



## HEALTH INSURANCE APPLICATION



## GUIDE TO COMPLETING THIS HEALTH APPLICATION

We understand that the questions we ask in this form may be sensitive, but it is very important that you give us all the information that may affect your application for insurance.

If we find out at a later time that you have failed to disclose all material information, your policy can be avoided altogether.

If you prefer, you can complete this form in private and post it directly to Sovereign Assurance Company Limited, Private Bag Sovereign, Victoria Street West, Auckland 1142.

Please complete a separate Application for each Life to be Assured, using **BLOCK LETTERS**.

Application	Section 1	Section 2	Sections 3 – 5	Section 6	Sections 7 – 8	Section 9
Absolute Health	✓	X	✓	✓	✓	✓
Health Transfer For all Health transfer applications where a child on their parent's Sovereign policy is taking out their own Health policy.	✓ Life to be Assured (1)	✓	✓	X	X	✓
Supplementary Child For all Supplementary child applications where a child is to be added on their parent's Sovereign Health policy. <b>Answers to all questions should be given on the basis they relate to the Child to be Assured.</b>	✓ Enter <b>Parent's details</b> in Life to be Assured (1) and Life to be Assured (2) fields and <b>Child's details</b> in Children to be Assured field	X	X	X	✓	✓

Please indicate how you would like us to refer to this policy in future correspondence (e.g. John's Protection Plan):

Would you like this policy to be grouped with another Sovereign policy for correspondence purposes?

☐

YES

☐

NO

If YES, please list policy numbers

(NB: Not all policies can be grouped. Contact the Operations Team for details)

1. Life to be Assured (1)

Mr/Mrs/Miss/Ms

Last name

First names

Previous name (if changed)

Mailing address

Street

Suburb

Town/City

Postcode

Home address (if different)

Contact details

Home phone  
(   )

Business phone  
(   )

Mobile  
(   )

Email

Birth details

Date of birth

Day

/

Month

/

Year

Place of birth

Male

Female

What is your height and weight?

cm/feet/inches

kg/stone/lb

Life to be Assured (2)

Mr/Mrs/Miss/Ms

Last name

First names

Previous name (if changed)

Mailing address

Street

Suburb

Town/City

Postcode

Home address (if different)

Contact details

Home phone  
(   )

Business phone  
(   )

Mobile  
(   )

Email

Birth details

Date of birth

Day

/

Month

/

Year

Place of birth

Male

Female

What is your height and weight?

cm/feet/inches

kg/stone/lb

Children To Be Assured

Is this a Supplementary child's application?

YES

NO

Child one

Last name

First names

Date of birth

Day

/

Month

/

Year

Place of birth

Male

Female

Child two

Last name

First names

Date of birth

Day

/

Month

/

Year

Place of birth

Male

Female

Child three

Last name

First names

Date of birth

Day

/

Month

/

Year

Place of birth

Male

Female

Child four

Last name

First names

Date of birth

Day

/

Month

/

Year

Place of birth

Male

Female

page 1 ➔

## 2. Current Health Policy

Please complete this section for Health Transfer only and **READ SECTION 9(s) of the Declaration and Consent.**

Current Health Policy	<input type="checkbox"/> MajorCare	<input type="checkbox"/> Absolute Health				
	<input type="checkbox"/> Other	<input type="text"/>				
Current Policy Number	<input type="text"/>					
Current Policy Owner Mr/Mrs/Miss/Ms	<table><tr><td>Last name</td><td>First names</td></tr><tr><td colspan="2"><input type="text"/></td></tr></table>		Last name	First names	<input type="text"/>	
Last name	First names					
<input type="text"/>						

## 3. Policy Owner(s)

Please identify policy ownership.

<input type="checkbox"/> Life to be assured (1)	<input type="checkbox"/> Life to be assured (2)	<input type="checkbox"/> Both lives to be assured	<input type="checkbox"/> Other Please provide details below.
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If the policy is owned by a business, a company director should complete this section and provide his/her authorisation in SECTION 9.

Policy Owner Mr/Mrs/Miss/Ms	<table><tr><td>Last name</td><td>First names</td></tr><tr><td colspan="2"><input type="text"/></td></tr></table>			Last name	First names	<input type="text"/>							
Last name	First names												
<input type="text"/>													
Or													
Company name	<input type="text"/>												
Mailing address	<table><tr><td colspan="3">Street</td></tr><tr><td>Suburb</td><td>Town/City</td><td>Postcode</td></tr></table>			Street			Suburb	Town/City	Postcode				
Street													
Suburb	Town/City	Postcode											
Home address (if different)	<input type="text"/>												
Contact details	<table><tr><td>Home phone (   )</td><td>Business phone (   )</td><td>Mobile (   )</td></tr><tr><td colspan="3">Email</td></tr></table>			Home phone (   )	Business phone (   )	Mobile (   )	Email						
Home phone (   )	Business phone (   )	Mobile (   )											
Email													
Date of birth	<table><tr><td>Day</td><td>/</td><td>Month</td><td>/</td><td>Year</td></tr><tr><td colspan="5"><input type="text"/></td></tr></table>			Day	/	Month	/	Year	<input type="text"/>				
Day	/	Month	/	Year									
<input type="text"/>													

## 4. Payment Details

Premium amount	\$	Deposit enclosed	\$							
Payment frequency	<input type="checkbox"/> Weekly (direct debit only)	<input type="checkbox"/> Fortnightly (direct debit/credit card only)	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annual						
Payment method	<table><tr><td><input type="checkbox"/> Direct debit (please complete the attached Payment Authority)</td></tr><tr><td><input type="checkbox"/> Credit/Debit card (please complete the attached Payment Authority)</td></tr><tr><td><input type="checkbox"/> Group deduction</td><td>Group name</td></tr><tr><td><input type="checkbox"/> Use existing Sovereign payment details</td><td>Policy number</td></tr></table>				<input type="checkbox"/> Direct debit (please complete the attached Payment Authority)	<input type="checkbox"/> Credit/Debit card (please complete the attached Payment Authority)	<input type="checkbox"/> Group deduction	Group name	<input type="checkbox"/> Use existing Sovereign payment details	Policy number
<input type="checkbox"/> Direct debit (please complete the attached Payment Authority)										
<input type="checkbox"/> Credit/Debit card (please complete the attached Payment Authority)										
<input type="checkbox"/> Group deduction	Group name									
<input type="checkbox"/> Use existing Sovereign payment details	Policy number									
Deduction date	Day / Month / Year	Please specify date of first regular payment (between 1st and 28th)								

## 5. Benefit Details

Please attach an Illustration setting out the benefits applied for.

## 6. Personal Statement

Do you have, or are you currently applying for, any other health cover with Sovereign or any other company? (Including this application)?

☐ YES ☐ NO

If YES, please give details below

Type of Insurance	Benefit Amount	New Cover	Existing Cover	Company	
Health Insurance	Excess level \$ <input type="text"/> Specialist and tests <input type="checkbox"/> YES <input type="checkbox"/> NO	Applied for <input type="checkbox"/>	To remain in force <input type="checkbox"/>	To be replaced* <input type="checkbox"/>	<input type="text"/>

\* If 'To be replaced' has been ticked, please complete the **Replacement Policy Advice** at the back of this Application.

## 7. Health Information

If you answer YES to any of the following questions, please provide the details in the space allocated. Should you need more space to provide answers to any of the questions in this form, please use the ADDITIONAL INFORMATION section on pages 5 – 6 and write 'refer to additional information' next to the original question.

Please provide the name and address of your usual doctor and any other doctor holding your records, if different.

Indicate the name of the medical professional or clinic holding your records with an asterisk\*.

Life Assured (1)	Doctor's name	Doctor's address	
	<input type="text"/>	Patient since	Day / Month / Year
Life Assured (2)	Doctor's name	Doctor's address	
	<input type="text"/>	Patient since	Day / Month / Year
Child (1)	Doctor's name	Doctor's address	
	<input type="text"/>	Patient since	Day / Month / Year
Child (2)	Doctor's name	Doctor's address	
	<input type="text"/>	Patient since	Day / Month / Year
Child (3)	Doctor's name	Doctor's address	
	<input type="text"/>	Patient since	Day / Month / Year
Child (4)	Doctor's name	Doctor's address	
	<input type="text"/>	Patient since	Day / Month / Year

(a) Have you had a medical exam, test, x-rays or advice, treatment or surgery from a health professional in the last five years? Please ✓ YES or NO.	Life Assured (1)	Life Assured (2)	Child (1)	Child (2)	Child (3)	Child (4)
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
(b) Are you currently receiving treatment, tests or observation from a health professional? Please ✓ YES or NO.	Life Assured (1)	Life Assured (2)	Child (1)	Child (2)	Child (3)	Child (4)
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
(c) Are you considering seeking advice, treatment, tests or surgery for your health? Please ✓ YES or NO.	Life Assured (1)	Life Assured (2)	Child (1)	Child (2)	Child (3)	Child (4)
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

## 7. Health Information (continued)

- (d) Do you suffer, or have you ever suffered from, or have you ever had treatment or surgery or medical tests or prescribed medication for any of the following? Please ✓ YES or NO.

☐ YES ☐ NO

	Life Assured (1)	Life Assured (2)	Child (1)	Child (2)	Child (3)	Child (4)
Ears, eyes, nose, throat:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Oral surgery, wisdom teeth problems:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart complaint, chest pain, high blood pressure, high cholesterol:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breathing problems including asthma, bronchitis, respiratory disease:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Brain or neurological disorder such as epilepsy, stroke, multiple sclerosis:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney disease, kidney stones, kidney infections:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver disease or disorder:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

- (e) Do you suffer, or have you ever suffered from, or have you ever had treatment or surgery or medical tests or prescribed medication for any of the following? Please ✓ YES or NO.

☐ YES ☐ NO

	Life Assured (1)	Life Assured (2)	Child (1)	Child (2)	Child (3)	Child (4)
Diabetes, gout, thyroid disorder:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bladder, urinary or prostate condition:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Gastro-intestinal problems including bowel complaints, ulcers or colitis:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer, tumour or cyst:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Disease, disorder or injury to bones, muscles, joints, including arthritis and rheumatism:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Reproductive organs, gynaecological disorders, abnormal cervical smears:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breast lumps, lesions or cysts:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Varicose veins: Blood disorder including anaemia and clotting disorders:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Irregular, heavy or painful menstrual bleeding, ovarian or hormonal problems, abortion or miscarriage:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

- (f) Is your health impaired in any way? Please ✓ YES or NO.

Life Assured (1)	Life Assured (2)	Child (1)	Child (2)	Child (3)	Child (4)
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

- (g) Do you suffer from, or have you ever suffered from, any other illness, sickness, disease or injury or medical condition? Please ✓ YES or NO.

Life Assured (1)	Life Assured (2)	Child (1)	Child (2)	Child (3)	Child (4)
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you answered YES to any of the questions, please give full details below, including the name of life or child to be assured, medical condition, treatment received and dates of treatment:

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## 8. Supplementary Information

- (a) Does any life, or child, to be assured currently smoke?

If YES, please provide the names of those who smoke and details.

<input type="checkbox"/> YES <input type="checkbox"/> NO		Cigarettes (quantity per day)	Cigars (quantity per day)	Tobacco (quantity per day)	Other (please specify)
Name					
Name					
Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	When?	For how long?	
Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	When?	For how long?	

- (b) Does any life, or child, to be assured drink alcohol?

If YES please provide the names of those who drink and details.

☐ YES
 ☐ NO
 Beer (average units per week)
 Wine (average units per week)
 Spirits (average units per week)

Name	(300ml = 1 unit)	(100ml = 1 unit)	(30ml = 1 unit)
Name	(300ml = 1 unit)	(100ml = 1 unit)	(30ml = 1 unit)

- (c) Do all lives, or children, to be assured have Permanent Residence, New Zealand citizenship or a Work Permit or Student Permit with a duration exceeding two years? If NO please give full details:

☐ YES
 ☐ NO

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- (d) If we require further information to complete this application, can we use our Telephone Underwriting Service?

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Best time to call	Phone number
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Telephone underwriting is a service that helps us process your Application quickly and simply. If we require information, a Sovereign Telephone Underwriter will phone you at a time and place that is most convenient to you. They may ask you questions about your health so we can process your Application. We use this additional information to assess the acceptance terms for your Application. The information you provide will be taken down and a copy of the questions and your answers will be posted to you. We ask that you check that the details are correct and advise us of any necessary amendments, within 7 days of receiving this information.

## Additional Information

**Additional Information** (continued)

Lined area for additional information.



# 9. Declaration and Consent

Please read your duty of disclosure and declaration carefully and sign the bottom of the page to show your acceptance of these terms. Failure to make the following declaration truthfully may invalidate your insurance.

**IMPORTANT NOTICE: Your Duty of Disclosure**

Before this contract of insurance ('Insurance') is issued you have a duty to disclose to Sovereign Assurance Company Limited ('Sovereign') every matter that is material to its decision whether to accept the risk of the Insurance and, if so, on what terms. If you are not sure if something is material it is best to disclose it on the application form to be safe. You have the same duty to disclose material matters to Sovereign before you apply to vary or reinstate the Insurance. If you make a claim we may request a copy of your entire medical file from your General Practitioner and other medical providers. If it becomes apparent that you have failed to comply with your duty of disclosure to us; and we would not have issued the Insurance on the same terms if disclosure had been made, we may cancel or avoid the Insurance from inception – if the insurance is avoided Sovereign will not pay your claim.

**Life assured:**

I understand the importance of full disclosure of all information required in this application for Insurance

I consent to Sovereign obtaining my medical records from my doctor and other medical providers and have read the 'My personal information' section below.

☐ YES☐ NO

☐ YES☐ NO

THE BELOW NAMED LIFE TO BE ASSURED AND POLICY OWNER(S) DECLARE AND AGREE THAT:

- Disclosure:**
- (a) I/We have read the notice explaining my/our duty of disclosure and all the statements contained in this Application ('Application') are true and complete to the best of my/our knowledge.
  - (b) Should the Life to be Assured 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 Sovereign immediately as this information is relevant to any decision Sovereign may make to accept this Application.
  - (c) I/We understand that statements made in this Application, including statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf, forms the entire basis of the Insurance contract between me/us and Sovereign.
  - (d) I/We acknowledge that my/our adviser receives commission from Sovereign.
  - (e) I/We acknowledge that I/we are signing on behalf of any children and declare that I/we have disclosed all health information, including any pre-existing conditions, for such children and ourselves.

- Underwriting:**
- (f) I/We will be bound by the standard conditions applicable to the proposed Insurance upon Sovereign's acceptance of this Application. I/We understand that if my/our Application requires underwriting, then special terms (including special conditions, premium loadings, exclusions or maximums) may be applied to my/our policy. I/We understand that any special terms will apply from the risk commencement date of my/our Insurance. I/We understand that the special terms will be set out in the schedule to my/our policy document and will form part of my/our Insurance contract. I/We will accept the special terms if I/we either make a premium payment after the policy free look period or agree to the special terms in writing.
  - (g) I/We have read Sovereign's Telephone Underwriting information sheet and understand if additional information is required to process my/our Application for insurance, I/we may be telephoned by a Telephone Underwriter. The information that I/we provide to the Telephone Underwriter will form part of my/our Application for Insurance.
  - (h) I/We understand that if I/we do not consent to Sovereign collecting personal information on this Application and the sources listed in paragraph (I) Sovereign may not be able to undertake a full underwriting assessment which may result in Sovereign declining to offer cover or offering cover on less favourable terms than I/we may otherwise be offered.

- Premiums:**
- (i) I/We understand the Insurance proposed in this Application shall not commence until this Application has been accepted by Sovereign and the initial premium or a completed Direct Debit Authority or premium payment direction (such as a Credit Card) has been received by Sovereign.
  - (j) I/We authorise Sovereign to debit the nominated credit card account with the premiums payable for the Insurance. Sovereign may debit the credit card account with an Insurance premium even where there may be insufficient clear funds in the credit card account, but Sovereign shall not be obliged to do so. If there are insufficient funds but Sovereign debits the credit card Sovereign may also debit the credit card account with any applicable fees and charges. If the Insurance premium cannot be recovered from me/us, then Sovereign may reverse the Insurance premium payment resulting in the premiums being treated as not having been paid and Sovereign may be entitled to cancel the Insurance in accordance with the Insurance terms relating to non-payment of premiums.

- My personal information:**
- (k) I/We consent to the use of the personal information provided in this Application or obtained from any source indicated in paragraph (I) by Sovereign and/or any related companies, their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application for Insurance, for the processing of this Application and administration of the Insurance and any claims, and for promotion of insurance and investment services to me/us. I/We understand that the personal information collected will be held at Sovereign's Head Office, 74 Taharoto Road, Takapuna. I/We understand access to and correction of my/our personal information may be requested by me/us.
  - (l) I/We consent and give authority to Sovereign and/or any of its related companies to seek from, and for all and any of the following, its officers and employees, to disclose to Sovereign and/or any of its related companies, their advisers, reinsurers, and to any legal tribunal before which any question concerning the Insurance may arise, any medical, financial or other personal information affecting such Insurance which they may hold in respect of me/us:
    - Dentists • Advisers • Employers (whether current or not) • Medical laboratories • Accident Compensation Corporation • Banks and other financial institutions
    - Accountants and other financial advisers • Insurers or reinsurers (whether public or private) • Counsellors, psychologists and therapists
    - Government departments, agencies, organisations and enterprises • Registered medical practitioners and specialists (which may include an entire copy of my/our medical file)

- (m) I/We understand that the supply of the information gathered from the above sources is voluntary and that Sovereign and/or any of its related companies may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my/our Insurance.
- (n) I/We understand that in collecting information that is relevant to this application Sovereign may also receive/collect information that is not relevant to the assessment of this application for Insurance.

- Insurance Policy:**
- (o) The above answers have/have not been entered by me/us in this Application but they have been checked by me/us and no statement affecting this Insurance has been made to any representative of Sovereign that is not recorded in this Application.
  - (p) I/We acknowledge that the Illustration attached to SECTION 5 of this Application forms part of the Application and sets out the insurance benefits I/we are applying for.
  - (q) I/We have been advised that a Specimen Policy Document and the financial statements of Sovereign are available to me/us on request from Sovereign's Head Office.

- General:**
- (r) I/We understand that neither ASB Bank Limited or its subsidiaries, the Commonwealth Bank of Australia, nor any other company in the Commonwealth Bank of Australia Group, nor any of their directors, nor any other person, guarantees Sovereign Assurance Company Limited or its subsidiaries, nor any of the products issued by Sovereign Assurance Company Limited or its subsidiaries.
  - (s) **THIS PARAGRAPH ONLY APPLIES TO HEALTH TRANSFER APPLICATION** This application is made on the basis of the information disclosed to Sovereign prior to the issue of the life assured's health cover that this policy is Replacing ('Old Cover'). I/We agree that all statements that were made to Sovereign prior to the issue of the Old Cover will be deemed to have been made to Sovereign in relation to this policy. Sovereign may avoid this policy if, prior to the issue of the Old Cover, Sovereign was not informed of every matter that could be material to Sovereign's decision whether to accept the risk of, or what terms to apply to, this policy.

Please print full names of Life to be Assured

Signature of Life to be Assured

Date

Day / Month / Year

## 9. Declaration and Consent (continued)

Please print full names of  
Child / Children to be Assured  
for Absolute Health

CHILD ONE

CHILD TWO

CHILD THREE

CHILD FOUR

### PLEASE COMPLETE THIS SECTION IF THE LIFE/CHILD TO BE ASSURED IS LESS THAN 16 YEARS OF AGE

**Parent's consent where Life/Child 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 the application are true and complete to the best of my knowledge.

Relationship (please tick)

☐

Parent

☐

Guardian

**Signature of parent or guardian of Life/Child to be Assured**

Date  Day  / Month  / Year

**Please note that Sections 67B and 67C of the Life Insurance Act 1908 provide the following limitations in respect of payments able to be made by Sovereign in the event of the death of a minor:**

#### **Where deceased minor is under the age of 10 years**

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

Sovereign 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 1st day of April 1996 to any person other than:

- (i) the parents or guardians of the minor, or one of them; or
- (ii) a parent or guardian of the minor and the spouse of that parent or guardian jointly; or
- (iii) any person who had District Court approval to effect the policy on the minor; or
- (iv) an executor or administrator of any of those persons; or
- (v) a person to whom payment may be made under Section 65(2) of the Administration Act 1969; or
- (vi) any person who is entitled to that sum by virtue of any assignment of policy approved by the District Court.

Signature of Individual policy owner(s)

(if other than Life to be Assured and as named in SECTION 3 of this application form)

Date  Day  / Month  / Year

Date  Day  / Month  / Year

Date  Day  / Month  / Year

Date  Day  / Month  / Year

Signature of company policy owner(s)

I/We acknowledge that we are signing on behalf of the company as named in SECTION 3 of this application form and that I/we have the authority to do so.

Name (please print)

Job title

Signature

Date  Day  / Month  / Year

Name (please print)

Job title

Signature

Date  Day  / Month  / Year



00809-11/10

## 1. Personal Details

Title		Other		Policy Number
<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	<input type="text"/>
First Name of policy owner				Telephone Home
<input type="text"/>				<input type="text"/>
Surname of policy owner				Email Address (optional)
<input type="text"/>				<input type="text"/>

Date of first payment (between 1st and 28th of the month)

Start Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Frequency (please tick one)

☐ fortnightly ☐ monthly

## 2. Authority to Accept Direct Debits

Name of Account		<div style="border: 1px solid black; padding: 10px; text-align: center;"> <p>Authority to Accept Direct Debits</p> <p>(Not to operate as an assignment or agreement)</p> </div>																																													
<input type="text"/>																																															
Customer (Debtor) to complete Bank/Branch number and Account Number and Suffix of Account to be debited.																																															
<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> <p>Bank</p>												<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> <p>Branch number</p>											<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> <p>Account number</p>											<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> <p>Suffix</p>													
To: The Manager (Insert name of Bank and Branch)		Start Date																																													
<input type="text"/>		<input type="text"/>																																													
Address (PO Box):	Town/City:																																														
<input type="text"/>	<input type="text"/>																																														
(Hereinafter referred to as the Bank)		Authorisation Code																																													
<p>I/We authorise you until further notice in writing to debit my/our account with you all amounts which <b>Sovereign Services Limited</b> (hereinafter referred to as the Initiator) the registered Initiator of the above Authorisation Code, may initiate by Direct Debit.</p>		<table border="1"> <tr> <td>1</td><td>2</td><td>0</td><td>0</td><td>3</td><td>6</td><td>5</td> </tr> </table>	1	2	0	0	3	6	5																																						
1	2	0	0	3	6	5																																									
<p>I/We acknowledge and accept that the bank accepts this authority only upon the conditions listed on the reverse of this form.</p>																																															
Information to appear in my/our Bank Statement																																															
Payer Particulars:	Payer Code:	Payer Reference:																																													
<table border="1"><tr><td>S</td><td>O</td><td>V</td><td>E</td><td>R</td><td>E</td><td>I</td><td>G</td><td>N</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	S	O	V	E	R	E	I	G	N							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><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><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
S	O	V	E	R	E	I	G	N																																							
Your signature must appear here – Name of Account – Customer (Debtor) to complete																																															
<input type="text"/>	<input type="text"/>																																														
Authorised signature(s)	Authorised signature(s)																																														

# 1. The Initiator:

## FOR IRREGULAR PAYMENTS

- (a) Has agreed to give advance notice of the net amount of each Direct Debit and the due date of debiting at least 10 calendar days before (but not more than two calendar months) the date the Direct Debit will be initiated.

The notice will be provided either:

- (i) in writing; or
- (ii) by electronic mail where the Customer has provided prior written consent to the Initiator.

The advance notice will include the following message:

"Unless advice to the contrary is received from you by (\*date), the amount of \$\_\_\_\_\_ will be directly debited to your bank account on (initiating date)."

\*This date will be at least two (2) days prior to the initiating date to allow for the amendment of Direct Debits.

## FOR REGULAR PAYMENTS

- (b) Undertakes to give notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the date the first Direct Debit is drawn, (but not more than two 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.

## FOR BOTH IRREGULAR AND REGULAR PAYMENTS

- (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.

# 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 1 (b) 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 the Direct Debit back to 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 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 dispute 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; and
  - 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 notice in accordance with 1(a) 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 1(b) 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. 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 signed 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.

## FOR BANK USE ONLY

Approved  0036 <hr style="width: 50%; margin: 5px auto;"/> 02   02	Date Received <div style="border: 1px solid black; height: 20px; width: 100%;"></div> Checked by <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Recorded by <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Bank Stamp
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3647-06/10

Full name of policy owner	<input type="text"/>
Residential phone number	( <input type="text"/> ) <input type="text"/>
Business phone number	( <input type="text"/> ) <input type="text"/>
Email	<input type="text"/>
For which policies do you want this authority to apply?	<input type="text"/>
Date of first payment (between 1st and 28th of the month)	<input type="text"/>

## Credit card or debit card details

Card type	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa	<input type="checkbox"/> Debit Card	
Payment frequency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Half-yearly	<input type="checkbox"/> Annually
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"/>
Name on card	<input type="text"/>			
Expiry date	<input type="text"/> / <input type="text"/>			

I/We declare and agree that:

I/We authorise Sovereign to debit the nominated credit card/debit card account with the premiums payable (and any increases to those premiums), for the insurance cover provided under the policies listed above. Sovereign may debit the credit card/debit card account with an insurance premium even when there may be insufficient clear funds in the credit card/debit card account, but Sovereign shall not be obliged to do so. If there are insufficient funds but Sovereign debits the credit card/debit card, Sovereign may also debit the credit card/debit card account with any applicable fees and charges. If the insurance premium cannot be recovered from me/us, then Sovereign may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and Sovereign may be entitled to cancel the Insurance in accordance with the insurance terms relating to non-payment of premiums.

Card holder's signature	<input type="text"/>	Day <input type="text"/> / Month <input type="text"/> / Year <input type="text"/>
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**Replacement Policy – Adviser Advice**

As an Adviser you have an important role in helping the insured be aware of the risks and advantages of changing their insurance policy. The ISI requires you to complete this declaration when a life insurance policy is being replaced, exchanged, or converted. This form relates to Term Life and Disability, Trauma, and Income Protection policies.

You need to provide a copy of this form to the new insurer who will then provide a copy to the policy owner and the old insurer.

It is important to note that this is not a cancellation request and it is the client's responsibility to cancel their existing cover once their new cover has been issued.

**Full Name of Life Insured:****Date of Birth:**

.....

NEW POLICY			
TYPE	POLICY NO	INSURER	

  

POLICY BEING REPLACED			
TYPE	POLICY NO	INSURER	POLICY ISSUE DATE

**Statement by Adviser** (please complete a, b and c in all cases)

a. Please tick the specific reason(s) for the replacement of the existing policy:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Reduction in premium   | <input type="checkbox"/> Dissatisfaction with insurer/service | <input type="checkbox"/> A stronger claims paying rating |
| <input type="checkbox"/> Change of cover amount | <input type="checkbox"/> Dissatisfaction with adviser/service | <input type="checkbox"/> Improved benefits coverage      |
| <input type="checkbox"/> Change of cover type   | <input type="checkbox"/> Changing the premium structure       | <input type="checkbox"/> Other – please specify below    |

b. The policy to be replaced cannot adequately fulfil the insured's objectives because:

.....

.....

c. The following risks are not covered by the new policy, but were covered by the old policy:

.....

.....

**Adviser Declaration**

I confirm that I have taken all reasonable steps to advise the policy owner of the risks and benefits of replacing the policy(ies) mentioned in this form. To the best of my knowledge and belief the information contained in this form is true and correct. I confirm that this change is in the best interests of the life insured and/or policy owner identified on this form.

NAME: ..... SIGNATURE: .....

FIRM: ..... EMAIL ADDRESS: .....

DATE: ..... PHONE NUMBER: .....



## Replacement Policy – Customer Protection Advice



### Before you replace your policy make sure you understand the pros and cons.

Life insurance provides important protection for you and your family. When you change your policy it is important that you are aware of the risks as well as the benefits.

This form helps make sure you are aware of the consequences of your decision. This completed form will be given to your old and new insurer.

Your old insurer may contact you to confirm that your old policy was not able to meet the requirements of your new policy.

It is important to note that this is not a cancellation request and it is your responsibility to cancel your existing cover once your new cover has been issued.

### Customer Acknowledgement and Declaration

1. I/We acknowledge there may be disadvantages when replacing an existing policy such as:

**It may cost more to retain your original benefits as you grow older:** If the policy being replaced was purchased for the life insured at a younger age, it may cost more to get the same or similar benefits in the new policy.

**If there has been a change in your health, leisure activities or your occupation, this may influence your insurability with a new provider:** The new policy might contain restrictions on covers, plus exclusions for any developed or pre-existing medical conditions you may now have.

**There may be longer periods without cover:** In a new policy, features like the suicide exclusion clause or the trauma benefit waiting period may recommence, and you may be without financial protection during this time.

**Conditions or benefits may be more or less favourable:** In a new policy, the date the policy ends, its terms and conditions, and/or benefit definitions may be different from your old policy.

**Costs to set up a new policy:** Remuneration is likely to be payable to your Adviser when you replace this policy. If you would like more information ask your Adviser.

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

☐ Yes ☐ No

3. I/We acknowledge that a copy of 'Your Old Policy May Have More Life In It Than You Think' brochure has been explained to me/us.

☐ Yes ☐ No

4. Did you establish whether the existing/terminated policy could be amended to provide similar benefits to the replacement policy?

☐ Yes ☐ No

If **Yes**, can you please describe why you decided not to amend your existing policy?

.....

5. I/We confirm that the Adviser/Intermediary has fully explained the advantages and disadvantages of the replacement of the policy(ies) mentioned in this form and I/we understand the consequences of such replacement(s).

6. I/We acknowledge that a copy of the completed form will be given to both the old and new insurer.

7. I/We acknowledge that the Adviser/Intermediary explained the amount of remuneration payable from this change.

☐ Yes ☐ No

8. I/We agree to ISI collating information contained in this form, that does not identify the applicant/policy holder/insured, for aggregate replacement statistics purposes for participant insurer members.

9. Where the Insurer is offering a 'free look' period, I am/We are aware I/we may withdraw my application in writing at any time within that period. (This free look period varies between Insurers but may be up to 14 business days.)

NAME OF POLICY OWNER: ..... PLEASE PRINT

SIGNATURE OF POLICY OWNER: .....

DATE: .....





Notes

Lined area for notes, consisting of multiple horizontal lines.

Notes

Lined area for notes, consisting of multiple horizontal lines.

## FOR ADVISER USE ONLY special instructions

- This Application form should be used for Health Insurance applications.
- This form can also be used for Health Transfer applications where a child on their parent's Sovereign Health policy is taking out their own Health policy.
- If the parents of a child to be assured want to add their child to their Sovereign Health policy, then this form can be used as a Supplementary Child's application.

### Adviser Checklist

To avoid delays in processing this Application, please check the following have been received as required, before submitting the form to Sovereign:

- ☐ Personal statement complete
- ☐ Payment method identified
- ☐ Declaration signed
- ☐ Illustration attached
- ☐ Copy of any Advice on Replacement Business form (original to remain with client)
- ☐ Details of doctor holding medical records
- ☐ Payment form complete
- ☐ Commencement date identified

Credit this case to Sovereign adviser code

Group Voluntary Code

Percentage split

Initial	Renewal
---------	---------

Adviser's company

Adviser name

Please tick one

<input type="checkbox"/> Variable %	<input type="checkbox"/> Pendulum %	<input type="checkbox"/> As earned
-------------------------------------	-------------------------------------	------------------------------------

#### SECOND ADVISER (if applicable)

Credit this case to Sovereign adviser code

Group Voluntary Code

Percentage split

Initial	Renewal
---------	---------

Adviser's company

Adviser name

Please tick one

<input type="checkbox"/> Variable %	<input type="checkbox"/> Pendulum %	<input type="checkbox"/> As earned
-------------------------------------	-------------------------------------	------------------------------------

Scanned/faxed?

☐

YES

Date

Day	/	Month	/	Year
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## LIFE INSURANCE • HOME LOANS • INVESTMENTS

**TELEPHONE** +64 9 487 9994 **FACSIMILE** +64 9 488 3951  
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Takapuna, North Shore City 0622  
**PO BOX 33845** Takapuna, North Shore City 0740