

# Protection Plan

## Application

## Partners Protection Plan

### Type of application

New application

Quote number

Increase/addition

Replacement business\*

Special terms review

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

### 1.0 Lives to be assured

#### Life assured 1 (LA1)

Title		First name(s)	
Surname			
Previous name			
Male	Female	Date of birth / /	
Place of birth			
Street address			
Suburb			
Town/city		Postcode	
Postal address (if different)			
Email address			
Home phone ( )			
Business phone ( )			
Mobile ( )			
Occupation		Industry	

#### Life assured 2 (LA2)

Title		First name(s)	
Surname			
Previous name			
Male	Female	Date of birth / /	
Place of birth			
Street address			
Suburb			
Town/city		Postcode	
Postal address (if different)			
Email address			
Home phone ( )			
Business phone ( )			
Mobile ( )			
Occupation		Industry	

### 2.0 Policy owners (if different from lives assured)

#### First owner

Title		First name(s)	
Surname or company name			
Postal address			
Town/city		Postcode	
Email address			
Contact phone number ( )			
Male	Female	Date of birth / /	

#### Second owner

Title		First name(s)	
Surname or company name			
Postal address			
Town/city		Postcode	
Email address			
Contact phone number ( )			
Male	Female	Date of birth / /	

Adviser/office use only

Adviser code

<input type="text"/>					
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### 3.0 Policy details

**a) Payment details**

Payment method    Direct debit     Annual cheque     Credit/debit card     Use existing payment method

Payment date

**b) Premium and benefit details**

Please **attach** an illustration setting out the benefits to be applied for and the applicable premiums payable.

### 4.0 Personal statement

**a) Partners Life may need to contact you to clarify details regarding your application. To enable us to do so please provide your preferred daytime contact number and your preferred day and time for us to contact you (between the hours of 8.30a.m. and 5.00p.m. Mon – Fri).**

Life assured 1           

Life assured 2           

**b) Please provide the name, address and telephone numbers of the health practice(s) that hold your medical records**

	Doctor's name	Clinic name	Clinic address	Clinic phone number	Clinic fax number
Life assured 1					
Life assured 2					

**c) Please answer the following questions:**

**Life assured 1**

**Life assured 2**

**i. Have you smoked tobacco or any other substance within the last 12 months? If yes what type and what is the average quantity you smoke in one day?**

Y | N

Type
Quantity

Y | N

Type
Quantity

**ii. Do you drink alcohol? If yes what type and what is the average quantity you consume in one week?**

Y | N

Type
Quantity

Y | N

Type
Quantity

**iii. What is your height?**

Height (cms/ft & inches)
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Height (cms/ft & inches)
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**iv. When were you last weighed and what was your weight?**

Date
Weight (kgs/lbs)

Date
Weight (kgs/lbs)

d) Please indicate below by ticking the box if you are currently suffering from, experiencing symptoms of or being treated for, or if you have ever suffered from, had symptoms of or had treatment for any of the following. (If you tick a box, please also complete the indicated questionnaire(s) in section 6.0).

	LA1	LA2
i. High blood pressure. <b>Questionnaire 1</b>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Abnormal or high cholesterol. <b>Questionnaire 2</b>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Respiratory or breathing disorder (e.g. asthma, lung disorder, bronchitis, emphysema, TB etc.). <b>Questionnaire 3</b>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Drug dependency, alcohol abuse or gambling addiction. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
v. Liver disease or disorder (e.g. hepatitis, fatty liver or abnormal liver function tests etc.). <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Kidney disease or disorder (e.g. kidney stones, infections or abnormal renal function tests etc.). <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
vii. Urinary tract or bladder disorder. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
viii. Prostate or gynaecological disorders. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
ix. Gastrointestinal tract, stomach or bowel disorder (e.g. ulcers, colitis, Crohn's disease etc.). <b>Questionnaire 4</b>	<input type="checkbox"/>	<input type="checkbox"/>
x. Skin disorders (e.g. dermatitis, psoriasis, eczema, cysts, suspicious moles, lesions etc.). <b>Questionnaire 8</b>	<input type="checkbox"/>	<input type="checkbox"/>
xi. Cancer or tumour. <b>Questionnaire 9</b>	<input type="checkbox"/>	<input type="checkbox"/>
xii. Diabetes, abnormal blood sugar test or impaired glucose tolerance. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xiii. Thyroid disorder, gout or any other glandular condition. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xiv. Disorders of the ears, eyes (excluding long or short sightedness), nose or throat. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xv. Epilepsy or seizures. <b>Questionnaire 6</b>	<input type="checkbox"/>	<input type="checkbox"/>
xvi. Blood disorders. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xvii. Varicose veins or haemorrhoids. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xviii. Mental or nervous disorders (e.g. depression, anxiety, stress, phobias). <b>Questionnaire 7</b>	<input type="checkbox"/>	<input type="checkbox"/>
xix. Chronic fatigue, fibromyalgia or chronic pain syndrome. <b>Questionnaire 7</b>	<input type="checkbox"/>	<input type="checkbox"/>
xx. HIV, AIDS or antibodies to HIV, or potential exposure to HIV. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxi. Sleep disorders (e.g. chronic insomnia or obstructive sleep apnoea etc.). <b>Questionnaire 7</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxii. Recurrent dizziness or vertigo. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxiii. Heart disorder (e.g. heart attack, heart failure, heart valve disorders, cardiomyopathy, angina, endocarditis, chest pain etc.). <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxiv. Muscle, joint, spine, tendon or bone disorder or injury. <b>Questionnaire 5</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxv. Arthritis or rheumatism. <b>Questionnaire 5</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxvi. Any other conditions not listed above for which you have 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). <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxvii. Any other conditions not listed above for which you currently take medications, drugs, sedatives or over the counter preparations (excluding medications for minor ailments such as colds, flu and contraception). <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
xxviii. Any other conditions not listed above for which you have undergone tests or investigations in the past five years. <b>Questionnaire 10</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please initial in the following boxes to confirm you have read and understood this question</b>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Life assured 1	Life assured 2										
e) Provide details of any claims you have made or are in the process of making against any life, trauma, disability or medical insurance benefits.	<table border="1"> <tr><td>Claims</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>	Claims					<table border="1"> <tr><td>Claims</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>	Claims				
Claims												
Claims												
f) Provide details of any applications you have made for any life, trauma, disability or medical insurance benefits which were declined, deferred or offered with special acceptance terms.	<table border="1"> <tr><td>Applications</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>	Applications					<table border="1"> <tr><td>Applications</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>	Applications				
Applications												
Applications												

**Life assured 1**

**Life assured 2**

**g) Provide details of life, trauma, disability or medical insurance benefits which you currently have or are currently applying for with any other company.**

Company, type of cover, sum assured

Company, type of cover, sum assured

**h) Provide details of any plans you have to travel, live or work overseas (excluding vacations of less than one month).**

Plans

Plans

**i) Please list your New Zealand residency status (e.g. citizen, permanent resident, work visa etc.). Please provide a copy of passport or visa if you are not a resident or citizen.**

Residency status

Residency status

**j) Please provide details of any convictions you may have had for offences involving fraud or dishonesty.**

Convictions

Convictions

**k) Please indicate below by ticking the box if you participate in or intend to participate in any of the following pastimes or hazardous sports. (If you tick a box, please also complete the questionnaire in section 7).**

	LA1	LA2
i. Abseiling	<input type="checkbox"/>	<input type="checkbox"/>
ii. Aviation	<input type="checkbox"/>	<input type="checkbox"/>
iii. Competitive boxing	<input type="checkbox"/>	<input type="checkbox"/>
iv. Equestrian – competitive show jumping, cross country or racing	<input type="checkbox"/>	<input type="checkbox"/>
v. Hang gliding	<input type="checkbox"/>	<input type="checkbox"/>
vi. Scuba diving – over 30m or solo	<input type="checkbox"/>	<input type="checkbox"/>
vii. Motor racing	<input type="checkbox"/>	<input type="checkbox"/>
viii. Parachuting	<input type="checkbox"/>	<input type="checkbox"/>
ix. Skydiving	<input type="checkbox"/>	<input type="checkbox"/>
x. Powerboat racing	<input type="checkbox"/>	<input type="checkbox"/>
xi. Mountaineering	<input type="checkbox"/>	<input type="checkbox"/>
xii. Hunting – using aircraft	<input type="checkbox"/>	<input type="checkbox"/>
xiii. Competitive martial arts	<input type="checkbox"/>	<input type="checkbox"/>
xiv. Voluntary fire-fighting	<input type="checkbox"/>	<input type="checkbox"/>
xv. Any other hazardous pursuit or sport	<input type="checkbox"/>	<input type="checkbox"/>

**Please initial in the following boxes to confirm you have read and understood this question**

<input type="checkbox"/>	<input type="checkbox"/>
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**l) Please provide 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	Life assured 1				Life assured 2			
	Relative	Age at diagnosis	Current age	Age at death	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).

Life assured 1: Type	Site
Life assured 2: Type	Site

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

Life assured 1
Life assured 2

**❖ For female lives who are currently pregnant only**

	Life Assured 1	Life Assured 2
<b>m) Please provide details of any complications you have or are experiencing with this pregnancy.</b>	Complications _____ _____ _____	Complications _____ _____ _____
<b>n) Please provide details of any complications you have had with any previous pregnancies.</b>	Previous complications _____ _____ _____	Previous complications _____ _____ _____

**(The next two questions are only required if applying for Income, Premium, Mortgage Repayment or TPD Covers).**

<b>o) Please provide details of any maternity leave plans including expected dates.</b>	Leave plans _____ _____ _____	Leave plans _____ _____ _____
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**p) Do you plan to return to work for more than 25 hours per week after this pregnancy? If yes please provide expected date.**

Y | N                          Y | N





### Questionnaire 3 – respiratory or breathing

- a) What is the disorder? (e.g. asthma etc.)
- b) When were you first diagnosed with this condition?
- c) What treatment or medication have you most recently been prescribed for this disorder?
- d) Do you always follow the treatment or take the medication as prescribed? If no please give details.
- e) If applicable, how many inhalers do you use in a year?
- f) Have you been prescribed steroids in the past two years? If yes please give date, type and reason.
- g) Have you been nebulised in the past two years? If yes please give date and reason.
- h) Have you had an attack requiring medical attention in the past two years? If yes give date, name of medical facility, reason and outcome.
- i) Are you considering or have you been advised to undergo any further tests or investigations for this condition? If yes please give details.

#### Life assured 1

Y   N
Date
Type
Reason
Y   N
Date
Facility
Reason
Outcome
Y   N

#### Life assured 2

Y   N
Date
Type
Reason
Y   N
Date
Facility
Reason
Outcome
Y   N

### Questionnaire 4 – gastric

- a) What is the disorder? (e.g. indigestion, colitis, ulcers, Crohn’s disease etc.)
- b) When were you first diagnosed with this condition?
- c) Give details of your specialist where applicable.
- d) What treatment or medication have you most recently been prescribed for this disorder?
- e) Do you always follow the treatment or take the medication as prescribed? If no please give details.
- f) What tests or investigations have you undergone for this condition and what were the results?
- g) How frequently do you experience symptoms and what are those symptoms?
- h) When did you last experience those symptoms?
- i) Have you been hospitalised for this condition? If yes please give date, reason and outcome.
- j) Are you considering or have you been advised to undergo any further tests or investigations for this condition? If yes please give details.

#### Life assured 1

Y   N
Date
Reason
Outcome
Y   N

#### Life assured 2

Y   N
Date
Reason
Outcome
Y   N







## Questionnaire 7 – mental health, sleep, and chronic conditions

Life assured 1

Life assured 2

a) What is the condition?	<input type="text"/>	<input type="text"/>
b) When were you first diagnosed with this condition?	<input type="text"/>	<input type="text"/>
c) Give details of your specialist where applicable.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
d) What treatment or medication have you most recently been prescribed?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
e) Do you still require treatment or medication for this condition?	Y   N	Y   N
f) Provide details of any impact this condition has had on your work.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
g) Do you always follow the treatment or take the medication as prescribed? If no please give details.	Y   N <input type="text"/>	Y   N <input type="text"/>
h) How frequently do you experience symptoms?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
i) When did you last experience symptoms?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
j) Have you been hospitalised or institutionalised for this condition? If yes please give date, reason and outcome.	Date <input type="text"/> Reason <input type="text"/> Outcome <input type="text"/>	Date <input type="text"/> Reason <input type="text"/> Outcome <input type="text"/>
k) Describe any long-term or permanent disability you suffer from as a result of this condition.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
l) Have you ever had suicidal thoughts or made a suicide attempt?	Y   N	Y   N

## Questionnaire 8 – skin

Life assured 1

Life assured 2

a) What is the condition?	<input type="text"/>	<input type="text"/>
b) What body parts are affected?	<input type="text"/>	<input type="text"/>
c) What tests or investigations have you undergone for this condition and what were the results including histology, if known?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
d) If the histology is not known was the lesion definitely benign?	Y   N	Y   N
e) Give details of your specialist where applicable.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
f) What treatment or medication have you most recently been prescribed?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
g) Do you still require treatment or medication for this condition?	Y   N	Y   N
h) When did you last experience symptoms?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
i) Have you been hospitalised for this condition? If yes please give date, reason and outcome.	Date <input type="text"/> Reason <input type="text"/> Outcome <input type="text"/>	Date <input type="text"/> Reason <input type="text"/> Outcome <input type="text"/>
j) How often do you require follow-up checks?	<input type="text"/>	<input type="text"/>













## 8.0 Occupation details (only required if applying for Income, Premium, Mortgage Repayment or TPD Covers)

### Life assured 1

a) What are your current occupational duties and how much time is spent on each?

Duty	%
Duty	%

b) What percentage of your role involves manual labour?

	%
--	---

c) How long have you been in your current occupation?

Months	Years
--------	-------

d) Provide details of any formal qualifications you hold for this occupation.

Qualifications
----------------

e) How many hours on average do you work each week?

Hours
-------

f) How many days do you work each week?

Days
------

g) How many weeks do you work each year?

Weeks
-------

h) What percentage of your work is done from home?

%
---

i) Give details of any second occupation you may have.


j) Are you aware of any pending liquidation of your current employer or have you been made aware of any potential for you to be made redundant from your current workplace? If yes please give details.

Y   N	

k) Have you ever been involved in disciplinary action or any other employment dispute with your current employer? If yes please give details.

Y   N	

l) Please provide the name and address of your current employer.

Name of employer	
Business address	
Town/city	Postcode

m) If you have been in your current occupation for less than three years please provide details of your previous occupation including dates, duties, industry and employer.

Occupation/industry	
Employer	Dates
Duties	

n) If you are employed do you intend to change your current occupation or become self-employed within the next 12 months? If yes please give details.

Y   N	

### Life assured 2

Duty	%
Duty	%

	%
--	---

Months	Years
--------	-------

Qualifications
----------------

Hours
-------

Days
------

Weeks
-------

%
---


Y   N	

Y   N	

Name of employer	
Business address	
Town/city	Postcode

Occupation/industry	
Employer	Dates
Duties	

Y   N	

**Life assured 1**

**Life assured 2**

**o) Do you own the company you work for or are you self-employed?** If **yes** please provide details of type of self-employment e.g. sole trader, partnership, company etc and your percentage shareholding of the business.

Y   N	
	%

Y   N	
	%

**p) If you are self-employed, how many employees do you have working for you?**



**q) If you are self-employed, have you been adjudged bankrupt in the past seven years? If yes please give details.**

Y   N	

Y   N	

**r) If you are self-employed, do you intend to change the structure of your business? If yes please give details.**

Y   N	

Y   N	

**9.0 Annual income details** (only required if applying for Income Cover)

**a) Please provide annual income details.**

Income details	Life assured 1	Life assured 2
Annual salary (for employed)	\$	\$
Fringe benefits (e.g. company car)	\$	\$
Commission income	\$	\$
Bonuses	\$	\$
Profit share	\$	\$
Other annual remuneration (please give details)	\$	\$
Your share of annual business income less business expenses for past three years (for self-employed)	Last year \$ Previous year \$ 2 years previous \$	Last year \$ Previous year \$ 2 years previous \$
Annual unearned income (not arising from personal exertion e.g. rental income, investment income, trust distributions etc.).	\$	\$

**b) Do you split income with your spouse/partner?** If **yes** please give details of how income is split and what work your spouse/partner actually does (if any).

Y   N	

Y   N	

**c) If you become totally disabled how much of your current income would continue and for how long?**



10.0 Mortgage details (only required if applying for Mortgage Repayment Cover).

a) Amount of mortgage debt to be covered?

\$

b) Who is the lender of this mortgage?

c) What is the term of the mortgage?

d) What is/was the mortgage advance date?

e) What is the type of mortgage? (e.g. table, revolving credit, interest only etc.)

f) What are your monthly mortgage repayments?

g) What is/are the address(es) of the property(ies) used as security?

Address 1
Address 2

h) What will the property(ies) be used for? (e.g. residential rental investment, etc.)

i) Details of any previous mortgage default including date, lender and reason.


## 11.0 Pre-assessment exclusion acceptance

### Pastimes

I/we hereby acknowledge that should death, disability or the occurrence of a covered condition arise as a direct or indirect result of participation in or preparation for the listed pursuits then no benefit will be payable under the listed benefits which are included in this contract.

Life assured 1	
Pursuit	Benefits

Life assured 2	
Pursuit	Benefits

### Disability

I/we hereby acknowledge that should disability arise as a direct or indirect result of any disease or disorder of the listed body parts or conditions, (including complications thereof), then no benefit will be payable under the listed benefits which are included in this contract.

Life assured 1	
Body part or condition	Benefits

Life assured 2	
Body part or condition	Benefits

### Trauma cover

I/we hereby acknowledge that the listed covered conditions have been removed from the trauma cover which is included in this contract.

Life assured 1 – covered condition

Life assured 2 – covered condition

### Private medical cover

I/we hereby acknowledge that any medical costs arising as a direct or indirect result of any disease or disorder or investigation of the listed body parts and conditions will not be covered under the private medical cover which is included in this contract.

Life assured 1 – condition or body part

Life assured 2 – condition or body part

## 11.0 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 named lives to be assured and 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 lives 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 Partners Life Limited immediately, as I/we acknowledge this information is relevant to Partners Life Limited's 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 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 understand that Partners Life Limited will draw money from our chosen payment method where applicable (bank account, credit card or debit card) on the date specified by you in your application, or on the nearest corresponding date thereafter (and ongoing in accordance with our specified payment frequency). I/we understand that, and give consent to, the first billing may be within 10 days of sending you confirmation that your chosen account will be debited.
7. I/we will be bound by the standard conditions applicable to the proposed insurance upon Partners Life Limited acceptance of this application; and
8. I/we have been advised a specimen policy document is available to me/us on request from Partners Life Limited head office; and
9. 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 10 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
10. 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
  - Employers (whether current or not); and
  - Government organisations and enterprises; and
  - Accountants and other financial advisers; and
  - Banks and financial institutions; and
  - Any credit rating agencies.
11. I/we acknowledge that the illustration attached to section 3 of this application (or any subsequently signed illustrations which are to amend the original illustration) forms part of the application and sets out the insured benefits I/we are applying for; and
12. I/we accept any pre-acceptance exclusions listed in section 10 of this application form will be applied to the benefits included under this policy; and
13. I/we agree that a photocopy, facsimile or scan of this application form, declaration and consent will be as valid as the original.

Date  /  /

Date  /  /

Date  /  /

Date  /  /

Parent or guardian if life to be assured is under the age of 16.

Date  /  /

## 12.0 Adviser details

Adviser's name

Adviser code

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# Direct Debit Authority

## Bank instructions

Name of account	<b>AUTHORITY TO ACCEPT DIRECT DEBITS (Not to operate as an assignment of agreement)</b>
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## Bank account from which payments to be made

Bank	Branch	Account number										Suffix							

(Please attach an encoded deposit slip to ensure your number is loaded correctly)

<b>Authorisation code</b> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; line-height: 20px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; line-height: 20px;">3</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; line-height: 20px;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; line-height: 20px;">9</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; line-height: 20px;">6</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; line-height: 20px;">3</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; line-height: 20px;">7</div> </div>
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### To: The Bank Manager

Bank
Branch
Town/city

I/we authorise you until further notice, to debit my/our account with all amounts which Partners Life Limited (hereinafter referred to as the initiator), the registered Initiator of the above authorisation code, may initiate by direct debit. I/we acknowledge and accept that the bank accepts this authority only upon the conditions listed on the reverse of this form.

## Policy details

Name(s) of policy owner(s)	Policy number(s) for which this authority applies
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## Information to appear on my/our bank statement

P A R T N E R S L I F E		
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Your signature(s)		Date    /    /
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**PLEASE ATTACH DEPOSIT SLIP**

<p>Approved</p> <p style="text-align: center;">1963</p> <hr style="width: 100%;"/> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-right: 1px solid black; padding: 5px;">03</td> <td style="padding: 5px;">11</td> </tr> </table>	03	11	<p style="text-align: center;">For Bank use only original – retain at branch</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 33%; padding: 5px;">Date received:</td> <td style="border: 1px solid black; width: 33%; padding: 5px;">Checked by:</td> <td style="border: 1px solid black; width: 33%; padding: 5px;">Recorded by:</td> </tr> </table>	Date received:	Checked by:	Recorded by:	<p>Bank stamp</p>
03	11						
Date received:	Checked by:	Recorded by:					

# Conditions of this Authority

## 1.0 The initiator

- a) Undertakes to give notice to the acceptor of the commencement date, frequency and amount at least 10 calendar days before the first direct debit is drawn (but no more than 2 calendar months). This notice will be provided either:
  - i) in writing; or
  - ii) by electronic mail where the customer has provided prior written consent to the Initiator.

Where the direct debit system is used for the collection of payments which are regular as to frequency, but variable as to amounts. The initiator undertakes to provide the acceptor with a schedule detailing each payment amount and each payment date. In the event of any subsequent change to the frequency or amount of the direct debits, the initiator has agreed to give advance notice of **at least 30 days before** changes come into effect. This notice must be provided either:

- i) in writing; or
  - ii) by electronic mail where the customer has provided prior written consent to the initiator.
- b) May, upon the relationship which gave rise to this authority being terminated, give notice to the bank that no further direct debits are to be initiated under the authority. Upon receipt of such notice the bank may terminate this authority as to future payments by notice in writing to me/us.

## 2.0 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.

## 3.0 The customer acknowledges that:

- a) This authority will remain in full force and effect in respect of all direct debits passed to my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the bank.
- b) In any event this authority is subject to any arrangement now or hereafter existing between me/us and the bank in relation to my/our account.
- c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the bank except in so far as the direct debit has not been paid in accordance with this authority. Any other disputes lies between me/us and the initiator.
- d) Where the bank has used reasonable care and skill in acting in accordance with this authority, the bank accepts no responsibility or liability in respect of:
  - the accuracy of information about direct debits on bank statements
  - any variations between notices given by the initiator and the amounts of direct debits.
- e) The bank is not responsible for, or under any liability in respect of the initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the initiator.
- 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 payment is a person other than me/us is a matter between me/us and the debtor concerned.

## 4.0 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.

## Credit Card Authority

Visa or MasterCard only\*

Payment type      Debit card       Visa       MasterCard

Expiry date

Credit/debit card account number

I/we authorise you, until further notice, to debit my/our credit/debit card account with all amounts which Partners Life Limited may initiate by credit/debit card.

Date

Payment frequency:

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

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

Partners Life Limited  
PO Box 33040, Takapuna  
Auckland 0740  
New Zealand  
0800 14 54 33  
[partnerslife.co.nz](http://partnerslife.co.nz)

## 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 of policy owner	
Name of company	
Type of contract/plan/policy	Annual premium or contribution \$

Is initial commission being received in relation to the new contract? Y | N

Is renewal commission being taken as an alternative form? Y | N

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

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

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

Life assured	Benefit type	Sum assured	Commencement date	Cancellation date	Acceptance terms*

\* 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?

### Details of replacement – statement by adviser/intermediary

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


**b) The policy replaced cannot adequately fulfill the owner's objectives because:**


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


Name of adviser/intermediary

Address of adviser/intermediary

Adviser code       Phone (  )

Your signature/s  Date  /  /

### Advice to policy owner(s)

You might find this advice 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 Partners Life Limited will refund any premium, deposit or other payment made in respect of the new contract/plan/policy.

Date

## 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 drivers licence
- New Zealand firearms licence
- New Zealand bank issued credit card or debit card
- New Zealand bank issued pre-printed deposit slip.

d) Identification

### Policy owner 1

- Identification previously provided
- Pre-printed deposit slip enclosed
- Photographic identification (e.g. current passport or drivers licence)

Type

Number (if applicable)

Expiry date (if applicable)     /     /

- Credit card      Debit card

Type

Number (if applicable)

Expiry date (if applicable)     /     /

### Policy owner 2

- Identification previously provided
- Pre-printed deposit slip enclosed
- Photographic identification (e.g. current passport or drivers licence)

Type

Number (if applicable)

Expiry date (if applicable)     /     /

- Credit card      Debit card

Type

Number (if applicable)

Expiry date (if applicable)     /     /

## Adviser declaration

I confirm that I have sighted the above identification documents as proof of identity in respect of the policy owner(s)

Name of adviser (please print)

Adviser signature

Date

Partners Life Limited  
PO Box 33040, Takapuna  
Auckland 0740  
New Zealand  
0800 14 54 33  
[partnerslife.co.nz](http://partnerslife.co.nz)