

c) Please indicate below by ticking the box if the child is currently suffering from, experiencing symptoms of or being treated for or if they have ever suffered from, had symptoms of or had treatment for any of the following. (If you tick a box, please also complete the questionnaire in section 3.0).

	C1	C2	C3	C4
i. Respiratory or breathing disorder (e.g. asthma, lung disorder, bronchitis etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Liver disease or disorder (e.g. hepatitis or abnormal liver function tests etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Kidney disease or disorder (e.g. kidney stones, infections or abnormal renal function tests etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Urinary tract or bladder disorder.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Gastrointestinal tract, stomach or bowel disorder (e.g. ulcers, colitis, Crohn's disease etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Skin disorders (e.g. dermatitis, psoriasis, eczema, cysts, suspicious moles, lesions etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vii. Cancer or tumour.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
viii. Diabetes, abnormal blood sugar test or impaired glucose tolerance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ix. Thyroid disorder, gout or any other glandular condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. Disorders of the ears, eyes (excluding long or short sightedness), nose or throat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xi. Epilepsy or seizures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xii. Blood disorders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xiii. Sleep disorders (e.g. chronic insomnia or obstructive sleep apnoea etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xiv. Recurrent* dizziness or vertigo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xv. Heart disorder (e.g. heart failure, heart valve disorders, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xvi. Muscle, joint, spine, tendon or bone disorder or injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xvii. Arthritis or rheumatism.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xviii. Recurrent* ear, nose, throat, adenoid or tonsil infections.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xix. Recent** ear, nose, throat, adenoid or tonsil infections.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xx. Grommet insertion (or been advised that this may be required).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xxi. Oral surgery, impacted or unerupted teeth, gum infections or cysts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xxii. Any other conditions not listed above for which the child has received treatment or therapy from any health provider, (including alternative practitioners), in the past five years (excluding minor ailments such as colds, flu and contraception).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xxiii. Any other conditions not listed above for which the child currently takes medications, drugs, sedatives or over the counter preparations (excluding medications for minor ailments such as colds, flu and contraception).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xxiv. Any other conditions not listed above for which the child has undergone tests or investigations in the past five years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Recurrent means more than once in any 12 month period

** Recent means within the past 12 months

d) Please give details of any claims that have been made or are in the process of being made against any insurance benefits.

	Claim
Child 1	
Child 2	
Child 3	
Child 4	

e) Please give details of any applications you have made for any insurance benefits which were declined, deferred or offered with special acceptance terms.

	Application
Child 1	
Child 2	
Child 3	
Child 4	

f) Please give details of any first degree relative (e.g. mother (m), father (f) brothers (b) or sisters (s),) who have ever suffered from any of the following conditions.

Condition	Applicable child	Relative	Age at diagnosis	Current age	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 disease					
Inherited blood disorder					
Any other Inherited or familial disease or disorder**					

* For cancer please specify type and site (where applicable).

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

3.0 Medical Questionnaire

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a) What is the condition and when was the condition first diagnosed?

Condition 1 DD/MM/YYYY	Condition 1 DD/MM/YYYY	Condition 1 DD/MM/YYYY	Condition 1 DD/MM/YYYY
Condition 2 DD/MM/YYYY	Condition 2 DD/MM/YYYY	Condition 2 DD/MM/YYYY	Condition 2 DD/MM/YYYY
Condition 3 DD/MM/YYYY	Condition 3 DD/MM/YYYY	Condition 3 DD/MM/YYYY	Condition 3 DD/MM/YYYY

b) Give details of the specialist where applicable.

Condition 1	Condition 1	Condition 1	Condition 1
Condition 2	Condition 2	Condition 2	Condition 2
Condition 3	Condition 3	Condition 3	Condition 3

c) What treatment or medication has most recently been prescribed and does the child still require treatment or medication for this condition?

Condition 1 Y N	Condition 1 Y N	Condition 1 Y N	Condition 1 Y N
Condition 2 Y N	Condition 2 Y N	Condition 2 Y N	Condition 2 Y N
Condition 3 Y N	Condition 3 Y N	Condition 3 Y N	Condition 3 Y N

d) Provide details of any time off school required as a result of this condition.

Condition 1	Condition 1	Condition 1	Condition 1
Condition 2	Condition 2	Condition 2	Condition 2
Condition 3	Condition 3	Condition 3	Condition 3

e) What tests or investigations have been undertaken for this condition and what were the results?

Condition 1	Condition 1	Condition 1	Condition 1
Condition 2	Condition 2	Condition 2	Condition 2
Condition 3	Condition 3	Condition 3	Condition 3



f) How frequently does the child experience symptoms, what are those symptoms and when did the child last experience those symptoms?

Condition 1 DD/MM/YYYY	Condition 1 DD/MM/YYYY	Condition 1 DD/MM/YYYY	Condition 1 DD/MM/YYYY
Condition 2 DD/MM/YYYY	Condition 2 DD/MM/YYYY	Condition 2 DD/MM/YYYY	Condition 2 DD/MM/YYYY
Condition 3 DD/MM/YYYY	Condition 3 DD/MM/YYYY	Condition 3 DD/MM/YYYY	Condition 3 DD/MM/YYYY

g) Has the child been hospitalised for this condition?
If yes please give date, reason and outcome.

Condition 1 DD/MM/YYYY 	Condition 1 DD/MM/YYYY 	Condition 1 DD/MM/YYYY 	Condition 1 DD/MM/YYYY
Condition 2 DD/MM/YYYY 	Condition 2 DD/MM/YYYY 	Condition 2 DD/MM/YYYY 	Condition 2 DD/MM/YYYY
Condition 3 DD/MM/YYYY 	Condition 3 DD/MM/YYYY 	Condition 3 DD/MM/YYYY 	Condition 3 DD/MM/YYYY

h) Describe any long-term or permanent disability suffered as a result of this condition.

Condition 1 	Condition 1 	Condition 1 	Condition 1
Condition 2 	Condition 2 	Condition 2 	Condition 2
Condition 3 	Condition 3 	Condition 3 	Condition 3

i) Are you considering or have you been advised to have the child undergo any further tests or investigations for this condition?
If yes please give details.

Condition 1 	Condition 1 	Condition 1 	Condition 1
Condition 2 	Condition 2 	Condition 2 	Condition 2
Condition 3 	Condition 3 	Condition 3 	Condition 3

5.0 Declaration and consent

Duty of disclosure

Before you enter this contract of insurance you have a duty to disclose to Partners Life Limited every matter that you know (or could reasonably be expected to know) is relevant to Partners Life 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 Partners Life Limited when you apply to vary or reinstate the insurance.

If you fail to comply with your duty of disclosure to Partners Life Limited, Partners Life Limited will enact the remedies available to it under the terms and conditions contained within the policy document.

The below policy owner(s) declare and agree that:

1. 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; and
2. Should the children to be insured undergo any alteration in mental or physical health between the date of this application and the issue of the insurance, I/we agree to notify Partners Life Limited immediately, as I/we acknowledge this information is relevant to Partners Life Limited decision to accept this application; and
3. I/we understand that statements made in this application, any statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf and any statements made to Partners Life Limited by phone or in writing form the basis of the insurance contract between me/us and Partners Life Limited; and
4. I/we acknowledge that any additional information 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 Partners Life Limited; and
5. I/we understand that the insurance proposed in this application shall not commence until this application has been accepted by Partners Life Limited and the initial premium or a completed direct debit or credit card authority has been received by Partners Life Limited; and
6. I/we will be bound by the standard conditions applicable to the proposed insurance upon Partners Life Limited acceptance of this application; and
7. I/we have been advised a specimen policy document is available to me/us on request from Partners Life Limited head office; and
8. I/we authorise Partners Life 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 Partners Life Limited, its related companies, reinsurers or 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; and
9. I/we consent and give authority to Partners Life Limited to seek from the following, including their officers and employees, any information (including full medical history) Partners Life 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 Partners Life Limited for this purpose:
 - Any and all health treatment providers; and
 - Any and all medical information providers; and
 - Insurers; and
 - Accident Compensation Corporation; and
 - Government organisations and enterprises.
10. I/we acknowledge that the illustration attached to the adult application that this children's application forms part of will form part of this application and sets out the insured benefits I/we are applying for; and
11. I/we accept any pre-acceptance exclusions listed in Section 4. of this application form will be applied to the benefits included under this policy; and
12. I/we agree that a photocopy of this application form, declaration and consent will be as valid as the original.

Date

Date

Partners Life Limited

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