OnePath
a company of ANZ

Children's Major Medical 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 Name of parents

Surname	First name(s)

2 Children to cover

	Surname	First name(s)	Male/ Female	Height cms/ft (if over 10 yrs old)	Weight kgs/lbs (if over 10 yrs old)	Date of birth	Are you a permanent NZ resident or citizen?	
Child 1						DD / MM / YYYY	Yes ☐	No ☐
Child 2						DD / MM / YYYY	Yes ☐	No ☐
Child 3						DD / MM / YYYY	Yes ☐	No ☐
Child 4						DD / MM / YYYY	Yes ☐	No ☐

3 Policy details

(a) Payment details

Payment frequency Weekly ☐ Fortnightly ☐ Monthly ☐ Half-yearly ☐ Annually ☐

Payment method Credit/Debit card ☐ Annual cheque ☐ Direct debit ☐ Or use existing payment method ☐

Payment date
(e.g. Monday, or 5th of every month)

(b) Premium details

Total premium amount
(including policy fee) $ ☐☐☐☐☐.☐☐

(c) Benefit Details

Please attach a signed illustration setting out benefits applied for.
(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) Please provide the name, address and phone number of medical practitioners, therapists, counsellors, or clinics your children have consulted.

Child 1	
Child 2	
Child 3	
Child 4	

(b) Are your children currently in good health? If **no** please provide details. Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(c) Have any of your children's birth parents, brothers or sisters (living or dead) had or been diagnosed with any of the following: Yes ☐ No ☐

Condition	Life assured's name	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	

(d) In the past five years, have any of your children ever received therapy or treatment from any health provider including but not limited to counsellors, therapists, or naturopaths for conditions other than for ailments such as colds, flu, etc.? If **yes** please provide details. Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(e) Have any of your children or are any of your children currently taking any medication, drug, sedative (prescribed or otherwise) or over the counter preparation for anything other than ailments such as colds, flu etc.? If **yes** please provide details.

Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(f) Are any of your children currently considering or have any of your children been advised to under-go any treatment, therapy, special tests, or operation? If **yes** please provide details.

Yes ☐ No ☐

	Condition	Treatment	Date of Treatment
Child 1			DD / MM / YYYY
Child 2			DD / MM / YYYY
Child 3			DD / MM / YYYY
Child 4			DD / MM / YYYY

(g) Do any of your children currently suffer from a disability of any kind? If **yes** please provide details.

Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(h) Have any of your children 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.

Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(i) In the past five years have any of your children ever had more than five consecutive days off work/school due to health issues? If **yes** please provide details. Please include date(s) and reason(s).

Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(j) Have any of your children ever claimed or are in the process of claiming against a Life, Sickness, Disability or Trauma benefit? If **yes** please advise reason for claim and the outcome.

Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(k) Have any of your children ever had an application on their lives declined, postponed or offered on sub-standard terms? If **yes** please advise details including the name of the company concerned.

Yes ☐ No ☐

Child 1	
Child 2	
Child 3	
Child 4	

(I) Please indicate below if any of your children are suffering or have ever suffered, had symptoms or treatment or are currently experiencing any of the following? If **yes** please complete Section 5.

		Yes ☐	No ☐	
i.	High blood pressure, chest pain, angina, heart disorder, rheumatic fever.	Yes ☐	No ☐	
ii.	Asthma, lung disorder, bronchitis, emphysema, TB, or any other respiratory or breathing disorder (e.g. snoring).	Yes ☐	No ☐	
iii.	Any disease or disorder of the liver e.g. hepatitis; fatty liver or abnormal liver function tests.	Yes ☐	No ☐	
iv.	Kidney disease/disorder, kidney stones or kidney infections.	Yes ☐	No ☐	
v.	Urinary condition, bladder, prostate or gynaecological disorders.	Yes ☐	No ☐	
vi.	Ulcers, colitis, Crohn's disease or any disease/disorder of the gastrontestinal tract or bowel including the passage of blood from the bowel, vomiting of blood or any other disorder of the bowel, intestine or stomach.	Yes ☐	No ☐	
vii.	Cancer or tumour.	Yes ☐	No ☐	
viii.	Skin disorder, including dermatitis, psoriasis, eczema, cyst, suspicious mole or any other lesion.	Yes ☐	No ☐	
ix.	Arthritis, rheumatism, tendonitis, or any disease/disorder or injury of the muscles, bones, or joints e.g. back, hips, shoulders, neck and/or knees.	Yes ☐	No ☐	
x.	Diabetes, abnormal blood sugar, impaired glucose tolerance, thyroid disorder, gout, or any other glandular condition.	Yes ☐	No ☐	
xi.	Any disease/disorder of the ears, nose, throat or eyes.	Yes ☐	No ☐	
xii.	Any history of recurrent* ear infections, tonsils and/or adenoid complaints.	Yes ☐	No ☐	
xiii.	Any current** or recent ear infections, tonsillitis or adenoid complaints.	Yes ☐	No ☐	
xiv.	Operation for grommets or advised one may be needed.	Yes ☐	No ☐	
xv.	Oral surgery, wisdom teeth, impacted or unerupted teeth or cysts, within last 12 months.	Yes ☐	No ☐	
xvi.	Any neurological disorders e.g. stroke, epilepsy, seizures, multiple sclerosis, paralysis, migraines, motor neurone disease.	Yes ☐	No ☐	
xvii.	Blood disorders, varicose veins or haemorrhoid.	Yes ☐	No ☐	
xviii.	Mental or nervous disorders, stress, anxiety, depression.	Yes ☐	No ☐	
xix.	Chronic fatigue, fibromyalgia, myalgia or chronic pain syndrome.	Yes ☐	No ☐	
xx.	Difficulty sleeping from which you have sought treatment.	Yes ☐	No ☐	
xxi.	Recurrent dizziness or vertigo.	Yes ☐	No ☐	
xxii.	Any other illness/condition/complaint or injury not already stated.	Yes ☐	No ☐	

5 Medical questionnaire

(a) Please describe your children's medical condition.

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

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

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(c) Please describe the symptoms.

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

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

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(e) What type of treatment are they currently taking and dosage amount?

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(f) Has the treatment changed during the last 18 months? If **yes** please provide details. Yes ☐ No ☐

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(g) Have your children ever had any surgery as a result of their condition or illness?
If **yes** please provide details including dates. Yes ☐ No ☐

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(h) Have they ever been hospitalised as a result of their condition or illness?
If **yes** please advise when, where and duration. Yes ☐ No ☐

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(i) How much time have they lost from work/school as a result of their condition or illness?

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(j) When did they last experience any symptoms?

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(k) Are these symptoms completely resolved? If **no** please provide details. Yes ☐ No ☐

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

(l) Were they referred to a specialist for the condition? If **yes** please provide details. Yes ☐ No ☐

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

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

	Condition 1	Condition 2	Condition 3
Child 1			
Child 2			
Child 3			
Child 4			

Notes

6 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 dis clo sure 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 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 rel e vant 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 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.

5. 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.

6. I/We will be bound by the standard conditions 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.

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

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

12. Authority and consent applies to signatories and named children

Name of Life to be Assured
(please print)

Signature of Life to be Assured

Date DD/MM/YYYY

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

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

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.

Name of parent or guardian
(please print)

Signature of parent or guardian of Life to be Assured

Date DD/MM/YYYY

7 Adviser details

Adviser name

Adviser code

Policy number

Is a Brokerage Variation form attached? Yes No

Adviser signature

Date DD / MM / YYYY

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OnePath
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