TotalCare**Max**

Life & Health Application

CLIENT NAME

ADVISER CODE

DATE

SOVEREIGN

GUIDE TO COMPLETING THIS LIFE AND 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 not disclosed 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**.

	Section 1–5	Section 6	Section 7	Section 8	Section 9	Section 10	Section 11
Life	✓	✗	✓ If YES to any health question in **Section 5**	✓ If YES to question (i) in **Section 5**	✗	✗	✓
Living Assurance - Early Cancer Upgrade	✓	✓ (optional Children's and maternity Benefit only)	✓ If YES to any health question in **Section 5**	✓ If YES to question (i) in **Section 5**	✗	✗	✓
Progressive Care	✓	✗	✓ If YES to any health question in **Section 5**	✓ If YES to question (i) in **Section 5**	✗	✗	✓
Disability Income Protection - Retirement Protection benefit Essential Disability Income Protection Total Permanent Disablement Mortgage and Income Protection Redundancy Start-Up Income Protection Locum Cover Business Overheads Rural Continuity - Business Income Support Waiver of Premium	✓	✗	✓	✓ If YES to question (i) in **Section 5**	✓	✗	✓
Business Continuity	✓	✗	✓ If YES to any health question in **Section 5**	✓ If YES to question (i) in **Section 5**	✓	✓	✓
Absolute Health	✓	✓ Children Only	✓ If YES to any health question in **Section 5**	✓ If YES to question (i) in **Section 5**	✗	✗	✓
Specialist and Diagnostic Testing	✓	✓ Children Only	✓ If YES to any health question in **Section 5**	✓ If YES to question (i) in **Section 5**	✗	✗	✓

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)

Is this application part of a joint policy? ☐ YES ☐ NO If YES, please complete a separate application form for each Life to be Assured

1. Life to be Assured

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

Date of birth

Day / Month / Year | Place of birth | ☐ Male ☐ Female

Occupation | Industry

Do you smoke, or have you been a smoker in the past 12 months?

☐ YES ☐ NO If YES, for how many years have you smoked? years

If yes, please state the type and quantity smoked e.g. Cigarettes, Tobacco, Cigars.

Cigarettes (average per day) | Tobacco (average per day) | Cigars (average per day)

2 Policy Owner(s)

If the policy is owned by a business, a company director should complete this section and provide his/her authorisation in SECTION 10

POLICY OWNER (1)

Mr/Mrs/Miss/Ms

☐ as above, **or**

Last name | First names

or Company name

Mailing address

Street

Suburb | Town/City | Postcode

Home address (if different)

Contact details

Home phone ( ) | Business phone ( ) | Mobile ( )

Date of birth

Day / Month / Year | Email

POLICY OWNER (2)

Mr/Mrs/Miss/Ms

☐ as above, **or**

Last name | First names

or Company name

Mailing address

Street

Suburb | Town/City | Postcode

Home address (if different)

Contact details

Home phone ( ) | Business phone ( ) | Mobile ( )

Date of birth

Day / Month / Year | Email

< THIS SECTION MUST BE COMPLETED >

3. Payment Details

Premium amount $ Deposit enclosed $

Payment frequency ☐ Weekly (direct debit only) ☐ Fortnightly (direct debit/credit card only) ☐ Monthly ☐ Annual

Payment method ☐ Direct debit (please complete the attached Payment Authority)

☐ Credit/Debit card (please complete the attached Payment Authority)

☐ Annual cheque Please make cheques payable to Sovereign Services Limited. Cheques should be marked 'not transferable' or 'account payee only'

☐ Use existing Sovereign payment details Policy number

Deduction date Day / Month / Year Please specify date of first regular payment (between 1st and 28th)

4. Benefit Details

Please attach Illustration setting out benefits applied for.

5. Personal Statement

Should you need more space to provide answers to any of the questions in this form, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

(a) Do you have, or are you currently applying for, any other Life, Income Protection, Trauma, Total Permanent Disablement or Health cover with Sovereign or any other company? ☐ YES ☐ NO

If YES, please give details below

Type of Insurance	Benefit Amount	New Cover: Applied for	Existing Cover: To remain in force	Existing Cover: To be replaced*	Company
Life	$	☐	☐	☐	
	$	☐	☐	☐	
Total Permanent Disablement	$	☐	☐	☐	
	$	☐	☐	☐	
Disability Income	$	☐	☐	☐	
	$	☐	☐	☐	
Mortgage and Income Protection	$	☐	☐	☐	
Redundancy	$	☐	☐	☐	
Retirement Protection Benefit	$	☐	☐	☐	
Living Assurance	$	☐	☐	☐	
	$	☐	☐	☐	
Progressive Care	$	☐	☐	☐	
	$	☐	☐	☐	
Health Insurance	Excess level $	☐	☐	☐	
Specialist and Diagnostic Testing	Excess level $	☐	☐	☐	

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

IMPORTANT NOTES:

- To assess your eligibility for the level of cover for which you are applying, Sovereign needs to know your level of existing cover and whether this cover is being replaced by the insurance you are applying for.
- If this application for insurance is intended to replace the existing cover listed above, you must cancel that existing cover. If you do not cancel the existing cover listed above, any claim made by you to Sovereign for the insurance applied for and accepted may not be considered.

< THIS SECTION MUST BE COMPLETED >

5. Personal Statement (continued)

(b) If you do not currently have any Life, Income Protection, Trauma, Total Permanent Disablement or Health cover with Sovereign, have you ever had any life, income protection, trauma or health cover with Sovereign? ☐ YES ☐ NO

(c) What is your height and weight? cm/feet/inches | kg/stone/lb

(d) Has any insurance you currently have, or have applied for (e.g. Life, Income Protection), ever been declined, deferred or modified including any loadings or exclusions? ☐ YES ☐ NO If YES, please give full details

(e) Have you ever claimed benefits from ACC/WINZ or an insurer due to sickness, injury or treatment for injury (e.g. physiotherapy)? ☐ YES ☐ NO If YES, please give name of condition below, and give details in the **General Health Questionnaire** in SECTION 7

Name of condition

(f) i. Please indicate your New Zealand residency status ☐ Citizen/ Permanent resident ☐ Work permit - Please enclose a copy ☐ Long-term business visa and permit ☐ Other

ii. How long have you resided in New Zealand? / Years/Months

(g) Do you intend to live, work or travel overseas within the next 12 months? ☐ YES ☐ NO If YES, please tick purpose and give details below ☐ Live ☐ Work ☐ Travel

Country | Start date | Duration

(h) Do you drink alcohol? ☐ YES ☐ NO If YES, please give details below

Beer (average units per week) (300ml = 1 unit) | Wine (average units per week) (100ml = 1 unit) | Spirits (average units per week) (30ml = 1 unit)

(i) Do you participate, intend to participate, or in the last three years have you participated, in any hazardous occupation or pursuit (e.g. motor racing, aviation, martial arts, parachuting, scuba diving, senior rugby or motor boat racing)? ☐ YES ☐ NO

If YES, please complete the **Hazardous Occupation or Pursuit Questionnaire** in SECTION 8

(j) i. **Family history**
Please indicate whether, **before the age of 60**, a parent, sister or brother has suffered from one of the following conditions: (Please tick YES or NO, if YES please give details)

CONDITION	YES	NO	RELATIONSHIP TO YOU	AGE when diagnosed (if known)	Current AGE	If deceased, AGE at death
Diabetes	☐	☐				
Stroke	☐	☐				
Mental illness	☐	☐				
Dementia	☐	☐				
Kidney disease	☐	☐				
Heart disease	☐	☐				
High blood pressure	☐	☐				
Cancer*	☐	☐				
Huntington's chorea	☐	☐				
Polycystic kidney	☐	☐				
Multiple Sclerosis	☐	☐				
Any hereditary or familial disease	☐	☐				

ii. If you ticked one of the above conditions, and your family member is not deceased, please give details of his/her current state of health

* For cancer please specify type

< THIS SECTION MUST BE COMPLETED >

5. Personal Statement (continued)

(k) Have you ever used any drug, not prescribed by a doctor, or received medical advice, counselling or treatment for the use of alcohol, drugs or gambling?

☐ YES ☐ NO If YES, please give full details

(l) In the last five years, have you had any medical examinations by a doctor or specialist, tests or X-rays?

☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 7

(m) Have you had surgery or been in hospital before?

☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 7

(n) Are you currently experiencing any health problems or are you receiving or considering seeking medical advice, counselling, tests, treatment or an operation from a health professional?

☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 7

(o) Have you ever had, or have you ever been diagnosed with or treated for, any of the following?

If YES, please complete the **General Health Questionnaire** in SECTION 7. If your symptom is underlined, please refer to the questionnaire specific to that condition.

Chest pain, heart complaint, high blood pressure or high cholesterol	☐ YES	☐ NO
Thyroid disorder or any other glandular condition	☐ YES	☐ NO
Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder or any other lesion	☐ YES – please complete **questionnaire i**	☐ NO
Any disease or disorder of the gastrointestinal tract or bowel e.g. irritable bowel, Crohn's disease, ulcers, colitis, reflux etc.	☐ YES – please complete **questionnaire ii**	☐ NO
Obesity e.g. stomach stapling or liposuction	☐ YES	☐ NO
Mental, nervous disorder, stress, depression, fatigue or phobia	☐ YES – please complete **questionnaire iii**	☐ NO
Blood disorders e.g. anaemia, varicose veins, blood clots, bleeding tendencies, leukaemia	☐ YES	☐ NO
Kidney problems, prostate, bladder or urinary condition e.g. weakness of the bladder, kidney stone etc.	☐ YES	☐ NO
Epilepsy, stroke or other neurological disorders e.g. motor neurone disease, multiple sclerosis, paralysis or seizures	☐ YES	☐ NO
Asthma or lung complaint e.g. bronchitis or breathing problems	☐ YES – please complete **questionnaire iv**	☐ NO
An injury, disease or disorder of your: • muscle, or • joint, or • bone. eg. arthritis, rheumatism, SLE, gout	☐ YES – please complete **questionnaire v**	☐ NO
Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis, ear infections etc	☐ YES	☐ NO
AIDS or HIV antibodies	☐ YES	☐ NO
Liver disease or disorder e.g. hepatitis etc.	☐ YES	☐ NO
Disease or disorder of cervix, breast, uterus, fallopian tube, ovary, vagina or vulva e.g. endometriosis etc.	☐ YES	☐ NO
Diabetes or abnormal blood sugar level	☐ YES	☐ NO
Any other illness, injury or condition not already stated	☐ YES	☐ NO

< THIS SECTION MUST BE COMPLETED >

5. Personal Statement (continued)

Health questions

If you are applying for Absolute Health in conjunction with TotalCareMax or Start-Up Income Protection, please answer the following questions. If children are to be insured as part of your Absolute Health policy, please complete SECTION 6.

(p) Do you suffer from, 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?

If YES, please complete the **General Health Questionnaire** in SECTION 7

Oral surgery or wisdom teeth problems	☐ YES	☐ NO
Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence.	☐ YES	☐ NO

Doctors' details

(q) Please give the details of any medical professional or clinic you have consulted in the last five years

Name of medical professional or clinic

Does this professional hold your records? ☐ YES ☐ NO

Mailing address

Business phone ( )

Business fax ( )

Years attended

Last date you attended

Reason

Name of medical professional or clinic

Does this professional hold your records? ☐ YES ☐ NO

Mailing address

Business phone ( )

Business fax ( )

Years attended

Last date you attended

Reason

Name of medical professional or clinic

Does this professional hold your records? ☐ YES ☐ NO

Mailing address

Business phone ( )

Business fax ( )

Years attended

Last date you attended

Reason

I/We understand that Sovereign may require my/our medical records from the last five years or longer, depending on the information I/we have disclosed

☐ YES ☐ NO

Your consent to Sovereign accessing these records is set out in Section 11 (n).

HealthScreen

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

☐ YES ☐ NO

HealthScreen® has been developed to provide you with an efficient, convenient and professional means of gathering medical information required for processing your Application for insurance.

Depending on your amount of cover and/or your medical history, different tests or medical questionnaires may be necessary. Usually your doctor or a specialist is responsible for providing this service and the necessary documentation. HealthScreen® provides an easier, more efficient way of gathering this information.

This is a completely confidential service provided free of charge. It enables a medical assessment to be conducted by a Registered Nurse at a time and place that is convenient for you.

Telephone Underwriting

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

☐ YES ☐ NO

Phone number ( )

Best time to call am/pm

Telephone Underwriting is a service that helps us process your Application quickly and simply. If we require further information, a Sovereign Telephone Underwriter will phone you at a time and place that is convenient for you. They may ask you questions about your health, your occupation or hazardous pursuits so we can process your Application. We use this additional information to assess the acceptance terms of 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 amendments, if necessary, within seven days of receiving this information.

< THIS SECTION MUST BE COMPLETED >

6. Children To Be Assured (Absolute Health, optional Children's and Maternity Benefit and Specialist and Diagnostic Testing Benefit Only)

This section applies to Absolute Health, the optional Children's and Maternity Benefit* and the Specialist and Diagnostic Testing Benefit. If applying for Absolute Health and the Specialist and Diagnostic Testing Benefit all questions need to be completed. Answers to all questions should be given by the parent or guardian on the basis that they relate to the child to be assured. If there are more than four children to be assured please complete the Health Insurance Application.

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 ☐

* Please note Section 6(a) to 6 (f) is not required to be completed if only applying for the Comprehensive Living Assurance optional Children's and Maternity Benefit.

< THIS SECTION MUST BE COMPLETED >

	Child one	Child two	Child three	Child four
(a) **Doctors' details** i. Please give the name and mailing address of any doctors the child has consulted in the last five years				
ii. and the doctor holding the child's records				
(b) Does the child smoke, or have they been a smoker in the past 12 months?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If YES, please state the type and quantity smoked (eg Cigarettes, tobacco or cigars)	Type Average per day	Type Average per day	Type Average per day	Type Average per day
(c) Does the child have permanent residency status in New Zealand?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If NO, please give details				
(d) Has the child had any medical examination or consultation, test, X-rays, treatment or surgery in the last five years, or is the child currently undergoing treatment, tests or observations or considering seeking advice, treatment or counselling for their health? (Disregard minor ailments such as colds or flu.) If YES, please give details in the **General Health Questionnaire** in SECTION 7	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

6. Children To Be Assured (continued)

(e) Has the child ever had, or ever been diagnosed with or treated for, any of the following:

If YES, please complete the **General Health Questionnaire** in SECTION 7.

If the child's symptom is underlined, please refer to the questionnaire specific to that condition.

	Child 1	Child 2	Child 3	Child 4
Chest pain, heart complaint, high blood pressure or high cholesterol	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Thyroid disorder or any other glandular condition	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder or any other lesion If YES – please complete **questionnaire i**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Any disease or disorder of the gastrointestinal tract or bowel e.g. irritable bowel, Crohn's disease, ulcers, colitis, reflux If YES – please complete **questionnaire ii**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Obesity e.g. stomach stapling, liposuction	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Mental, nervous disorder, stress, depression, fatigue or phobia If YES – please complete **questionnaire iii**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Blood disorders e.g. anaemia, varicose veins, blood clots or bleeding tendencies, leukaemia	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Kidney problems, prostate, bladder or urinary condition e.g. weakness of the bladder, kidney stone etc.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Epilepsy, stroke or other neurological disorders e.g. motor neurone disease, multiple sclerosis, paralysis, seizures etc.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Asthma or lung complaint e.g. bronchitis, breathing problems etc. If YES – please complete **questionnaire iv**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
An injury, disease or disorder of your: • muscle, or • joint, or • bone. e.g. arthritis, rheumatism, SLE or gout If YES – please complete **questionnaire v**	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis, ear infections etc	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
AIDS or HIV antibodies	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Liver disease or disorder e.g. hepatitis etc	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Disease or disorder of cervix, breast, uterus, fallopian tube or ovary e.g. endometriosis etc.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Diabetes or abnormal blood sugar level	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Any other illness, injury or condition not already stated	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

(f) Does the child suffer from or has the child ever suffered from or ever had treatment or surgery or medical tests or prescribed medication for, any of the following:

If YES, please complete the **General Health Questionnaire** in SECTION 7.

	Child 1	Child 2	Child 3	Child 4
Oral surgery or wisdom teeth problems	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

7. General Health Questionnaire

Please complete this section if you answered YES to any of the selected questions in SECTIONS 5 or 6. If you need extra space to provide your response, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name | First names

	CONDITION	CONDITION
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

Life to be Assured / Child

Last name | First names

	CONDITION	CONDITION
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

7. General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name	First names

	CONDITION	CONDITION
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

Life to be Assured / Child

Last name	First names

	CONDITION	CONDITION
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

7. General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name | First names

	CONDITION	CONDITION
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

Life to be Assured / Child

Last name | First names

	CONDITION	CONDITION
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

7. General Health Questionnaire (continued)

i. Tumour questionnaire

Please complete this section if you answered YES for **cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder, or any other lesion.**

Life to be Assured / Child — Last name | First names

(a) What was the site of the tumour?

(b) Histology of the tumour if known — ☐ Benign ☐ Malignant or pre-malignant ☐ Unknown

(c) How long ago was the initial diagnosis made? — ☐ Years ☐ Months

(d) Have you received treatment within the last three years? — ☐ YES ☐ NO — If YES, please give details

(e) Has there been any recurrence? — ☐ YES ☐ NO — If YES, please give details

(f) Are you undergoing any ongoing follow-up or have you been advised that follow-up treatment is required? — ☐ YES ☐ NO — If YES, please give details

(g) Date of last cervical smear, mammogram or other routine screening? — Day / Month / Year — Result

ii. Gastrointestinal tract/bowel questionnaire

Please complete this section if you answered YES for **any disease or disorder of the gastrointestinal tract or bowel e.g. irritable bowel, Crohn's disease, ulcers, colitis or reflux.**

Life to be Assured / Child — Last name | First names

(a) Do you suffer, or have you ever been advised by a medical practitioner that you suffer, from:

☐ Indigestion ☐ Heartburn ☐ Gastro-oesophageal reflux ☐ Hiatus hernia
☐ Gastritis ☐ Ulcer ☐ Ulcerative colitis ☐ Crohn's disease
☐ Irritable bowel syndrome ☐ Other

If OTHER, please give name of condition

(b) Have you ever consulted a specialist about symptoms of any of the above? — ☐ YES ☐ NO

(c) Are you on continuous medication? — ☐ YES ☐ NO — If YES, is your medication prescribed by your GP/specialist? ☐ YES ☐ NO

(d) Have you ever had any investigations of the gastrointestinal tract? — ☐ YES ☐ NO — If YES, please give details below

Name of investigation	**Result** Normal	Abnormal	Unknown
	☐	☐	☐

Name of investigation	**Result** Normal	Abnormal	Unknown
	☐	☐	☐

(e) How frequently do you suffer from symptoms? — times per year

(f) When were your last symptoms? — Day / Month / Year

7. General Health Questionnaire (continued)

iii. Mental health questionnaire

Please complete this section if you answered YES for **mental, nervous or stress disorder, depression, fatigue or phobia**.

Life to be Assured / Child

Last name | First names

(a) Do you suffer, or have you ever been advised by a medical practitioner that you suffer, from:

☐ Anxiety ☐ Compulsive disorder ☐ Headaches ☐ Irritability
☐ Stress ☐ Fear or phobia ☐ Hyperventilation ☐ Depression
☐ Fatigue ☐ Sleeplessness ☐ Post-traumatic stress disorder ☐ Other

If OTHER, please give name of condition

(b) How long ago were the first symptoms? ☐ Years ☐ Months

(c) How long ago were the last symptoms? ☐ Years ☐ Months

(d) Have you had any recurrence of the symptoms? ☐ YES ☐ NO If YES, please give details

(e) Have you ever been hospitalised or had time off work or school as a result of this condition? ☐ YES ☐ NO If YES, please give details

(f) Has your condition ever led you to intentionally or unintentionally harm yourself or have suicidal thoughts? ☐ YES ☐ NO If YES, please give details

(g) Have you ever been recommended, prescribed or received treatment for any of the conditions or symptoms listed above e.g. medication or counselling? ☐ YES ☐ NO If YES, please give details

Treatment period? Date started Day / Month / Year Date ceased Day / Month / Year

(h) Have you ever been assessed by a psychiatrist or a psychologist? ☐ YES ☐ NO If YES, please give details

iv. Asthma questionnaire

Please complete this section if you answered YES for **asthma**.

Life to be Assured / Child

Last name | First names

(a) Frequency of symptoms in the last five years (please tick the appropriate box)

☐ Daily ☐ Weekly ☐ Occasionally ☐ One-off episode ☐ None – childhood only

(b) Severity of symptoms in the last five years (please tick the appropriate box)

☐ Nil symptoms – childhood only ☐ Mild, e.g. exercise-induced only, seasonal (related to hayfever allergy, colds or flu) ☐ Moderate, e.g. all year around, no specific triggers ☐ Severe, e.g. constant, reduced lung capacity, restriction of lifestyle or work duties

(c) Have you, over the last two years, required: (please tick the appropriate boxes)

☐ YES ☐ NO Daily preventative inhalers, e.g. ventolin

☐ YES ☐ NO Occasional use of a nebuliser or oral steroid medication e.g. prednisolone

☐ YES ☐ NO Hospitalisation/ emergency treatment

(d) Maximum number of consecutive days off work / school you have had over the last two years due to this condition ☐ Days

7. General Health Questionnaire (continued)

v. Musculoskeletal questionnaire

Please complete this section if you answered YES for **muscle, joint or bone disorders, injury or disease e.g. arthritis, rheumatism, SLE or gout.**

Life to be Assured / Child

Last name | First names

	CONDITION ONE	CONDITION TWO
(a) Name of condition		
Areas affected (e.g left shoulder, right knee)		
(b) How long ago did you first suffer from this condition/pain/ discomfort/injury?	Years ☐ Months ☐	Years ☐ Months ☐
(c) How long did these symptoms last?	Years ☐ Months ☐ Weeks ☐	Years ☐ Months ☐ Weeks ☐
(d) Has this condition occurred more than once?	YES – please give full details at (j) ☐ NO ☐	YES – please give full details at (j) ☐ NO ☐
(e) Have you had any special investigations or surgery?	YES – please give full details at (j) ☐ NO ☐	YES – please give full details at (j) ☐ NO ☐
(f) Have you had any time off work or school as a result of this condition?	YES – please give full details at (j) ☐ NO ☐	YES – please give full details at (j) ☐ NO ☐
(g) Are you currently receiving treatment?	YES – please give full details at (j) ☐ NO ☐	YES – please give full details at (j) ☐ NO ☐
(h) Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery may be required?	YES – please give full details at (j) ☐ NO ☐	YES – please give full details at (j) ☐ NO ☐
(i) Do you have any residual, ongoing effects or restrictions as a result of this condition?	YES – please give full details at (j) ☐ NO ☐	YES – please give full details at (j) ☐ NO ☐
(j) Please give full details if you have answered YES to question (d), (e), (f), (g), (h) or (i) above		

8. Hazardous Occupation Or Pursuit

Please complete this section if you answered YES to question (i) in SECTION 5.

	OCCUPATION / PURSUIT ONE	OCCUPATION / PURSUIT TWO
(a) Name of occupation or pursuit?		
(b) How long have you participated in this activity?	Years Months	Years Months
(c) Are you a certified instructor?	YES NO	YES NO
(d) In the last 12 months how many events / trips / climbs / jumps did you participate in?		
(e) Please advise the number of hours you engaged in this activity in the last 12 months	hours	hours
(f) Where do you participate in this activity (geographically)?		
(g) If your occupation or pursuit is scuba diving, do you ever dive alone?	YES NO	YES NO
(h) Do you have any plans to become a professional?	YES NO	YES NO
	If YES, please give details	If YES, please give details
(i) Please disclose maximum heights, speeds, depths		
(j) Please give full details including the engine size for boats or other equipment used		
(k) Are you involved in any record attempts?	YES NO	YES NO
	If YES, please give details	If YES, please give details

9. Occupation And Income Details

If you are applying for **Disability Income Protection (DI)** including **Essential DI, Loss of Earnings, Retirement Protection, Redundancy, Mortgage and Income Protection, Business Continuity, Locum Cover, Business Overheads**, **Rural Continuity** and **Start Up Income Protection** please complete questions **(a)** to **(u)**.

If you are applying for **Total Permanent Disablement (TPD)** and **Waiver of Premium** please complete questions **(a)** to **(n)**. (For TPD applications Sovereign may request additional financial information as necessary.)

(a) What is your current main occupation?

(b) Do you hold a professional or trade qualification? ☐ YES ☐ NO If YES, please give details

(c) Is your income derived from: (select all that apply)

i. Salaried employment

☐ Full-time ☐ Part-time ☐ Seasonal

ii. Self-employment

☐ Sole proprietor — Name of business

☐ Partnership — Name of business

☐ Company (in which you have a shareholding of 25% or more) — Name of business

☐ Other (e.g. director's fees, trusts) — Please give details (e.g. name of trusts)

(d) If self-employed, please state

Number of partners/shareholders

Year your business was established

Number of part-time employees

Number of full-time employees

Profit share entitlement %

(e) If you are applying for a Rural Continuity benefit and you are a sharemilker, what type of sharemilker are you?

50:50

Variable order

Casual

Contract

Please state percentage: %

(f) Are you intending to change your occupation or duties or sell your business? ☐ YES ☐ NO If YES, please give details

(g) Are you aware of any pending redundancy or liquidation at your place of permanent employment or have you been advised that you may be made redundant? ☐ YES ☐ NO If YES, please give details

(h) Describe your exact duties (including details as applicable of heights, depths and locations at which you work and chemicals, gases or any toxic substances used) and provide the % of time spent on each duty and the % of time that each duty requires manual or physical work, including driving

Exact duties	% of time on each duty	% that requires manual or physical work, including driving

(i) Number of hours worked? per week

(j) Do you work from home? ☐ YES ☐ NO If YES, please give details of your home set up and % of time spent in this workplace

(k) Do you have any other occupation? ☐ YES ☐ NO If YES, please give details

(l) Have you ever been convicted of fraud or any offence involving dishonesty? ☐ YES ☐ NO If YES, please give details

(m) Have you ever been adjudged bankrupt, been under administration or in receivership? ☐ YES ☐ NO If YES, please give details

9. Occupation And Income Details (continued)

(n) Give details of your current and previous occupations during the last five years?

From	To	Occupation	Employer

(o) Is the cover for a mortgage taken out in respect of an investment (e.g. a mortgage to purchase an investment property)? ☐ YES ☐ NO
(Mortgages where the funds are to be used for investment purposes are not eligible for Mortgage and Income Protection)

(p) Annual earned income details

Have you selected the Retirement Protection Benefit

☐ YES ☐ NO

Salary/wage	$
Fringe benefits (e.g. company car)	$
Commission income	$
Bonus	$
Share of profits	$
Other (please specify)	$
Total earned income	$
Less business expenses	$
Net earned income – before tax	$

(q) Do you have any unearned income? ☐ YES ☐ NO

(r) Annual unearned income details

Interest	$
Rental	$
Dividend	$
Annuity	$
Other (please specify)	$
Total unearned income	$
Less related expenses	$
Net unearned income – before tax	$
NET INCOME (earned and unearned)	**$**

(s) How much of your income would continue if you were disabled? How long would it continue for? What would be the source of income?

E.g. sick leave, outstanding accounts, retainers, superannuation benefits, ongoing profits or entitlements

(t) Have you attached evidence of income? ☐ YES ☐ NO

(u) Have you attached evidence of mortgage? ☐ YES ☐ NO

Please speak to your adviser for requirements

10. Totalcare Max Business Continuity (Supplmentary Proposal)

Only complete the following if you are applying for Business Continuity

(a) What are the duties of the income producing employees/Partners?

Income producing employee/Partner	**Duties of employee/Partner**

(b) Are you aware or have you been advised that you are likely to be made redundant, or that your business will cease to trade?

☐ Yes ☐ No If Yes, please explain:

(c) How has the percentage of Gross Profit attributable to the life assured been calculated

(d) What would happen to the business if the life assured were disabled for a short-term period of 3-12 months?

(e) Does the Life Assured have any personal or business cover? For example - Income protection, Locum Cover, Business Overheads, Key Person, Business Revenue Cover.

☐ Yes ☐ No If Yes, please complete below:

	Policy One	Policy Two	Policy Three
(f) Owner			
Policy Type			
Amount of Cover			
Reason for Cover			

(z) Can we contact your Accountant direct for financial evidence?

☐ Yes ☐ No

Name of Accountant

Name of Firm

Address

Street

Suburb | Town/City | Postcode

Phone number | E-mail Address

WHAT YOU NEED TO TELL US

1. ALWAYS TELL THE TRUTH. Insurance is based on the principle of utmost good faith. Put simply you have a positive duty to provide truthful, complete and correct information about yourself, including your health and medical history. Your duty of disclosure extends to the date the contract of insurance is concluded between us. For example, you are required to tell us if you are diagnosed with a medical condition after the date of your application but before you agree to any terms of cover we may offer. If we offer to cover you, you will be insured on the basis of the information you have provided.

2. ANSWER QUESTIONS AS FULLY AS YOU CAN. Applying for insurance involves responding to a number of questions. Your answers need to include as much detail relating to your current and past circumstances as possible. While this may take time, it is important to ensure that we have all the information we need when we make the decision to insure you and on what terms.

3. IF IN DOUBT, TELL US. If you are uncertain of the relevance of any information, our advice is to include it on your form because, even if you aren't sure, it may be important to us. If someone else is completing the form on your behalf, it is important that you check that the information is correct and nothing has been left out.

4. IF YOU DON'T KNOW SOMETHING, SAY SO. If you say that you don't know what the answer to a question is and we think we need more information about your answer to a question so we can offer you insurance, we will need to obtain the information from somewhere else. By signing the declaration and consent, you give us your consent to get this information.

5. KNOW WHAT YOU'RE SIGNING. By signing the declaration on your form, you are saying that you have answered all the questions completely and to the best of your knowledge, as well as providing any other information that may influence our decision about your policy. If you are uncertain about any of your answers, ask us or your adviser before signing the declaration.

6. HOW NON-DISCLOSURE AFFECTS CLAIMS. When you make a claim we may look further into your personal history. If we discover that you did not provide us material information that would have changed our decision to insure you or the terms of that insurance, we may amend the terms of your insurance policy. It does not matter if the new information is about a condition unrelated to your claim. If we discover that you haven't told us something material, we may either alter the terms of your policy – which might affect your claim, or we may avoid your policy from its inception which means that you would not be able to make a claim as no policy would exist.

7. HELP US TO HELP YOU WHEN YOU NEED TO CLAIM. Depending on what you tell us on your claim form, we might need more information to make a decision about your claim. We may get this information by calling you, asking you to fill out another form or asking you to take a medical test. Sometimes we will need to get information from other people who may include your doctor, your employer, ACC or other government departments. By signing the consent form you give us the consent to do this.

8. KNOW WHAT YOU ARE CONSENTING TO. We can only request information that we need to assess your application for insurance or for payment of a claim. At all times, the information we hold about you is your information, you have the right to access and, if it is wrong, to ask us to correct it.

9. DON'T BE AFRAID TO ASK. If there is anything you're not sure of, don't be afraid to ask us for help. Contact your adviser, or phone Sovereign on **0800 500 108.**

11. 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
When you apply for this insurance, and whenever you apply to vary or reinstate it, you have a duty to disclose to Sovereign Assurance Company Limited ("Sovereign") all information you know (or could reasonably be expected to know) that would influence the judgment of a prudent underwriter in deciding whether or not to insure you, and if so, on what terms and at what cost. If you fail to comply with your duty of disclosure, Sovereign may avoid this insurance from the beginning, which means any claim will not be paid.

Please note, in some cases, Sovereign may request a copy of your entire medical file from your General Practitioner and other medical providers, when you make a claim. IF IN DOUBT - DISCLOSE. WE TREAT ALL INFORMATION CONFIDENTIALLY.

Life assured:

I/We understand the importance of full disclosure of all information required in this application for Insurance	☐ YES	☐ NO
I/We 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

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 for insurance ('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 understand if additional information is required to process my/our Application, 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.

(h) I/We understand that if I/we do not consent to Sovereign collecting personal information on this Application and from the sources listed in paragraph (n) 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.

(i) I/We understand that financial information may be required as part of the Illustration (quoting) process, and that any such information, if requested, will form part of my/our Application.

Replacement Policy:

(j) I/We consent and give authority to Sovereign to cancel the policy/ies and/or benefits selected by me/us under Section 5(a) above, and that are to be replaced by the policy issued under this Application. Such cancellation is to take effect as at the date of issue of the new/replacement policy.

Premiums:

(k) 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.

(l) 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:

(m) I/We consent to the use of the personal information provided in this Application or obtained from any source indicated in paragraph (n) by Sovereign and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application, for the processing of this Application and administration of my/our insurance cover and any claims including assessing if I/we have met my/our duty of disclosure under this Application or any prior applications, for promotion of insurance and investment services to me/us and for market research purposes. I/We understand that my/our personal information will be stored at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I/We understand that Sovereign will take reasonable steps to keep such information secure. I/We understand that Sovereign may be required to disclose my/our personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I/We understand access to and correction of my/our personal information may be requested by me/us.

(n) 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)

(o) 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.

(p) 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 or the assessment and administration of my claim and Sovereign will not use this non-relevant information for any purpose.

(q) I/We consent to the release of my/our name/s and basic contact details to Business Mentors under my/our Business Continuity Benefit, if applicable.

Insurance Policy:

(r) 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.

(s) 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.

(t) 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:

(u) I/We understand that none of ASB Bank Limited or its subsidiaries, the Commonwealth Bank of Australia, or any other company in the Commonwealth Bank of Australia Group, or any of their directors, or any other person, guarantees Sovereign Assurance Company Limited or its subsidiaries, or 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 Day / Month / Year

11. 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 1986 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 2 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 2 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

00501 1013

Sovereign House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag Sovereign,
Victoria Street West,
Auckland 1142

Freephone 0800 500 108
Freefax 0800 329 768
Email enquire@sovereign.co.nz
Web www.sovereign.co.nz

AUTHORITY TO ACCEPT DIRECT DEBITS

SOVEREIGN

1. Personal Details

Title: Mr | Mrs | Miss | Ms

Other

Policy Number

First Name of policy owner

Telephone Home ( )

Surname of policy owner

Email Address (optional)

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

You do not need to complete this date field if you want the payment date relating to this new authority to remain the same as your existing direct debit.

2. Authority to Accept Direct Debits

Authority to Accept Direct Debits

(Not to operate as an assignment or agreement)

Name of Account

Customer (Debtor) to complete Bank/Branch number and Account Number and Suffix of Account to be debited.

Bank | Branch number | Account number | Suffix

To: The Manager (Insert name of Bank and Branch)

Start Date: D D M M Y Y Y Y

Address (PO Box):

Town/City:

(Hereinafter referred to as the Bank)

Authorisation Code: 1 2 0 0 3 6 5

I/We authorise you until further notice in writing to debit my/our account with you all amounts which **Sovereign Services 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.

Information to appear in my/our Bank Statement

Payer Particulars: **S O V E R E I G N**

Payer Code:

Payer Reference:

Your signature must appear here – Name of Account – Customer (Debtor) to complete

Authorised signature(s)

Authorised signature(s)

Date: D D M M Y Y Y Y

Date: D D M M Y Y Y Y

SOVEREIGN

Conditions of Authority to Accept Direct Debits

1. The Initiator:

1.1. Will provide notice either:
  1.1.1. in writing; or
  1.1.2. by electronic means, including SMS and email, where the Customer has provided prior written consent to the Initiator.

1.2. Has agreed to give advance notice of the net amount of each Direct Debit and the due date of the debiting at least 2 calendar days (but not more than 2 calendar months) before the date when the Direct Debit will be initiated.
  1.2.1. 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 amendment of Direct Debits.

1.3. Alternatively, the Initiator 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).
  1.3.1. 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.
  1.3.2. 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 the changes comes into effect. This notice must be provided either:
  (a) in writing; or
  (b) by electronic mail where the Customer has provided prior written consent to the Initiator.

1.4. May initiate a Direct Debit on my/our account when authorisation is received from me/us in accordance with the terms and conditions agreed between me/us and the Initiator of each amount to be debited from my/our account.
  1.4.1. Notice will be sent of the net amount of each Direct Debit and the due date of debiting after receiving authorisation from me/us under clause 1.4 but no later than the date the Direct Debit will be initiated. This notice must be provided either:
  (a) in writing; or
  (b) by any other means which provides a verifiable record of the initiated transaction and where the Customer has provided prior written consent to the Initiator.
  1.4.2. Where the notice is in writing it must include the following message:
  "The amount $ ..... was directly debited to your Bank account on (initiating date)."
  1.4.3. Where the notice is provided by other means:
  (a) the Initiator should hold prior written consent of those means of providing notice; and
  (b) the notice should provide a verifiable record of the initiated transaction and include the amount and initiating date of that transaction.

1.5. May, upon the relationship which gave rise to this Instruction being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Instruction. Upon receipt of such notice the Bank may terminate this Instruction as to future payments by notice in writing to me/us.

1.6. May rely on this authority to debit a different bank account upon receipt of instructions from the customer via a bank to which their account has been transferred.

2. The Customer may:

2.1. At any time, terminate this Instruction as to future payments by giving written (or by the means previously agreed in writing) notice of termination to the Bank and to the Initiator.

2.2. Stop payment of any Direct Debit to be initiated under this Instruction by the Initiator by giving written notice to the Bank prior to the Direct Debit being paid by the Bank.

2.3. Where no advance notice is provided under clause 1.4 a variation to the amount agreed between the Initiator and the Customer from time to time to be Direct Debited had been made without notice being given in terms of clause 1.4 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 Direct Debit back to the Initiator through the Initiator's Bank PROVIDED such 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:

3.1. This Instruction 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 Instruction until actual notice of such event is received by the Bank.

3.2. In any event this Instruction is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.

3.3. 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 Instruction. Any other disputes lie between me/us and the Initiator.

3.4. Where the Bank has used reasonable care and skill in acting in accordance with this Instruction, the Bank accepts no responsibility or liability in respect of:
  3.4.1. the accuracy of information about Direct Debits on Bank statements; and
  3.4.2. any variations between notices given by the Initiator and the amounts of Direct Debits.

3.5. The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give notice in accordance with clauses 1.1 to 1.4. 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.

3.6. Where notice given by the Initiator in terms of clause 1.4 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:

4.1. In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other Instruction, cheque or draft properly signed by me/us and given to or drawn on the Bank.

4.2. At any time terminate this Instruction as to future payments by notice in writing to me/us.

4.3. Charge its current fees for this service in force from time to time.

4.4. Upon receipt of an "authority to transfer form" signed by me/us from a bank to which my/our account has been transferred, transfer to that bank this Authority to Accept Direct Debits.

FOR BANK USE ONLY

Approved

0036

02 I 02

Date Received

D	D	M	M	Y	Y	Y	Y

Recorded by

Checked by

Bank Stamp

3647 07/13

Sovereign House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag Sovereign,
Victoria Street West,
Auckland 1142

Freephone 0800 500 108
Freefax 0800 329 768
Email enquire@sovereign.co.nz
Web www.sovereign.co.nz

CREDIT CARD / DEBIT CARD PAYMENT AUTHORITY

SOVEREIGN

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

Credit card or debit card details

Card type ☐ MasterCard ☐ Visa ☐ Debit Card

Payment frequency ☐ Monthly ☐ Quarterly ☐ Half–yearly ☐ Annually

Account number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Name on card

Expiry date /

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

Day / Month / Year

4318-11/11

REPLACEMENT POLICY ADVICE

SOVEREIGN

Replacement Policy Advice for Advisers

Adviser to Complete

This form is to be completed whenever an existing Term Life, Disability, Trauma, and/or Income Protection policy or benefit is to be replaced, exchanged or converted. This includes all situations where a new policy is issued within six (6) months of another policy being discontinued and the life insured (or one of the lives insured) is the same.

Details of New Policy or Benefit

Name(s) of Life Insured		
Date(s) of Birth of Life Insured		
Name of Insurer		Type of Policy/Benefit:
Sum Insured	$	Annual Premium: $ (Level/Stepped)

Will the Adviser receive something from the Insurer in return for arranging the new contract/benefit? ☐ Yes ☐ No

Details of Policy or Benefit Being Replaced

Name(s) of Life Insured		
Name of Insurer*		
Policy Number		Type of Policy/Benefit:
Sum Insured	$	Annual Premium: $ (Level/Stepped)

***If a Sovereign policy or benefit is being cancelled or altered due to replacement, please describe the change(s) below.**

☐ Cancel full policy ☐ Alter or change existing policy (provide details below)

Existing benefit	Life assured	Sum assured	Changes	Is this benefit being replaced?

Reasons for Replacement

The current policy/benefit is being replaced because (tick all applicable and please provide details):

☐ the Policy Owner's needs have changed and a new policy/benefit is required

☐ the Policy Owner's needs have not changed but the same cover is available at a lower premium

☐ the Policy Owner's needs have not changed but the new insurer offers better service

☐ the Policy Owner's needs have not changed but the new insurer has a better claims rating/experience

☐ Other (please provide details)

NOTE: The Policy Owner is intended as a broad term in this form, including the life insured, the premium payer and any nominated beneficiary.

The following risks are covered by the current policy/benefit but will NOT be covered by the new policy/benefit:

Declaration of Advice (delete if not applicable)

I confirm that I have taken all reasonable steps to advise the Policy Owner(s) of the risks and benefits of replacing the policy/benefit listed on this form. To the best of my knowledge the information contained in this form is true and correct. I confirm that this change is in the best interests of the Policy Owner(s).

Declaration of No Advice (delete if not applicable)

I confirm that I have not given any advice to the Policy Owner in respect of this replacement.

Although I have not made any comparison between the new policy/benefit and the existing policy/benefit I have advised the Policy Owner of the types of adverse circumstances which might occur as a result of changing products.

Adviser Name:	Signature:	Date:

SEE OVER

SOVEREIGN

Replacement Policy Advice for Policy Owners

Policy Owner to Read and Complete (Please read before you sign the Acknowledgement and Declaration below)

Making an Informed Decision

Before you replace your existing policy/benefit with a new one it is important you have all the relevant information to help you make the best decision.

The Financial Advisers Act requires Advisers to exercise care, diligence and skill when providing clients with financial advice. That advice should include an accurate explanation of the differences between your existing and proposed policy/benefit, the advantages and disadvantages of switching, and the reasons why replacement is your best option.

This comparison should consider key aspects of your policy/benefit, such as:

› **Your personal situation** – changes in your health, leisure activities or occupation may mean your new policy contains restrictions or exclusions that your old policy doesn't have. Similarly, any improvements in your health or lifestyle may mean improved terms and conditions.

› **Cover** – understand what your existing policy/benefit covers and what you'll be covered for under the new policy/benefit. Also understand any loss of benefits such as value or type of cover, and any unusual features.

› **Medical Conditions** – different policies, while covering similar risks, often cover significantly different conditions (particularly policies that cover disablement or serious illness).

› **"Stand down" periods** – a new policy/benefit can have initial "stand down periods" so you may temporarily lose some of your cover if you switch to a new policy/benefit. For example, new trauma policies/benefits often exclude cover for cancer within 3 months of the commencement of the policy/benefit.

› **Definitions** – there can be subtle differences in the definitions used between policies (e.g. medical conditions, employment, occupation, income, etc).

› **Cost** – if there have been changes to the insured person's personal situation since the policy was taken out, the new policy/benefit may cost more to get the same or similar benefits. If their personal situation has improved or remained the same, the premiums for the new policy/benefit may even be lower.

› Differences in financial strength ratings between the old and new insurers.

As well as policy comparisons, Advisers are also required to disclose any other material information that may influence their recommendation and any potential conflicts of interest, such as whether or not they are receiving some form of payment from the Insurer.

A copy of this completed form will be given to the new insurer who will send you a copy for your records.

PLEASE NOTE: You must contact the old insurer directly to cancel your existing policy/benefit. DO NOT cancel your existing policy/benefit until you have disclosed everything necessary to your new insurer, the new policy/benefit has been issued and you are happy that you are appropriately insured.

Policy Owner(s) Acknowledgement and Declaration (on behalf of all affected parties)

1.	I/We acknowledge that my/our adviser has provided me/us with a detailed comparison between my/our existing and proposed policies/benefits that covers the key aspects outlined above, and that I/we understand the consequences of my/our adviser's recommendation.	☐ Yes	☐ No
2.	I/We acknowledge that my/our adviser has not provided us with advice in respect of this replacement but I/we have been advised of the types of adverse circumstances which might occur as a result of changing products.	☐ Yes	☐ No
3.	I/We acknowledge that a copy of the brochure 'Get the most out of life' has been given to me/us and I/we have read it and understand what it means to me/us.	☐ Yes	☐ No
4.	I/We acknowledge that this information was provided and explained to me/us before I/we signed the application for the new policy/benefit.	☐ Yes	☐ No

Only applicable if Sovereign Policy or Benefit is being cancel or altered as described.

5 I/we request that the policy(ies) listed above be cancelled/altered immediately.

6 I/we acknowledge that where my/our existing policy(ies) is/are cancelled or altered, the cover that I/we had in place has changed and therefore I/we may no longer be covered for any event that was previously covered by the policy(ies).

7 I/we acknowledge that any alterations to my/our policy(ies) requested by me/us will be based on the information provided in this form, together with the information provided in the original proposal.

8 I/we acknowledge that in the case of alteration the changes I/we have requested may mean that the values illustrated in the latest annual statement or progress report for this policy(ies) may no longer be valid.

IMPORTANT NOTICE: Signatures are required from ALL policy owners on joint policy(ies).
Written confirmation will be sent to the policy owners named below If a Sovereign policy or benefit is being cancelled or altered due to replacement.

Policy owner 1	Full name:	
	Signature:	Date:
Policy owner 2	Full name:	
	Signature:	Date:
Policy owner 3	Full name:	
	Signature:	Date:

Based on the Financial Services Council Replacement Best Practice Guidelines.

Sovereign House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag Sovereign,
Victoria Street West,
Auckland 1142

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Freefax 0800 329 768
Email enquire@sovereign.co.nz
Web www.sovereign.co.nz

4032 0813
4032-08/13

FOR ADVISER USE ONLY special instructions

This Application form should be used for all TotalCareMax applications. This form can also be used for Start-Up Income Protection applications. If the Life to be Assured is applying for either Absolute Health or Key Health, in addition to TotalCareMax and Start-Up Income Protection, this form can be used for both products. If children are to be insured as part of Absolute Health, this form can also be used.

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
- ☐ Evidence of income
- ☐ 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			
FSPR number or QFE name			
Group Voluntary Code			
Percentage split	Initial	Renewal	
Adviser's company			
Adviser name			
Please tick one	☐ Variable %	☐ Pendulum %	☐ As earned

SECOND ADVISER (if applicable)

Credit this case to Sovereign adviser code			
FSPR number or QFE name			
Group Voluntary Code			
Percentage split	Initial	Renewal	
Adviser's company			
Adviser name			
Please tick one	☐ Variable %	☐ Pendulum %	☐ As earned

Scanned/faxed? ☐ YES Date Day / Month / Year

00501 1013

NOTES

NOTES

0800 500 108
SOVEREIGN.CO.NZ

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