



# Assurance Extra

Application Form

# What should I tell my insurer?

In this application form, we will be asking you for a significant amount of information about your current health, medical history, financial position, occupation and lifestyle.

We need this information so that we can assess your application and determine the nature of the contract that we will offer you. It is extremely important that the information you provide is truthful, complete, correct and given in good faith.

We've put together the following questions and answers to help you understand why it's so important to give us the right information.

**Q What do I have to tell you?**

**A** We need you to tell us everything that may affect our decision to insure you.  
If you are in doubt about what we might want to know, you should tell us everything.

**Q What should I do if something happens after I have completed this application form and before the cover starts?**

**A** If you visit the doctor, develop a health problem, have a change in financial circumstances, or your situation changes in some other way between completing the application and your cover starting, you need to tell us.

**Q What happens if I don't give you all of the information you wanted – even if I just forgot or didn't leave out the information on purpose?**

**A** It's important that you double-check your application form to make sure you have told us everything. Even if you leave out information unintentionally, a claim may still be declined. It's best that everyone is clear upfront so that both parties fully understand the contract that is being made and there's no room for misunderstanding.

It's important that you write everything down yourself, check it to make sure you have completed each section in full, read over it again and then sign it.

Remember – if you're in doubt about something, it's best to tell us. That way you'll clearly understand what you're covered for, well before you ever need to make a claim.

# Assurance Extra Application Form

## Type of application

 Adviser code      

 New policy ☐ Increase/addition ☐ Replacement\* ☐ Other 

 Policy number (if not a new policy)      

\* Please complete the Advice on Replacement Business form attached.

## 1 Life to be Assured (Please complete a separate application for each Life to be Assured).

Mr/Mrs/Miss/Ms/Dr	<input type="text"/>		<input type="text"/>	
Home address	<input type="text"/>			
	<input type="text"/>		<input type="text"/>	
Mailing address (if different from above)	<input type="text"/>			
	<input type="text"/>		<input type="text"/>	
Date of birth	<input type="text"/>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Place of birth	<input type="text"/>	Previous names	<input type="text"/>	
Email address	<input type="text"/>	Business No.	<input type="text"/>	
Home telephone	<input type="text"/>	Mobile	<input type="text"/>	
Occupation	<input type="text"/>	Industry	<input type="text"/>	

## 2 Policy Owner(s) (If different from Life to be Assured).

Where the policy is owned by a business, the authorised signatory must complete this section and provide his/her authorisation in Section 11 Declaration and Consent.

Mailing address	<input type="text"/>	
	<input type="text"/>	<input type="text"/>

### Policy Owner 1

 Same as Life Assured Yes ☐ No ☐

Company name <input type="text"/>	
Mr/Mrs/Miss/Ms/Dr	<input type="text"/>
Home address	<input type="text"/>
	<input type="text"/>
Email address	<input type="text"/>
Telephone	<input type="text"/>
Date of birth	<input type="text"/>

### Policy Owner 2

Company name <input type="text"/>	
Mr/Mrs/Miss/Ms/Dr	<input type="text"/>
Home address	<input type="text"/>
	<input type="text"/>
Email address	<input type="text"/>
Telephone	<input type="text"/>
Date of birth	<input type="text"/>



### 3 Policy details

#### (a) Payment details

Payment frequency	Weekly <input type="checkbox"/>	Fortnightly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Half-yearly <input type="checkbox"/>	Annually <input type="checkbox"/>
Payment method	Credit/Debit card <input type="checkbox"/>	Annual cheque <input type="checkbox"/>	Direct debit <input type="checkbox"/>	Or use existing payment method <input type="checkbox"/>	
Payment date (e.g. Monday, or 5 <sup>th</sup> of every month)	<input type="text"/>				

#### (b) Premium details

Total premium amount (including policy fee) \$

#### (c) Benefit details

Please attach a signed illustration setting out benefits applied for.

#### (d) Children's Trauma Cover

(Please complete medical application form if you are applying for Major Medical Cover for any child).

Child's last name	Child's first name (s)	Male/female	Date of birth
			DD/MM/YYYY
			DD/MM/YYYY
			DD/MM/YYYY

### 4 Personal statement

#### (a) To ensure speedier processing, we may need to contact you to clarify details regarding your application.

Please provide a contact number, and a suitable day and time of availability (between the hours of 8.30am-8.00pm Monday to Friday).  
(If you do not wish to be contacted directly, please leave blank).

Preferred contact number:	Day:	Time:
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#### (b) Please provide the name, address and telephone numbers of all medical practitioners, therapists, counsellors, or clinics you have consulted in the last five years.


#### (c) Please advise which of these practitioners hold your medical records.


#### (d) Are you currently in good health? If no please provide details.

Yes ☐ No ☐


#### (e) Have you smoked tobacco or any other substance within the last 12 months?

If yes please state type and quantity smoked.

Yes ☐ No ☐

Type	Amount per day
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#### (f) What is your current height and weight?

cm/feet/inches	kg/stone/lb
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#### (g) Do you drink alcohol? If yes please state quantity and type of alcohol consumed weekly.

Yes ☐ No ☐

Type (e.g. wine/beer/spirits)	Quantity (e.g. glass/nip/mls)
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1 standard drink = 1 glass (330mls) of ordinary strength beer / 1 glass (100mls) of wine/fortified wine (e.g. table wine, sherry, martini, port)

1 pub measure of spirits (nip/fingers/30mls) of spirits (e.g. whiskey, gin, vodka)

**(h) Please indicate below if you are suffering or have ever suffered, had symptoms or treatment or are currently experiencing any of the following? If yes please complete the indicated Questionnaire in Section 6.**

i. High blood pressure. If yes <b>Questionnaire 1</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ii. Abnormal or high cholesterol test. If yes <b>Questionnaire 2</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iii. Asthma, lung disorder, bronchitis, emphysema, TB or any other respiratory or breathing disorder (e.g. snoring). If yes <b>Questionnaire 3</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iv. Drug dependency, alcohol abuse or gambling addiction. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
v. Any disease or disorder of the liver e.g. hepatitis, fatty liver or abnormal liver function tests. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
vi. Kidney disease/disorder, kidney stones or kidney infections. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
vii. Urinary condition, bladder, prostate or gynaecological disorders. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
viii. Ulcers, colitis, Crohn's disease or any disease of the gastrointestinal tract or bowel including the passage of blood from the bowel, vomiting of blood or any other disorder of the bowel, intestine or stomach. If yes <b>Questionnaire 4</b> .	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ix. Skin disorder, including dermatitis, psoriasis, eczema, cyst, suspicious mole, or any other lesion. If yes <b>Questionnaire 8</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
x. Cancer or tumour. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xi. Arthritis, rheumatism, tendonitis, or any disease/disorder or injury of the muscles, bones, or joints, e.g. back, hips, shoulders, neck, and/or knees. If yes <b>Questionnaire 5</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xii. Diabetes, abnormal blood sugar, impaired glucose tolerance, thyroid disorder, gout or any other glandular condition. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xiii. Any disease/disorder of the ears, eyes, nose or throat. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xiv. Any neurological disorder, e.g. stroke, multiple sclerosis, paralysis, migraines, motor neurone disease. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xv. Epilepsy and/or seizures. If yes <b>Questionnaire 6</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xvi. Blood disorders, varicose veins or haemorrhoids. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xvii. Mental or nervous disorders, stress, anxiety or depression. If yes <b>Questionnaire 7</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xviii. Chronic fatigue, fibromyalgia, myalgia or chronic pain syndrome. If yes <b>Questionnaire 7</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xix. Do you have Acquired Immune Deficiency Syndrome (AIDS) or are you carrying the HIV virus or antibodies to that virus? If yes <b>Questionnaire 9</b> or contact our underwriters	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xx. Within the last five years have you been exposed to the risk of AIDS, or HIV virus or antibodies to that virus? If yes <b>Questionnaire 9</b> or contact our underwriters	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xxi. Difficulty sleeping for which you have sought treatment. If yes <b>Questionnaire 7</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xxii. Recurrent dizziness or vertigo. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xxiii. Any chest pain, angina, heart disorder or rheumatic fever. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
xxiv. Any other illness/condition/complaint or injury not already stated. If yes <b>Questionnaire 9</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**(i) In the past five years, have you ever received therapy or treatment from any health provider including but not limited to counselors, therapists or naturopaths for conditions other than for ailments such as colds, flu, contraception, or those ticked above? If yes please provide details.**

Yes ☐ No ☐

Condition	Treatment	Date of treatment	Result/outcome
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

(j) Have you or are you currently taking any medication, drug, sedative (prescribed or otherwise) or over the counter preparation for anything other than ailments such as colds, flu, contraception, etc.? If yes please provide details. Yes ☐ No ☐


(k) Are you currently considering or have you been advised to undergo any treatment, therapy, special tests or operation? If yes please provide details. Yes ☐ No ☐

Condition	Treatment	Date of treatment
		DD/MM/YYYY
		DD/MM/YYYY

(l) Do you currently suffer from a disability of any kind? If yes please provide details. Yes ☐ No ☐


(m) Have you been hospitalised or had any tests, medical treatment or investigations in the last five years, e.g. X-rays, blood tests, scans? If yes please provide details. Please include date(s) and result(s). Yes ☐ No ☐


(n) In the past five years have you ever had more than five consecutive days off work due to health issues? If yes please provide details. Please include date(s) and reason(s). Yes ☐ No ☐


(o) Have you ever claimed or are in the process of claiming against a Life, Sickness, Disability or Trauma benefit? If yes please provide reasons for the claim and outcome. Yes ☐ No ☐


(p) Have you ever had an insurance application on your life declined, postponed or offered on sub-standard terms? If yes please provide details, including the name of the company concerned. Yes ☐ No ☐


(q) Do you currently have or are you currently applying for Life, Trauma, Medical or Disability benefits with any other company? If yes please provide name of company, type of cover and level of cover. Yes ☐ No ☐

Name of company	Type of cover	Level of cover

(r) Does this application replace any of these benefits? If yes please complete Advice on Replacement Business Form. Yes ☐ No ☐

(s) Do you plan to travel overseas, live or work in another country (excluding vacations of less than one month)? If yes please provide when, where, for how long and for what reason. Yes ☐ No ☐

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(t) Are you a permanent New Zealand resident or citizen? If no please provide details including a copy of your work permit(s) and passport.

Yes ☐

No ☐

(u) Have you ever been convicted of fraud or any offence involving dishonesty? If yes please provide details.

Yes ☐

No ☐

(v) Please advise if you participate or intend to participate in any of the following pastimes or any other hazardous sports or pastimes: abseiling, aviation, equestrian, hang-gliding, scuba-diving, motor racing, parachuting, skydiving, powerboat racing, mountaineering, boxing, senior rugby union/league, hunting, martial arts, voluntary firefighter, surf lifesaver. If yes please complete Section 7.

Yes ☐

No ☐

(w) Have any of your natural parents, brothers or sisters (living or dead) been diagnosed with any of the following ?

Yes ☐

No ☐

Condition	Relationship to you	Age when diagnosed (if known)	Current age	If deceased age at death
Cancer*				
Stroke				
Heart Disease				
Diabetes				
Kidney Disease				
Mental Health Condition (including depression)				
Huntington's Chorea				
Muscular Dystrophy				
Cystic Fibrosis				
Familial Polyposis				
Polycystic Kidney Disease				
Multiple Sclerosis				
Inherited neurological or blood disease or any familial disease or disorder**				

\*For cancer please specify type and site

\*\*For inherited neurological or blood disease, or familial disease or disorder, please specify disease or disorder

(x) If you are female:

i. Are you pregnant? Yes ☐ No ☐ If yes please state when are you due?

DD/MM/YYYY

ii. If pregnant, are there any complications expected with this pregnancy? If yes please provide details.

Yes ☐

No ☐

iii. Have you had any complications with any previous pregnancies? If yes please provide details.

Yes ☐

No ☐

## 5 Major Medical or Major Medical Guaranteed Insurability

Following questions to be completed if applying for Major Medical or Major Medical Guaranteed Insurability.

**(a) Are you currently receiving, or have you ever received counselling or treatment from a health professional for any of the following? If yes please provide details in Section 6, Questionnaire 9.**

i. Any disease/disorder of the ears, nose, throat or eyes.

Yes ☐ No ☐

ii. Any history of recurrent\* ear infections, tonsils and/or adenoid complaints.

Yes ☐ No ☐

iii. Any current\*\* or recent ear infections, tonsillitis or adenoid complaints.

Yes ☐ No ☐

iv. Operation for grommets or advised one may be needed.

Yes ☐ No ☐

v. Oral surgery, wisdom teeth, impacted or unerupted teeth or cysts, within the last 12 months.

Yes ☐ No ☐

\* Recurrent means more than once in any 12 month period. \*\* Current means within the past 12 months.

**To be completed by males only**

**(b) Are you currently receiving, or have you ever received counselling or treatment from a health professional for any of the following? If yes please provide details in Section 6, Questionnaire 9.**

i. Blood in the urine, slow urinary stream, problems passing urine, disease or disorder of the testicles, bladder, urethra or sexual dysfunction likely to require treatment.

Yes ☐ No ☐

**To be completed by females only**

**(c) Are you currently receiving, or have you ever received counselling or treatment from a health professional for any of the following? If yes please provide details in Section 6, Questionnaire 9.**

i. Irregular, heavy or painful menstrual bleeding, ovarian or hormonal problems, abortion or any miscarriages.

Yes ☐ No ☐

## 6 Medical questionnaires

### Questionnaire 1 – blood pressure

**(a) When did you first become aware you had high blood pressure?**


**(b) What medication or treatment are you currently taking or are you supposed to be taking for blood pressure?**


**(c) Are you compliant with the treatment you have been advised to follow? If no please provide details.**

Yes ☐ No ☐


**(d) What was your blood pressure reading immediately prior to commencing treatment?**


**(e) How often is your blood pressure checked and by whom?**


**(f) What were your three most recent blood pressure readings? Please include dates that the readings were obtained.**


**(g) Have you ever been admitted to hospital or consulted a specialist for blood pressure?**

If yes please provide dates and names.

Yes ☐ No ☐




(h) Do you suffer from any complication or associated condition? If **yes** please provide details.

Yes ☐

No ☐


(i) Do you consider your blood pressure to be:

Poor ☐

Fair ☐

Good ☐

Excellent ☐

### Questionnaire 2 – cholesterol

(a) When did you first become aware you had abnormal cholesterol?


(b) What medication or treatment are you currently taking or are you supposed to be taking for cholesterol?


(c) Are you compliant with the treatment you have been advised to follow? If **no** please provide details.

Yes ☐

No ☐


(d) What were your cholesterol results immediately prior to commencing treatment?


(e) How often is your cholesterol checked and by whom?


(f) What were your most recent cholesterol results (total cholesterol, HDL cholesterol, LDL cholesterol)?

Please include dates that the results were obtained.


(g) Do you suffer from any complication or associated condition? If **yes** please provide details.

Yes ☐

No ☐


(h) Do you consider your cholesterol control to be:

Poor ☐

Fair ☐

Good ☐

Excellent ☐

### Questionnaire 3 – breathing disorders

(a) Please provide details of the type of breathing disorder, e.g. asthma.


(b) Have you had an attack in the last two years that required you to seek medical attention from a doctor or other medical practitioner? If **yes** please provide details including date of last symptoms and frequency of symptoms/attacks.

Yes ☐

No ☐


(c) What treatment have you been prescribed? (Please include name of medication, dosage and frequency of dosage.)


(d) If applicable how many inhalers do you use in a year?

(e) Have you been hospitalised in the last two years? If **yes** please provide the cause and date.

Yes ☐ No ☐

(f) Have you been prescribed steroids, e.g. Prednisone, in the last two years? If **yes** please provide details.

Yes ☐ No ☐

(g) Have you been on a nebuliser in the last two years? If **yes** please provide details.

Yes ☐ No ☐

(h) Do you consider your breathing disorder to be: Mild ☐ Moderate ☐ Severe ☐

#### Questionnaire 4 - gastrointestinal tract

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

Indigestion ☐ Ulcer ☐ Gastritis ☐ Gastro-oesophageal Reflux (GORD) ☐

Irritable Bowel Syndrome ☐ Ulcerative Colitis ☐ Heartburn ☐ Hiatus Hernia ☐

Crohn's Disease ☐ Other, please specify

(b) What date did you first seek an opinion on this condition?

(c) Have you consulted a specialist about symptoms of any of the above? If **yes** please provide details.

Yes ☐ No ☐

(d) What treatment have you been prescribed for this condition?

(e) Have you ever undergone or been advised to undergo any investigations of the gastrointestinal tract, e.g. Gastroscopy, Endoscopy, Colonoscopy? If **yes** please provide details.

Yes ☐ No ☐

(f) How frequently do you suffer from these symptoms? Please specify times per year.

Yes ☐ No ☐

(g) Date of last symptoms?

#### Questionnaire 5 – musculoskeletal

(a) What is the type of condition/disorder/injury and what body part is affected?

(b) How long ago did you first suffer from this condition/disorder/injury, and how did it occur?

(c) How long did the symptoms last?

(d) When did you last suffer symptoms?

(e) Has this condition occurred more than once? If **yes** please provide details.

Yes ☐ No ☐

(f) Have you had any investigations? If **yes** please provide details of type, date and results.

Yes ☐

No ☐


(g) Have you had any surgery? If **yes** please provide details including date.

Yes ☐

No ☐


(h) Have you had any time off work as a result of this condition? If **yes** please provide details of date and duration.

Yes ☐

No ☐


(i) Are you currently receiving treatment? If **yes** please provide details.

Yes ☐

No ☐


(j) Are you awaiting investigations, treatment or surgery or have you been advised that treatment or surgery will be required? If **yes** please provide details.

Yes ☐

No ☐


### Questionnaire 6 – epilepsy

(a) What type of epilepsy have you been diagnosed with? Grand Mal ☐ Petit Mal ☐ Other, please specify

(b) When did you first suffer symptoms?

(c) Are you currently taking any regular medication? If **yes** please provide details of drug and dose.

Yes ☐

No ☐

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(d) Do you follow your doctor's advice regarding medication, driving and occupation?

Yes ☐

No ☐

(e) On average how many seizures have you had in the last five years?

(f) Date of last seizure.

(g) Do you still suffer from seizures? Yes ☐ No ☐

If **no** did you achieve this on medication? Yes ☐

No ☐

(h) Has your condition impacted on your employment? If **yes** please provide details.

Yes ☐

No ☐


(i) Have you ever undergone any investigations, e.g. EEG or MRI?

If **yes** please provide details of the type of investigation and results.

Yes ☐

No ☐


### Questionnaire 7 – mental health

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

Anxiety ☐ Stress ☐ Depression ☐ Fatigue or Sleeplessness ☐

Compulsive Disorder ☐ Fears or Phobias ☐ Headaches ☐ Post Traumatic Stress Disorder ☐

Other, please give details

(b) When did you first suffer from this condition and what was the reason behind it?


(c) What treatment were you recommended or prescribed for this condition and when?

Yes ☐ No ☐


(d) Were you compliant with the recommended treatment? If no please provide details.

Yes ☐ No ☐


(e) Are you still on treatment? If no please advise date that treatment ceased.

Yes ☐ No ☐


(f) Have you had any recurrence of these symptoms? If yes please provide details.

Yes ☐ No ☐


(g) Have you been hospitalised or required time off work as a result of this condition? If yes please provide details.

Yes ☐ No ☐


(h) Has your condition ever led you to intentionally or unintentionally harm yourself or have you ever had suicidal thoughts? If yes please provide details.

Yes ☐ No ☐


(i) Have you ever been assessed by a Psychiatrist or Psychologist? If yes please provide details.

Yes ☐ No ☐


### Questionnaire 8 – skin disorder

(a) Please provide details of the type of disorder or lesion.


(b) Which body part is affected by this disorder/lesion?


(c) What date did you first seek an opinion on this disorder/lesion?

DD/MM/YYYY

(d) Date of last symptoms.

DD/MM/YYYY

(e) What was the treatment undertaken or advised? (If surgical removal, please give the date and place.)


(f) What was the condition or lesion formally diagnosed as?


(g) Was any follow-up treatment required, e.g. radiotherapy, etc.?


**(h) Do you require ongoing checkups?** If **yes** please provide details. If no when did treatment cease?

Yes ☐

No ☐


### Questionnaire 9 – other medical conditions

**(a) Please describe your medical condition.**

Condition 1
Condition 2
Condition 3

**(b) Please provide the date when you first experienced symptoms.**

Condition 1
Condition 2
Condition 3

**(c) Please describe the symptoms.**

Condition 1
Condition 2
Condition 3

**(d) When did you last experience any symptoms?**

Condition 1
Condition 2
Condition 3

**(e) Are these symptoms completely resolved?** If **no** please provide details.

Yes ☐

No ☐

Condition 1
Condition 2
Condition 3

**(f) How frequent and severe are the occurrences or attacks of the condition?**

Condition 1
Condition 2
Condition 3

**(g) What type of treatment are you currently taking and dosage amount?**

Condition 1
Condition 2
Condition 3

**(h) Has the treatment changed during the last 18 months?** If **yes** please provide details.

Yes ☐

No ☐

Condition 1
Condition 2
Condition 3

**(i) Have you ever had any surgery as a result of your condition or illness?** If **yes** please provide details including dates.

Yes ☐

No ☐

Condition 1
Condition 2
Condition 3

**(j) Have you ever been hospitalised as a result of your condition or illness?**

If **yes** please advise when, where and duration.

Yes ☐

No ☐

Condition 1

Condition 2

Condition 3

**(k) How much time have you lost from work as a result of your condition or illness?**

Yes ☐

No ☐

Condition 1

Condition 2

Condition 3

**(l) Were you referred to a specialist for the condition? If yes please provide details.**

Yes ☐

No ☐

Condition 1

Condition 2

Condition 3

**(m) Name and address of health professional who has full details.**

Condition 1

Condition 2

Condition 3

## 7 Hazardous sport or pastime details

**(a) Please advise what activity, pastime or pursuit you are involved in?** (If hunting, please advise the type of game and any helicopter involvement.)

**(b) How long have you been involved in this pastime?**

**(c) How many times a year do you participate in this pastime including number of hours?**

**(d) Do you have any qualifications, certificates, associations or club memberships for this pastime? If yes please provide details.**

Yes ☐

No ☐

**(e) Do you participate in this pastime alone or in a group?**

**(f) What formal training have you had for this pastime?**

**(g) Do you compete in this activity? If yes at what level of competition?**

Yes ☐

No ☐

**(h) Please advise the maximum speed, heights, depths you obtain for this pastime?**

**(i) What safety measures and precautions do you take?**

**(j) Please provide full details of engine size and model for any boats, planes, cars or other equipment used and fuel type used.**

## 8 Mortgage details

To be completed if applying for Mortgage Repayment Cover.

(a) What is the amount of mortgage debt that is being covered by this policy?

\$

(b) Who is the lender of this mortgage?

(c) What is/was the mortgage advance date?

DD/MM/YYYY

(d) What are your mortgage repayment commitments?

\$

Weekly ☐ Fortnightly ☐ Monthly ☐

(e) What is(are) the address(es) of the property(ies) that this mortgage advance is secured against?


(f) Do you live at this address? If **no** please provide details of the use of the property,  
e.g. residential rental investment, etc.

Yes ☐ No ☐


(g) What is the term of the mortgage(s)?

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(h) What is the type of mortgage e.g. Table Mortgage, Revolving Credit Mortgage etc.?

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(i) Have you ever defaulted on mortgage repayments regardless  
of the reason for the default? If **yes** please give details.

Yes ☐ No ☐


## 9 Occupation and income details

All questions to be completed if applying for any of the following: Income Cover, Sickness Only Income Cover, Complete Disablement Cover and Trauma Cover with TPD. Questions 9a – 9k to be completed if applying for Mortgage Repayment Cover and Premium Cover.

(a) Please describe your current occupational duties in detail, including the percentage of time spent on each duty.

	<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"/>	%

(b) What percentage of work duties involve manual labour?

   %

(c) i. How many hours do you work each week?

 PW

ii. How many days do you work each week?

 Days

iii. How many weeks do you work each year?

 Weeks

(d) If you work from home, please provide the amount of hours worked there.

 Hours

(e) Have you been adjudged bankrupt in the past seven years?

Yes ☐ No ☐

(f) Are you self-employed or employed by your own company?

Yes ☐ No ☐

(g) If you are employed, please advise the name and address of your employer.

(h) Do you have a second occupation? If yes please provide details.

Yes ☐ No ☐


(i) Do you intend changing your current occupation? If yes please provide details.

Yes ☐ No ☐


(j) Are you aware of any pending redundancy or liquidation at your place of permanent employment or have you been advised that you may be made redundant? If yes please provide details.

Yes ☐ No ☐


(k) What were your previous two occupations, including when you started and finished each one?

Occupation	From	To
	DD/MM/YYYY	DD/MM/YYYY
	DD/MM/YYYY	DD/MM/YYYY

(l) Annual earned (income from personal exertion) Income details.

(m) Annual unearned (income not from personal exertion) Income details.

Salary/Wages	\$ <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"/>	Interest	\$ <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"/>
Fringe Benefits, e.g. Company Car	\$ <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"/>	Rental	\$ <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"/>
Commission Income	\$ <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"/>	Dividend	\$ <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"/>
Bonus	\$ <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"/>	Annuity	\$ <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"/>
Share of Profits	\$ <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"/>	Other (please specify)	\$ <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"/>
Other (please specify) e.g. Dividends	\$ <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"/>	Total Unearned Gross Income	\$ <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"/>
Total Earned Gross Income	\$ <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"/>	Less Related Expenses	\$ <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"/>
Less Business Expenses	\$ <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"/>	Net Unearned Income before Tax	\$ <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"/>
Net Earned Income before Tax	\$ <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"/>	Total Income (Earned and Unearned)	\$ <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"/>



(n) How much of your income would continue if you were disabled and for how long, and what would be the source of the income?  
(e.g. sick leave, profits, outstanding accounts, retainers, superannuation benefits, ongoing profits, renewal commission or entitlements)

--

(o) If any, what professional or trade qualifications do you hold?

--

(p) Please advise details of any other Income Cover currently held by you.

Insured with	Annual Benefit Amount											
<table border="1"><tr><td></td></tr></table>		\$ <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
<table border="1"><tr><td></td></tr></table>		\$ <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										

Please complete the following if self-employed or employed by your own company.

(q) For self-employed people please also confirm your total annual business income less business and professional expenses over the last three years?

Last Year	Previous Year	Two Years Previous			
<table border="1"><tr><td></td></tr></table>		<table border="1"><tr><td></td></tr></table>		<table border="1"><tr><td></td></tr></table>	

(r) How long have you owned /operated the current business you are in? Years 

--

 Months 

--

(s) Which of the following categories would you currently come under?

Sole Trader	<input type="checkbox"/>	Business Name	<table border="1"><tr><td></td></tr></table>	
Partnership	<input type="checkbox"/>	Partnership Name	<table border="1"><tr><td></td></tr></table>	
Company	<input type="checkbox"/>	Company Name	<table border="1"><tr><td></td></tr></table>	

(t) Please provide details of the following:

Number of Employees 

--

 Number of Partners/Shareholders 

--

 Percentage Shareholding 

--

--

--

 %

(u) Please describe the occupational duties of the other shareholders including the percentage of time spent on each duty.

Name of Shareholder	Duties	% of time					
<table border="1"><tr><td></td></tr></table>		<table border="1"><tr><td></td></tr></table>		<table border="1"><tr><td></td></tr></table> <table border="1"><tr><td></td></tr></table> <table border="1"><tr><td></td></tr></table> %			
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<table border="1"><tr><td></td></tr></table>		<table border="1"><tr><td></td></tr></table>		<table border="1"><tr><td></td></tr></table> <table border="1"><tr><td></td></tr></table> <table border="1"><tr><td></td></tr></table> %			

(v) Are you intending to change the current structure of your business in the future? If yes please provide details. Yes ☐ No ☐

--

(w) Is your income split with your spouse/partner? If yes please advise the percentage split, the hours and nature of the work done by your spouse/partner in this business.

Yes ☐ No ☐

<table border="1"><tr><td></td></tr></table>		% Hours	Work done

## 10 Pro-Forma Exclusions

### Pastimes

It is further hereby acknowledged that should death, disability or a Covered Condition occur as a direct or indirect result of participation in or preparation for the following pastimes and/or hazardous pursuits;

then no benefit will be payable under the

Cover benefit(s) attached to this contract.

### Income Cover, Mortgage Repayment Cover, Complete Disablement Cover, Trauma Cover including TPD & Premium Cover

It is hereby acknowledged that should disability occur as a direct or indirect result of any disease or disorder of or injury to the following body part (e.g. back or right knee)

including complications thereof, then no benefit will be payable under the

Cover benefit(s) attached to this contract.

It is hereby acknowledged that should disability occur as a direct or indirect result of the following condition, including complications thereof;

then no benefit will be payable under the

Cover benefit(s) attached to this contract.

### Trauma Cover

It is hereby acknowledged that the following Covered Conditions have been removed from the Trauma Cover attached to this contract;

### Major Medical Cover

It is hereby acknowledged that should any medical costs be incurred as a direct or indirect result of any disease or disorder of or injury to the following body part (e.g. back or right knee)

including complications thereof, then no benefit will be payable under the Major Medical Cover to this contract. It is further hereby acknowledged that should any medical costs be incurred as a direct or indirect result of the following conditions, including complications thereof; or should any medical costs be incurred as a direct or indirect result of any other conditions that have been exacerbated by or complicated by the following conditions


then no benefit will be payable under the Major Medical Cover to this contract.

[illegible]

## Notes

[illegible]

## 11 Declaration and consent

### Duty of disclosure

Before you enter this contract of Insurance you have a duty to disclose to OnePath Life (NZ) Limited every matter that you know or could reasonably be expected to know is relevant to OnePath Life (NZ) Limited's decision whether to accept the risk of the Insurance and if so on what terms. You have the same duty to disclose those matters to OnePath Life (NZ) Limited before you apply to vary or reinstate the Insurance. If you fail to comply with your duty of disclosure to OnePath Life (NZ) Limited and OnePath Life (NZ) Limited would not have issued the Insurance on the same terms if disclosure had been made, OnePath Life (NZ) Limited may cancel or alter the amounts and terms of the Insurance as OnePath Life (NZ) Limited sees fit.

The below named Life to be Assured and Policy Owner(s) declare and agree that:

1. I/We declare the information provided in this Application whether in my/our handwriting or not is true and complete and I/we have not withheld or misstated any material fact.
2. Should the Life to be Assured, or any children to be insured undergo any alteration in mental or physical health or have a change of occupation or change in financial circumstances between the date of this Application and the issue of the Insurance, I/we agree to notify OnePath Life (NZ) Limited immediately as this information is relevant to any decision OnePath Life (NZ) Limited may make to accept this Application.
3. I/We understand that statements made in this Application including any statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf forms the basis of the Insurance contract between me/us and OnePath Life (NZ) Limited.
4. I/We acknowledge that any additional information forwarded on my/our behalf, including but not limited to copies of other companies' application forms, will form part of this Application and will be used to form the basis of the Insurance contract between me/us and OnePath Life (NZ) Limited.
5. I/We understand that the Insurance proposed in this Application shall not commence until this Application has been accepted by OnePath Life (NZ) Limited and the initial premium or a completed Direct Debit or Credit Card Authority has been received by OnePath Life (NZ) Limited.
6. I/We will be bound by the terms, conditions and exclusions applicable to the proposed Insurance upon OnePath Life (NZ) Limited's acceptance of this Application.
7. I/We have been advised a Specimen Policy Document is available to me/us on request from OnePath Life (NZ) Limited's Head Office.
8. I/We authorise OnePath Life (NZ) Limited, its related companies, reinsurers or its appointed financial advisers to use information contained herein and any other information (including but not limited to full medical history) obtained from any of the organisations listed in clause 9 below to enable OnePath Life (NZ) Limited, its related companies, reinsurers or its appointed financial advisers to manage the proposed offer of insurance or to enforce, maintain and manage any resulting insurance contract or to market other products and services or in such manner as is required to meet legal and regulatory obligations.
9. I/We consent and give authority to OnePath Life (NZ) Limited to seek from the following, including their officers and employees, any information (including full medical history) OnePath Life (NZ) Limited requires for the purposes of assessing this Application or any claim arising from this Application. I/We consent for the following to disclose full information to OnePath Life (NZ) Limited for this purpose:
  - Any and all health treatment providers
  - Any and all medical information providers
  - Insurers
  - Accident Compensation Corporation
  - Employers (whether current or not)
  - Government organisations and enterprises
  - Accountants and other financial advisers
  - Banks and financial institutions
  - Any credit rating agencies.
10. I/We acknowledge that the illustration attached to Section 3 of this Application forms part of the Application and sets out the insured benefits I/we are applying for.
11. I/We understand that OnePath Life (NZ) Limited may provide credit rating agencies with the information contained herein and such information may be used for inclusion on credit rating agency databases and for the provision of the information to clients of credit rating agencies.

I/We agree that a photocopy of this authority will be as valid as an original.

Name of Life to be Assured  
(please print)

Signature of Life to be Assured

Date

Name(s) of Policy Owner(s)  
(please print)

Signature(s) of Policy Owner(s)  
(If different from Life Assured)

Date

If the Policy Owner is a business, the authorised signatory who signs on behalf of the company must be identified below.

Signature(s) of Company  
Policy Owner(s)

I/We acknowledge that we are signing on behalf of the company named in Section 2 Policy Owner(s) of this Application Form and that I/we have authorisation to do so.

Name

Signature

Date

DD/MM/YYYY

Name

Signature

Date

DD/MM/YYYY

Parent's consent where  
Life 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 this Application are true and complete to the best of my knowledge.

Relationship (please tick)

Parent

☐

Guardian

☐

Name of parent or guardian  
of Life to be Assured

Date

DD/MM/YYYY

Signature of parent or guardian  
of Life to be Assured

Where deceased minor  
under the age of 10 years

Please note that Sections 67B and 67C of the Life Assurance Act 1908 provide the following limitations in respect of payments able to be made by OnePath Life (NZ) Limited in the event of the death of a minor.

Payment is limited to a return of premiums paid plus interest thereon (compounded annually) at the rate prescribed for the purpose 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  
under the age of 16 years

OnePath Life (NZ) Limited 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 first day of April 1996 to any person other than:

1. The parents or guardians of the minor, or one of them; or
2. A parent or guardian of the minor and the spouse of that parent or guardian jointly; or
3. Any person who had District Court approval to effect the policy on the minor; or
4. An executor or administrator of any of those persons; or
5. Any person who is entitled to that sum by virtue of an assignment of policy approved by the District Court.

## 12 Adviser details

Adviser name

Adviser code

(a) I confirm that I am registered to provide a financial adviser service on the Financial Service Providers Register as required under the Financial Service Providers (Registration and Dispute Resolution) Act 2008.

Yes ☐

No ☐

(i) If **no**, I confirm that I am an employee or nominated representative of a Qualifying Financial Entity (QFE) within the meaning of the Financial Advisers Act 2008, and am permitted by the QFE to provide financial adviser services in relation to OnePath's category 2 products.

Yes ☐

No ☐

Name of QFE

(b) Is a Brokerage Variation form attached?

Yes ☐

No ☐

Adviser signature

Date

DD/MM/YYYY

### OnePath Life (NZ) Limited

205 Wairau Road, Glenfield, Auckland 0627  
Private Bag 92131, Victoria Street West, Auckland 1142  
Toll Free T 0508 464 543 F 0508 464 329  
onepath.co.nz

# Policy Owner Identity Verification

- (a) The following information must be completed for each Policy Owner in order to comply with the Financial Transactions Reporting Act 1996.
- (b) Where the policy owner is a company, partnership, incorporated society or club, the individual who signs on behalf of the company, partnership, incorporated society or club must be identified below.
- (c) Details of only one of the following acceptable forms of identification is required:
- Current and valid passport
  - New Zealand Driver Licence
  - New Zealand Firearms Licence
  - New Zealand bank issued credit or debit card
  - New Zealand bank issued pre-printed deposit slip.
- (d) Identification

## Policy Owner 1

Name of Policy Owner	<input type="text"/>
• Identification previously provided	<input type="checkbox"/>
• Pre-printed deposit slip enclosed	<input type="checkbox"/>
• Photographic identification (e.g. Current passport or Driver Licence)	<input type="checkbox"/>
Type	<input type="text"/>
Number (if applicable)	<input type="text"/>
Expiry date (if applicable)	<input type="text" value="DD/MM/YYYY"/>
Credit card <input type="checkbox"/> or Debit card <input type="checkbox"/>	
Type	<input type="text"/>
Number (if applicable)	<input type="text"/>
Expiry date (if applicable)	<input type="text" value="DD/MM/YYYY"/>

## Policy Owner 2

Name of Policy Owner	<input type="text"/>
• Identification previously provided	<input type="checkbox"/>
• Pre-printed deposit slip enclosed	<input type="checkbox"/>
• Photographic identification (e.g. Current passport or Driver Licence)	<input type="checkbox"/>
Type	<input type="text"/>
Number (if applicable)	<input type="text"/>
Expiry date (if applicable)	<input type="text" value="DD/MM/YYYY"/>
Credit card <input type="checkbox"/> or Debit card <input type="checkbox"/>	
Type	<input type="text"/>
Number (if applicable)	<input type="text"/>
Expiry date (if applicable)	<input type="text" value="DD/MM/YYYY"/>

## Adviser declaration

I confirm that I have sighted the above identification documents as proof of identity in respect of the Policy Owner(s).

Adviser name (please print)	<input type="text"/>		
Adviser signature	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>







Name of account	AUTHORITY TO ACCEPT DIRECT DEBITS  (Not to operate as an assignment of agreement)
-----------------	-----------------------------------------------------------------------------------------------

<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"/>
Bank		Branch		Account number								Suffix			

0	1	0	8	7	0	4
---	---	---	---	---	---	---

Bank
Branch
Town/City

Name of Policy Owner(s)		Policy number(s) for which this authority applies	
-------------------------	--	---------------------------------------------------	--

Preferred date of first payment  Weekly ☐ Fortnightly ☐ Monthly ☐ Half-yearly ☐ Annually ☐

[illegible]

Your signature(s) \_\_\_\_\_ Date DD/MM/YYYY

**PLEASE ATTACH DEPOSIT SLIP**

Approved <hr/> 1042 <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>01</span> <span>04</span> </div>	For Bank use only Original – retain at branch <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 33%; padding: 5px;">Date received:</td> <td style="width: 33%; padding: 5px;">Checked by:</td> <td style="width: 33%; padding: 5px;">Recorded by:</td> </tr> </table>	Date received:	Checked by:	Recorded by:	Bank Stamp
Date received:	Checked by:	Recorded by:			



# Conditions of this authority

## 1. The Initiator

- (a) The Initiator undertakes to give written notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the first Direct Debit is drawn (but not more than 2 calendar months). In the event of any subsequent change to the frequency or amount of the Direct Debits, the Initiator has agreed to give written advance notice at least 30 days before the change comes into effect.
- (b) Where the Direct Debit system is used for the collection of payments which are regular as to frequency but variable as to amounts, the Initiator undertakes to provide the Acceptor with a schedule detailing each payment amount and each payment date.
- (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.
- (d) May, upon receiving an "authority transfer form" (dated after the day of this authority) signed by me/us and addressed to a Bank to which I/we have transferred my/our Bank account, initiate Direct Debits in reliance of that transfer form and this Authority for the account identified in the authority transfer form.

## 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 clause 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 a Direct Debit back to the Initiator through the Initiator's Bank. PROVIDED such a request is made not more than 120 days from the date when the Direct Debit was debited to my/our account.

## 3. The Customer acknowledges that:

- (a) This Authority will remain in full force and effect in respect of all Direct Debits made from 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 lie 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 of liability in respect of:
  - The accuracy of information about Direct Debits on Bank statements
  - Any variation 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.
- (f) Notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for the payment is a person other than me/us is a matter between me/us and the debtor concerned.

## 4. The Bank may:

- (a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other Authority, Cheque or Draft properly 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.
- (d) Upon receipt of an "authority to transfer form" signed by me/us from a Bank to which my/our account has been transferred, transfer to that Bank this Authority to Accept Direct Debit.

### OnePath Life (NZ) Limited

205 Wairau Road, Glenfield, Auckland 0627  
Private Bag 92131, Victoria Street West, Auckland 1142  
Toll Free T 0508 464 543 F 0508 464 329  
onepath.co.nz

## Credit/Debit Card Authority

### Visa or MasterCard only\*

Name of Policy Owner	<input type="text"/>
Policy number(s) for which this authority applies	<input type="text"/>
Payment type	Debit Card <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/>
Name on Credit/Debit Card	<input type="text"/>
Expiry date	<input type="text" value="DD/MM/YYYY"/>
Credit/Debit Card 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"/>

I/We authorise you, until further notice, to debit my/our credit/debit card account with all amounts which OnePath Life (NZ) Limited may initiate by Credit/Debit Card.

<input type="text" value="Cardholder's signature"/>	Date <input type="text" value="DD/MM/YYYY"/>
-----------------------------------------------------	----------------------------------------------

### Payment frequency:

Preferred date of first payment	<input type="text" value="DD/MM/YYYY"/>	Weekly	<input type="checkbox"/>	Fortnightly	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Half-yearly	<input type="checkbox"/>	Annually	<input type="checkbox"/>
---------------------------------	-----------------------------------------	--------	--------------------------	-------------	--------------------------	---------	--------------------------	-------------	--------------------------	----------	--------------------------

\* Please note that we only accept Visa or MasterCard. We do not accept American Express, Diner's Club etc.





# Advice on Replacement Business

A separate form is to be completed for each existing contract, plan or policy to be replaced. The original of this form should be kept by the Policy Owner, and a copy held by the Company issuing the new contract, plan or policy.

## Details of the new contract/plan/policy

Name(s) of Policy Owner(s)	<input type="text"/>		
Name of company	<input type="text"/>		
Type of contract/plan/policy	<input type="text"/>	Annual Premium or contribution	\$ <input type="text"/>
Is initial commission being received in relation to the new contract?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is renewal commission being taken as an alternative form?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

## Details of the contract/plan/policy being replaced

Name(s) of Policy Owner(s)	<input type="text"/>		
Name of company	<input type="text"/>		
Contract/plan/policy No(s)	<input type="text"/>	Annual Premium or contribution	\$ <input type="text"/>

## Details of the contract/plan/policy being replaced

Life Assured	Benefit type	Sum assured	Commencement date	Cancellation date	Acceptance terms*
<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"/>

\* Note: If the life assured's health has changed since the commencement date of the benefit to be replaced, he/she may not be able to obtain acceptance terms as beneficial as they already have.

Is this application for replacement benefits dependent on the acceptance terms at least matching those already in place? Yes ☐ No ☐

## Details of replacement – statement by Adviser/Intermediary

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

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

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

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

(c) The following risks are not covered by the new contract/plan/policy which were covered by the old contract/plan/policy:

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



Name of Adviser/Intermediary	<input type="text"/>	
Address of Adviser/Intermediary	<input type="text"/>	
OnePath Adviser code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Phone <input type="text"/> ( <input type="text"/> ) <input type="text"/>
Adviser Signature	<input type="text"/>	Date <input type="text" value="DD/MM/YYYY"/>

### Information for Policy Owner(s)

You might find this information helpful in deciding whether to replace an existing contract/plan/policy.

This includes all situations where a new contract/plan/policy is being issued within a period of six months after an existing one has been discontinued, or six months before an existing contract/plan/policy 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.

### Policy Owner(s) Acknowledgement

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

1. There are sometimes establishment costs in setting up a contract/plan/policy.  
Replacing it with a new contract/plan/policy 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/plan/policy which is being replaced. For example, the contract duration, wording and/or benefit definitions may differ.

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

I am/We are aware I/we may cancel this Application, in writing, within the 'free look' period of 30 days from the date the new contract/plan/policy is received. In this event OnePath Life (NZ) Limited will refund any premium, deposit or other payment made in respect of the new contract/plan/policy.

Name of Policy Owner(s) (please print)	<input type="text"/>	
Signature of Policy Owner(s)	<input type="text"/>	Date <input type="text" value="DD/MM/YYYY"/>

## Certificate of Interim Cover

Thanks for choosing OnePath to be your insurer. We are pleased to present you with a certificate of interim cover.

### What's covered?

The Life to be Assured is covered if they suffer an accidental bodily injury directly resulting in total disability, complete disablement, diagnosis of one of the trauma cover conditions listed below or death, provided that:

- the death, total disability, complete disablement, or diagnosis happens within 90 days of the accidental bodily injury and must solely result from that accidental bodily injury; and
- the accidental bodily injury must happen for the first time, during the lifetime of the Life to be Assured, during the period of interim cover under this certificate.

### OR

A sickness or illness directly resulting in death, providing:

- the death happens within 90 days of the diagnosis of the sickness or illness and must solely result from that sickness or illness; and
- the diagnosis of the sickness or illness must happen, for the first time, during the lifetime of the Life to be Assured, during the period of interim cover under this certificate; and
- the sickness or illness is not the result of a medical condition that already existed prior to the date the interim cover starts, and the Life to be Assured is not contemplating seeking medical advice in the 30 days following the date this interim cover starts.

Trauma Cover conditions covered are: hemiplegia, diplegia, paraplegia, quadriplegia, tetraplegia, major head trauma, coma, intensive care, loss of speech, major burns, loss of hearing, loss of independent existence, loss of two limbs, combined loss of limb and sight, and blindness.

This cover starts on the date that we receive your completed application form.

### This cover ends without prior notice at the earliest of:

- the date the cover starts on the policy
- 60 days from the date the application form was signed
- the date a cancellation or withdrawal of, or change request to, the application is sent to OnePath from the intended owner(s)
- the date on which the owner(s) is notified by OnePath of its acceptance. This acceptance being subject to modification of the terms of acceptance, declination or deferral
- if a claim is paid in relation to a Life to be Assured, all interim cover under this certificate ends for that person at that time.

### To be entitled to interim cover under this certificate:

1. You need to pay the first premium to OnePath, complete a valid direct debit authority or premium payment direction (such as credit card or debit card) and include this with your application form.
2. State the occupation, activities, sport(s) or pastime(s) (for the cover(s) applied for where this is required) for the Life to be Assured which would usually be accepted by OnePath.
3. The result of the accidental bodily injury, or the sickness or illness must be covered under the policy applied for as if the policy had already started.

### Amount of interim cover

Your interim cover is the sum insured payable under the policy you are applying for, but limited to the following:

Life	\$500,000
Trauma Cover	\$200,000
Complete Disablement	\$200,000
Total Disability for Income Cover*	\$2,500 per month
Total Disability for Business Overheads Cover*	\$2,500 per month
Total Disability for Self-employed Income Cover*	\$2,500 per month
Total Disability for Mortgage Repayment Cover*	\$2,500 per month*

\* where the Life to be Assured can claim Total Disability under more than one cover, then OnePath will pay up to a maximum of \$2,500 per month.

### We only pay once

If OnePath pays any claim under this certificate, then OnePath is not liable to pay anything further under the policy applied for in relation to the same sickness or illness or accidental bodily injury. If a Life to be Assured is covered with us by more than one certificate of interim cover, then we will only pay cover under one of those certificates, and at our discretion.

When OnePath won't pay

We won't pay if the accidental bodily injury is caused by, or results from:

- a sickness or illness (unless that accidental bodily injury directly results in death)
- the Life to be Assured deliberately taking or using non-prescribed drugs, other than for proper therapeutic or medical purpose and in accordance with the manufacturers, directions for use, or the deliberate misuse by the Life to be Assured of prescribed drugs
- flying in an aircraft (except as a fare-paying passenger or ticket-holding passenger on a regular airline or established charter service ; or a commercial pilot who would have been assessed by OnePath at standard rates without the terms of acceptance modified), scuba-diving, parachuting, skydiving, bungee jumping, hang-gliding, mountaineering or rock climbing, or any participation or practice in any form of racing (except on foot)

- intentional self-injury or suicide, whether sane or insane
- participation in any criminal act
- anything that happens to the Life to be Assured prior to the date the application form was received by OnePath.

OnePath also won't pay for any cover(s) applied for (excluding accidental bodily injury directly resulting in death) which would have been deferred, declined, or the terms of acceptance modified, by OnePath, for medical, financial or occupational reasons.

What terms are applicable?

The conditions, definition and exclusions for the policy(s) applied for will apply in addition to those stated in this certificate. This certificate is issued on the basis that the information in the application is true, correct and complete.

Name(s) of Policy Owner(s)  
(please print)

Name of Life to be Assured  
against this certificate  
(please print)

Signature of Life to be Assured

Date

Name of Adviser  
(please print)

Adviser signature

Date



# Client Membership Benefits

## The OnePath Client Membership Benefits Philosophy

"Client Membership Benefits add real value to OnePath clients by helping them maintain their well being".  
It's in the interest of the client, the adviser and OnePath to help our clients stay healthy in every way.

## What are Client Membership Benefits?

Client Membership Benefits are designed to help protect what you wish to insure. You buy insurance so that you know, for example, that you can expect an income if you become disabled. Of course it would be better if you could avoid becoming disabled at all.

Don't take chances with your life. There are areas where we can help you to prevent problems and maintain the lifestyle you wish to protect.

As life becomes more complicated we often need the support and advice of professionals to find our feet in difficult times. OnePath can offer you free access to individual services that you may require from time to time.

## What services are on offer?

### Illness services include:

- If you lose a loved one
  - Grief Counselling
- If you find out that you have a serious illness
  - Illness Crisis Counselling
- You may be having trouble with life in general
  - Anxiety Counselling
  - Depression Counselling
  - Anger Management
- Encountering relationship difficulties?
  - Relationship Guidance

### Support services include:

- Wanting counselling for your addiction?
  - Stop Smoking
  - Drug Addiction
  - Alcohol Addiction
  - Gambling Addiction
- Struggling to keep an existing business afloat?
  - Small Business Advice
- Been made redundant or having issues at work?
  - Career Counselling
- You may be going through financial hardship or difficulties
  - Budgeting Advice

Our intention is that as a member of OnePath, you'll have less chance of having your chosen lifestyle interrupted by long-term disability or death.

We see our products as the safety net at the bottom of the cliff and our Client Membership Benefits as the safety barrier at the top of the cliff.

## How do I use the service?

By contacting your adviser or the OnePath Client Membership Benefit co-ordinator who will assist you with a choice of a providers suitable to your needs. You will then be supplied with a provider's contact details and you can make an appointment at a time that suits you.

## Are these services confidential?

Yes. The services are confidential as you either go through your adviser or our Client Membership Benefits co-ordinator who will keep your information completely confidential.

## How many times can I use the service?

Once your request has been approved, you will be eligible to receive the following sessions for each individual life event, courtesy of OnePath:

### \* Maximum of:

- 4 Illness service type sessions
- 3 Support services type sessions

You may of course, decide that you wish to continue with the service past these limits, however any further costs incurred will be at your expense.

**With expert advice and support it is possible to reduce your risk of financial problems, depression, heart disease and many causes of disability. As a member of OnePath you can actually work on prevention - while having the security of financial protection.**

\* These limits may be altered from time to time by OnePath, at its sole discretion.

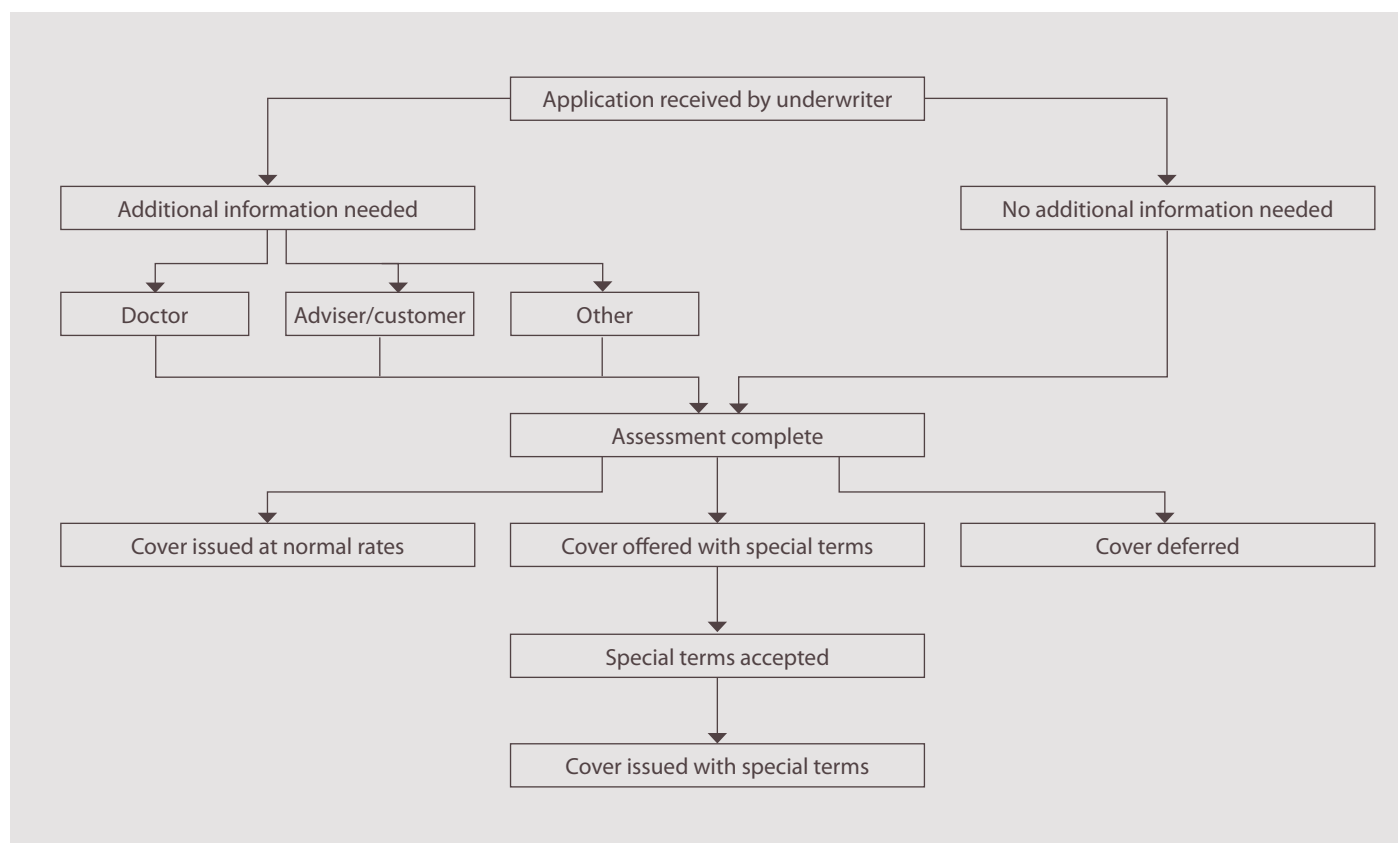
## What happens next?

An underwriter will review your application form. It's the Underwriter's job to make sure that you have been charged the correct premium and that you qualify for the cover you are applying for.

Sometimes we need to clarify something we have been told on an application form, and in these instances we will make a request for additional information.

We will let you know if this happens.

Below is the route we will follow to get your cover in place as quickly as possible.



### What are 'normal rates'?

This is when we have assessed an application for cover and have accepted it without any special terms. Your cover and premium will match the quote you submitted with your application form.

### What are 'special terms'?

In some cases, we can't offer cover at normal rates so we would look to offer 'special terms'. This may result in an additional premium or we may exclude a medical condition.

### What does 'cover deferred' mean?

Occasionally we are unable to offer cover due to the uncertainty surrounding an applicant's current situation. In this case, we would defer the cover and invite the applicant to re-apply if their situation improves.

If you have any questions please don't hesitate to contact your adviser. Alternatively, we welcome your call on 0508 464 999.



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