

TOTALCAREMAX LIFE AND LIVING ASSURANCE APPLICATION

This application can be used only for Life applications up to \$1 million and Living Assurance applications up to \$500,000 (inclusive of all existing Sovereign cover).



1. Life to be Assured

Mr/Mrs/Miss/Ms
Previous name (if changed)
Date of birth
Home address
Postal address (if different)
Email address
Phone (home)
Mobile

Last name
First names
Male
Female

2. Ownership

Same as life assured
Mr/Mrs/Miss/Ms
Previous name (if changed)
Date of birth
Postal address
Email address
Phone (home)
Mobile

Last name
First names
Male
Female

If you answer YES to any of the questions below, we may need to contact you for more information.

If we require further information to process your application quickly, can we use our Telephone Underwriting service?

If we require that you undergo medical tests, would you use our HealthScreen® service?

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

Children to be assured

Child 1
Date of birth
Place of birth

Child 2
Date of birth
Place of birth

Child 3
Date of birth
Place of birth

Child 4
Date of birth
Place of birth

3. Benefit details

Please attach Illustrations setting out benefits applied for.

4. Personal statement

Occupation
Industry

In the course of this, do you have to work

Please indicate your residency status

Do you intend to live, work or travel overseas in the next 12 months?

If YES, Please give details below:

Do you have, or are you currently applying for, any other life, income protection, trauma or health cover with Sovereign or any other company?

If YES, Please give details below:

Name of company	Type of cover	Sum insured	Date commenced	To be replaced?
				Yes No
				Yes No
				Yes No

Has any insurance you have, or you have applied for, ever been declined, deferred or modified including any loadings or exclusions?

If YES, Please give details:

Have you smoked in the last 12 months?

If YES what and how much do you smoke?

Amount per day

Height

Weight



00471-02/10

4. Personal statement (continued)

Do you use, or have you ever used recreational and/or non-prescription drugs (except 'over the counter' medications)? ☐ Yes ☐ No

If YES, Please give details:

How many standard alcoholic drinks do you consume per week on average? (Standard drink = 1 nip or 30ml spirits, 100ml wine, 300ml beer) Standard drinks/week

Do you engage, or intend to engage in, any of the following hazardous sports or activities? ☐ Yes ☐ No If YES, please specify:

☐ Aviation ☐ Motor racing ☐ Motor boat racing ☐ Diving ☐ Mountaineering

☐ Other (specify)

Please give details:

Have either of your parents or any of your brothers or sisters suffered from (before the age of 60 : diabetes, stroke, heart disease, high blood pressure, kidney disease, polycystic kidney, cancer (please specify type), Huntington's chorea, mental illness, dementia, or any hereditary or familial disease. ☐ Yes ☐ No

If YES, Please give details:

Have you ever suffered from any of the following illnesses/conditions?

Stroke, spinal injury, neurological condition (e.g. MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disease (e.g. anaemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nervous disorder (e.g. depression)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disorders (e.g. asthma or emphysema)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, tumour, cyst, melanoma, skin lesion/condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney, bladder, prostate, ovarian disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech impairment, loss of hearing, vision impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes, thyroid disorder, or any other glandular condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disorder (e.g. hepatitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease or disorder of cervix, breast, uterus, fallopian tube or ovary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach, pancreas, gall bladder, bowel, intestinal or oesophageal disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain, heart disease or disorder (e.g. high blood pressure or high cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No

☐ Other (please specify)

Condition	Date of first symptoms	Date of last symptoms	Details (include treatment, test results, time off work, recurrence, current status)
<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"/>
<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"/>
<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"/>

Are you currently experiencing any health problems, or are you considering seeking medical advice, counselling, tests, treatment or an operation which is not disclosed above from any health professional? ☐ Yes ☐ No

If YES, Please give details:

Provide the details below of general practitioners, specialists or medical centres you have attended in the last five years

Name of GP, specialist or clinic	Reason for visiting	Address	Years/months attended	Date of your last visit	Do they hold your medical records?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sovereign may require your medical notes from the last five years or longer, depending on the information you have disclosed. Your consent to Sovereign accessing these notes is set out in Section 5 (I).

Please use the space below to provide further details

FOR ADVISERS USE ONLY:	Credit this case to Sovereign adviser code	<input type="text"/>	Adviser name	<input type="text"/>	Adviser's company	<input type="text"/>	
	Percentage split	<input type="text"/> Initial	<input type="text"/> Renewal				
	Group name	<input type="text"/>			Campaign code	<input type="text"/>	
	Please tick one	<input type="checkbox"/> Variable	%	<input type="checkbox"/> Pendulum	%	<input type="checkbox"/> As earned	%

5. 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 the life assured understand the importance of full disclosure of all information required in this application for insurance

☐ 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 consent to the use of the personal information provided in this Application or obtained from any source indicated in paragraph (l) 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.
- (h) 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.
- (i) I/We understand that if I/we do not consent to Sovereign collecting personal information from the Application and the sources listed in paragraph (l) 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:

- (j) 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.
- (k) I/We authorise Sovereign to debit the nominated credit card account with the premiums payable pursuant to the Insurance premium. 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:

- (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 4 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.

Please print full names of Life to be Assured

Signature of Life to be Assured

Date

 / /

Signature(s) of Policy Owner(s)

Payment details

Payment method	<input type="checkbox"/> Direct Debit (Please fill in details below)	<input type="checkbox"/> Credit/Debit card (Please fill in details below)	<input type="checkbox"/> Cheque
Premium amount	\$ <input type="text"/>		Deposit enclosed \$ <input type="text"/>
Payment frequency	<input type="checkbox"/> Weekly <input type="checkbox"/> Fortnightly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		Please specify date of first regular payment, e.g. 17th <input type="text"/> Use existing Sovereign Direct Debit <input type="text"/> Policy number
Direct Debit details	<input type="checkbox"/> I have read and understand the terms and conditions (see below) <input type="checkbox"/> I am the account holder (if not, please complete separate Direct Debit form)		
Account details	Name of account <input type="text"/> <div style="display: flex; justify-content: space-between;"> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Bank Branch number </div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Account number </div> <div> <input type="text"/> <input type="text"/> <input type="text"/> Suffix </div> </div>		Authorisation code <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 3 <input type="text"/> 6 <input type="text"/> 5
Credit/Debit card details	<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa 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"/> Name on card <input type="text"/> Expiry date <input type="text"/> / <input type="text"/>		
Other payment types	<input type="checkbox"/> Annual cheque Please make cheques payable to Sovereign Services Limited . Cheques should be marked 'not transferable' or 'account payee only'.		
Authorised signature	<input type="text"/>		Date <input type="text"/> / <input type="text"/> / <input type="text"/>

Direct Debit Terms and Conditions

1. **The Initiator:**

10-DAY ADVANCE NOTICE OF EACH DIRECT DEBIT

(a) Has agreed to give written 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 advance 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 due date to allow for the amendment of Direct Debits.

REGULAR PAYMENTS

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

(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(a) and (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 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. **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) The Bank accepts no responsibility or liability for the accuracy of information about payments on Bank Statements.

(e) The Bank is not responsible for, or under any liability in respect of:

 - any variations between notices given by the Initiator and the amounts of Direct Debits.
 - 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 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 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.



00483-02/10