

DECLARATION OF CONTINUED GOOD HEALTH

Policy number	<input type="text"/>	Date of original Application	<input type="text"/> / <input type="text"/> / <input type="text"/>
Full name of Life to be Assured	<input type="text"/>		
Height & weight of Life to be Assured	<input type="text"/> cms/feet & inches	<input type="text"/>	<input type="text"/> kgs/lbs

1. Questions a - h must be completed for all benefits

a) Have you experienced ANY health problems or received or considered seeking any advice, counselling, tests, treatment or operation from a health professional since completing your application for the policy referred to above ("Application")? Yes No If YES, please give details

b) Have you been advised to undergo ANY operation, treatment, or tests in the future? Yes No If YES, please give details

c) Have your occupation or duties changed since completing your Application? Yes No If YES, please give details

d) Have you participated in any hazardous occupation or pursuit since completing your Application or do you intend to participate in any hazardous occupation or pursuit? Yes No If YES, please give details

e) Has ANY other insurance you have applied for been declined, deferred, withdrawn, or accepted with a premium loading or exclusion since completing your Application? Yes No If YES, please give details

f) Has there been ANY change in your family's medical history since completing your Application? Yes No If YES, please give details

g) Has there been ANY change in ANY other circumstance that could affect the risk on your health since completing your Application? Yes No If YES, please give details

h) Have you smoked in the last 12 months? If YES, what and how many a day? Yes No If YES, please give details

2. Questions i – j must also be completed for one or more of the following benefits: Disability Income, Total Permanent Disablement, Waiver of Premium, Essential Disability Income, Business Overheads and Locum Cover.

i) What is your annual income (earned income after business expenses but before tax) for the period since completing your Application, to now?

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j) Have you made a claim on any other disability policy or required full or part time care since applying for the above benefits?

Yes No If YES, please give details

3. Declaration and consent to be completed by all applicants

I declare and agree that:

- a) This Declaration of Continued Good Health (“Declaration”) forms part of my application for insurance with Sovereign Assurance Company Limited (“Sovereign”).
- b) If I fail to provide any information that is material to Sovereign’s decision as to whether to accept my application or what terms to apply to my insurance, then Sovereign may cancel the insurance or avoid the insurance from inception. The answers on this Declaration, whether or not they are in my handwriting, are true and correct and I have not withheld any material information.
- c) If I undergo any alteration in mental or physical health between the date of this Declaration and the issue of the insurance, I agree to notify Sovereign immediately as this information is relevant to any decision Sovereign may make to accept my application.
- d) The answers that I provided in the Application were true and correct at the time of the Application and I did not withhold any material information from the Application.
- e) This Declaration collects personal information about me and Sovereign will hold such information at Sovereign’s Head Office, 74 Taharoto Road, Takapuna, Auckland. I have rights under the Privacy Act 1993 to access and request correction of such information.
- f) I consent to the use of the personal information provided in this Declaration by Sovereign, its related companies, officers, advisers and reinsurers for the purposes of assessment of my application and the maintenance and administration of my insurance.

Signature of Life to be Assured

Date

Confirmation by parent/ guardian if Life to be Assured is under 16 years of age. Please print full name and sign

