement - Statement by Insurance Adviser

(a) The specific reasons for the replacement of this existing policy are:

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

(c) The following death or disability risks are not covered by the new policy which were covered by the previous policy:

Name of Insurance Adviser

Address of Insurance Adviser

Postcode

Phone No. ()

Signature of Insurance Adviser

Date

/ /

Advice to Applicant

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

- the Life Assured (or one of the Lives Assured) is the same; or
- the applicant (or one of the applicants) is known to be the same; or
- the premium payer (or one of the premium payers) is known to be the same.

Applicant Acknowledgement

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

1. There are sometimes establishment costs (including commission) in setting up a policy. Replacing it with a new policy may involve further establishment costs.
2. If the policy which is being replaced was purchased on the Life Assured at a younger age, the same or similar benefits in the new policy may now cost more.
3. A change in health, pastimes or occupation of the Life Assured may affect insurability and the new policy may contain restrictions, limitations and/or be more costly.
4. Conditions or benefits may be more (or less) favourable under the policy which is being replaced, for example, the contract duration, wordings, and/or definitions may differ.
5. AIA New Zealand will not be on risk until the original insurance cover being replaced by this policy is cancelled.

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

I am/We are also aware I/we may withdraw this application in writing within the 14 day “free look” period from the date the new policy is received. In this event AIA New Zealand will refund any premium, deposit or other payment made in respect of the proposed replacement policy and the proposed replacement policy will be cancelled.

Full Name of Life Assured (1)	<input type="text"/>		
Signature of Life Assured (1)	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Full Name of Life Assured (2)	<input type="text"/>		
Signature of Life Assured (2)	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Full Name of Life Assured (3)	<input type="text"/>		
Signature of Life Assured (3)	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Full Name of Life Assured (4)	<input type="text"/>		
Signature of Life Assured (4)	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>