

application

Start-Up Income Protection

If you mean business,
you'll be ready for anything

For adviser use only - special instructions

This application form should be used for all Start-Up Income Protection applications. This form can also be used to apply for TotalCareMax benefits and Absolute Health insurance.

Adviser checklist

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

<input type="checkbox"/> Personal statement complete	<input type="checkbox"/> DD form complete	<input type="checkbox"/> Payment method identified
<input type="checkbox"/> Commencement date identified	<input type="checkbox"/> Declaration signed	<input type="checkbox"/> Copy of Advice on Replacement Business Form (original to remain with client)
<input type="checkbox"/> Illustration attached	<input type="checkbox"/> Details of doctor holding medical records	<input type="text" value="/"/> <input type="text" value="/"/> What risk commencement date was used on the illustration?

**Credit this case to
Sovereign adviser code**

Percentage split

Adviser's company

Adviser name

Please tick one

<input type="checkbox"/> Variable: %	<input type="checkbox"/> Pendulum: %	<input type="checkbox"/> As earned
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Second adviser (if applicable)

Scanned/faxed? Date

<input type="checkbox"/> Yes	<input type="text" value="/"/> <input type="text" value="/"/>
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Guide to completing this Start-Up Income Protection 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 given correct answers to our questions, your policy can be cancelled or avoided altogether.

If you have an existing income protection policy with Sovereign or another insurer, an application for Start-Up Income Protection will not be accepted.

If you prefer, you can complete this form in private and post directly to Sovereign Assurance Company Limited, Private Bag Sovereign, Auckland Mail Centre 1142.

- Sections 1 – 5 and 7 – 9 MUST be completed.
- Section 6 to be completed if you answer YES to certain questions in section 5.

1 Life to be Assured (PLEASE USE BLOCK LETTERS.)

Mr/Mrs/Miss/Ms	Last name		First name(s)	
Home address				
Mailing address (if different)				
Contact details	Home phone ()	Business phone ()	Mobile phone ()	
	Email	Previous name (if changed)		
Date of birth	Date of birth / /	Place of birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Occupation			Industry	
What is your height and weight?	cm/feet/inches		kg/stone/lb	
Do you smoke or have you been a smoker in the past 12 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, for how many years have you smoked? years	
	If YES, please state the type and quantity smoked e.g. cigarettes, cigars, tobacco			
	Cigarettes (average per day)	Tobacco (average per day)	Cigars (average per day)	

2 Policy owner(s) (If the policy is to be owned by a business, two company directors should complete this section and provide their authorisation in Section 9.)

Policy owner (1)

Mr/Mrs/Miss/Ms	<input type="checkbox"/> as above, or	Last name	First name(s)
Home address			
Mailing address (if different)			
	Daytime phone ()	Email	Date of birth / /

Additional policy owner (2)

Mr/Mrs/Miss/Ms	Last name	First name(s)
Home address		
	Daytime phone ()	Email
	Date of birth / /	

3 Payment details

Premium amount	\$ <input type="text"/>		Deposit enclosed	\$ <input type="text"/>
Payment frequency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually	<input type="checkbox"/> Fortnightly (For Direct Debit payments only)	Please specify date of first payment, e.g. 17th. <input type="text"/>
Payment method	<input type="checkbox"/> Direct Debit (Please complete the attached Sovereign Direct Debit Authority.)		or	<input type="checkbox"/> Use existing Sovereign Direct Debit
Credit Card details	<input type="checkbox"/> MasterCard		<input type="checkbox"/> Visa	Policy number <input type="text"/>
	Account No.	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Name on card	<input type="text"/>		Expiry date <input type="text"/> / <input type="text"/> / <input type="text"/>
	Please specify date of first payment, e.g. 17th.	<input type="text"/>	Payment amount	\$ <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'.

4 Benefit details

Please attach Illustrations 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 section on page 15 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, health, or savings policies with life cover (existing cover), with Sovereign or any other company?

☐ Yes - please give details below
 ☐ No

Type of insurance	Benefit amount	New cover		Existing cover		Company
		Applied for		To remain in force	To be replaced*	
Disability Income	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Life	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Total Permanent Disability	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Living Assurance	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Medical	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
	\$ <input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

* If 'To be replaced' has been ticked, please complete the Advice on Replacement Business form at the back of this document

Important Note: To assess your eligibility for the level of cover you are applying for, Sovereign needs to know your level of existing cover and whether this cover is being replaced by the insurance you are applying for.

If you have an existing income protection policy with Sovereign or another insurer, an application for Start-Up Income Protection will not be accepted.

Personal statement (continued)

(b) Has any insurance you have or applied for (e.g. life, income protection) ever been declined, deferred or modified?

☐

Yes

☐

No

If YES, please give full details.

(c) Have you ever claimed benefits from ACC 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 6.

(d) (i) Has a parent, sister or brother suffered from diabetes, stroke, mental illness, dementia, kidney disease, heart disease, high blood pressure, cancer (specify type), before the age of 60?

☐

Yes

☐

No

If YES, please give details below.

Details of condition suffered and current state of health

Relationship to you

Age when condition diagnosed (if known)

Current age

Age at death

And/or

(ii) Is there a history of Huntington's chorea, polycystic kidney, or any hereditary or familial disease or disorder?

☐

Yes

☐

No

If YES, please give details below.

Details of condition suffered and current state of health

Relationship to you

Age when condition diagnosed (if known)

Current age

Age at death

(e) Doctor's details

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

Name of medical professional or clinic		Years attended
Mailing address		
Business phone ()	Does this professional hold your records?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of medical professional or clinic		Years attended
Mailing address		
Business phone ()	Does this professional hold your records?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of medical professional or clinic		Years attended
Mailing address		
Business phone ()	Does this professional hold your records?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Personal statement (continued)

(f) Please indicate your New Zealand residency status.

☐ Citizen/permanent resident
 ☐ Work permit
 ☐ Long-term business visa and permit
 ☐ Other

(g) Do you intend to live, work or travel overseas within 12 months?

☐ Yes ☐ No
 If YES, please give details below.

Country	Start date	Duration

(h) Do you drink alcohol?

☐ Yes ☐ No
 If YES, please give details below.

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

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

☐ Yes ☐ No
 If YES, please give details in the General Health Questionnaire in section 6.

(j) Have you had any medical examinations by a doctor or specialist, tests or x-rays in the last five years?

☐ Yes ☐ No
 If YES, please give details in the General Health Questionnaire in section 6.

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

☐ Yes ☐ No
 If YES, please give details in the General Health Questionnaire in section 6.

(l) If we require you to 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 the 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.

(m) If we require further information to process your application quickly, can we use our telephone underwriting service?

☐ Yes ☐ No
 Phone number

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 your 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.

Personal statement (continued)

(n) 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 6. If your symptom is underlined, please refer to the questionnaire specific to that condition.

Chest pain, heart complaint, high blood pressure, high cholesterol	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thyroid disorder or any other glandular condition	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles, skin disorder or any other lesion</u>	<input type="checkbox"/> YES – please complete questionnaire i	<input type="checkbox"/> NO
<u>Any disease or disorder of the gastrointestinal tract or bowel</u> e.g. irritable bowel, Crohns, ulcers, colitis or reflux	<input type="checkbox"/> YES – please complete questionnaire ii	<input type="checkbox"/> NO
Obesity e.g. stomach stapling, liposuction	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use of drugs, or counselling for alcoholism, drug or gambling addiction	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Mental, nervous or stress disorder, depression, fatigue or phobia</u>	<input type="checkbox"/> YES – please complete questionnaire iii	<input type="checkbox"/> NO
Blood disorders e.g. anaemia, varicose veins, blood clots or bleeding tendencies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Kidney problems, endometriosis, prostate, bladder or urinary condition e.g. weakness of the bladder, kidney stone	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy, stroke or other neurological disorders e.g. motor neurone disease, multiple sclerosis, paralysis or seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Asthma</u> or lung complaint e.g. bronchitis, breathing problems	<input type="checkbox"/> YES – please complete questionnaire iv	<input type="checkbox"/> NO
<u>Muscle, joint or bone disorders, injury, or disease</u> e.g. arthritis, rheumatism, SLE, gout	<input type="checkbox"/> YES – please complete questionnaire v	<input type="checkbox"/> NO
Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis or ear infections	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Aids or HIV antibodies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other illness, injury or condition not already stated	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Liver disease or disorder e.g. hepatitis	<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
<u>Diabetes</u>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Health questions

If you are applying for Absolute Health or Key Health, in conjunction with Start-Up, please answer the following question. If children are to be insured as part of your Absolute Health policy, all Lives to be Assured should complete a separate Health Insurance Application form.

(o) Do you suffer, or have you ever suffered from, or have you ever had treatment or surgery or medical tests or prescribed medication for any of the following?

If YES, please complete the **General Health Questionnaire** in SECTION 6.

Oral surgery or wisdom teeth problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Reproductive organs, gynecological disorders, irregular heavy or painful menstrual bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO

6 Health section

General Health Questionnaire

Please complete this section if you answered YES to any of the selected questions in section 5. If you need extra space to provide your response, please use the Notes section on page 15 and write 'refer to notes' next to the original question.

	Condition 1	Condition 2
(a) Name of condition	<input type="text"/>	<input type="text"/>
(b) Date of first symptoms	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>
(c) Date of last symptoms	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g).	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

	Condition 3	Condition 4
(a) Name of condition	<input type="text"/>	<input type="text"/>
(b) Date of first symptoms	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>
(c) Date of last symptoms	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g).	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

General Health Questionnaire (continued)

	Condition 5	Condition 6
(a) Name of condition	<input type="text"/>	<input type="text"/>
(b) Date of first symptoms	<input type="text" value="/"/> <input type="text" value="/"/>	<input type="text" value="/"/> <input type="text" value="/"/>
(c) Date of last symptoms	<input type="text" value="/"/> <input type="text" value="/"/>	<input type="text" value="/"/> <input type="text" value="/"/>
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g).	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

	Condition 7	Condition 8
(a) Name of condition	<input type="text"/>	<input type="text"/>
(b) Date of first symptoms	<input type="text" value="/"/> <input type="text" value="/"/>	<input type="text" value="/"/> <input type="text" value="/"/>
(c) Date of last symptoms	<input type="text" value="/"/> <input type="text" value="/"/>	<input type="text" value="/"/> <input type="text" value="/"/>
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(g) Have you ever had any recurrence of this condition?	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No	<input type="checkbox"/> Yes - please give full details below at (h). <input type="checkbox"/> No
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g).	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

i. Tumour Questionnaire

Please complete this section for cancer, abnormal cervical smear, tumour, cyst or breast lump.

(a) What was the site of the tumour?	<input type="text"/>		
(b) Histology of the tumour	<input type="checkbox"/> Benign	<input type="checkbox"/> Malignant or Pre-malignant	<input type="checkbox"/> Unknown
(c) How long ago was the initial diagnosis made?	<input type="checkbox"/> Years	<input type="checkbox"/> Months	
(d) Have you received treatment within the last three years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text" value="If YES, please give details."/>
<input type="text"/>			
(e) Has there been any recurrence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text" value="If YES, please give details."/>
<input type="text"/>			
(f) Are you on any ongoing follow-up or have you been advised that follow-up or treatment is required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="text" value="If YES, please give details."/>
<input type="text"/>			

ii. Gastrointestinal Tract/Bowel Questionnaire

Please complete this section for ulcers, colitis, indigestion or any other disease/disorder of the gastrointestinal tract.

(a) Do you suffer or have you been advised by a medical practitioner that you suffer from:	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Gastro-oesophageal reflux	<input type="checkbox"/> Hiatus hernia
	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Crohn's disease
	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Other	<input type="text" value="If Other, please give name of condition."/>	
<input type="text"/>				
<input type="text"/>				
(b) Have you consulted a specialist about symptoms of any of the above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
(c) Are you on continuous medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, is your medication prescribed by your GP/specialist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Have you ever had any investigations of the gastrointestinal tract?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, please give details below.	
			Result	
Name of investigation			Normal	Abnormal
<input type="text"/>			<input type="checkbox"/>	<input type="checkbox"/>
			Result	
Name of investigation			Normal	Abnormal
<input type="text"/>			<input type="checkbox"/>	<input type="checkbox"/>
(e) How frequently do you suffer from symptoms?	<input type="text" value="Times per year"/>			

iii. Mental Health Questionnaire

Please complete this section for mental disorder e.g. anxiety, depression, stress, fatigue or phobia.

(a) Do you suffer or have you been advised by a medical practitioner that you suffer from:	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Compulsive disorder	<input type="checkbox"/> Headaches	<input type="checkbox"/> Irritability
	<input type="checkbox"/> Stress	<input type="checkbox"/> Fear or phobias	<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Depression
	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleeplessness	<input type="checkbox"/> Post-traumatic stress disorder	<input type="checkbox"/> Other
<input type="text" value="If Other, please give name of condition."/>				
(b) How long ago were the first symptoms?	<input type="text" value="Years"/>	<input type="text" value="Months"/>		
(c) How long ago were the last symptoms?	<input type="text" value="Years"/>	<input type="text" value="Months"/>		
(d) Have you had any recurrence of the symptoms?	<input type="text" value="Yes"/>	<input type="text" value="No"/>		
(e) Have you ever been hospitalised or had time off work or school as a result of this condition?	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="If YES, please give details."/>	
	<input type="text"/>			
	<input type="text"/>			
(f) Has your condition ever led you to intentionally or unintentionally harm yourself or have suicidal thoughts?	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="If YES, please give details."/>	
	<input type="text"/>			
	<input type="text"/>			
(g) Have you ever been recommended, prescribed or received treatment for any of the conditions or symptoms listed (e.g. medication or counselling)?	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="If YES, please give details."/>	
	<input type="text"/>			
	<input type="text"/>			
(h) Have you ever been assessed by a psychiatrist or psychologist?	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="If YES, please give details."/>	
	<input type="text"/>			
	<input type="text"/>			

iv. Asthma Questionnaire

Please complete this section for asthma or lung complaint e.g. bronchitis.

(a) Have you had an attack in the last two years that required attendance by a doctor?	<input type="text" value="Yes"/>	<input type="text" value="No"/>	<input type="text" value="If YES, please give details."/>
<input type="text"/>			
(b) How many inhalers do you use in a year?	<input type="text"/>		
(c) Have you been hospitalised in the last two years?	<input type="text" value="Yes"/>	<input type="text" value="No"/>	
(d) Have you been prescribed steroids (e.g. prednisone) in the last two years?	<input type="text" value="Yes"/>	<input type="text" value="No"/>	

v. Musculoskeletal Questionnaire

Please complete this section for muscle, joint or bone disorders, injury, or disease e.g. arthritis or rheumatism.

[illegible]

7 Hazardous occupation or pursuit

- (a) Do you participate, intend to participate, or 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) in the last three years?
- ☐ Yes ☐ No - please go to section 8.

	Occupation/pursuit 1	Occupation/pursuit 2
(b) Name of occupation or pursuit	<input type="text"/>	<input type="text"/>
(c) How long have you participated in this activity?	<input type="text"/> Years <input type="text"/> Months	<input type="text"/> Years <input type="text"/> Months
(d) Are you a certified instructor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) In the last 12 months how many events/trips/climbs/jumps did you participate in?	<input type="text"/>	<input type="text"/>
(f) Please advise the number of hours you engaged in this activity in the last 12 months.	<input type="text"/>	<input type="text"/>
(g) Where do you participate in this activity (geographically)?	<input type="text"/>	<input type="text"/>
(h) Do you have any plans to become a professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If YES, please give details. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	If YES, please give details. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
(i) Please disclose maximum heights, speeds, depths.	<input type="text"/>	<input type="text"/>
(j) Please give full details including the engine size for boats or other equipment used.	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
(k) Are you involved in any record attempts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If YES, please give details. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	If YES, please give details. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

8 Occupation and income details

(a) What is your current main occupation?

(b) Do you hold a professional or trade qualification? ☐ Yes ☐ No

(c) How many hours are you currently working in your business?

(d) Is your income derived from (select all that apply)

<input type="checkbox"/> Sole proprietor	<input type="text" value="Name of business"/>
<input type="checkbox"/> Partnership	<input type="text" value="Name of business"/>
<input type="checkbox"/> Company (in which you have a greater than 25% shareholding)	<input type="text" value="Name of business"/>
<input type="checkbox"/> Other (e.g. director's fees, trusts)	<input type="text" value="Please give details e.g. name of trusts."/>
<input type="text"/>	

(e) Please state

Number of partners/shareholders	<input type="text"/>	Year your business was established	<input type="text"/>
Number of part-time employees	<input type="text"/>	Number of full-time employees	<input type="text"/>
Profit share entitlement	<input type="text" value=""/>	%	

(f) Are you intending to change your occupation or duties or sell your business? ☐ Yes ☐ No

(g) 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 % that each duty requires manual or physical work.

Exact duties	% of time on each duty	% requires manual work
<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"/>

Number of hours worked per week

(h) Do you work from home? ☐ Yes ☐ No

(i) Do you have any other occupation? ☐ Yes ☐ No

(j) Have you ever been convicted of fraud or any offence involving dishonesty? ☐ Yes ☐ No

(k) Have you ever been adjudged bankrupt, been under administration or in receivership? ☐ Yes ☐ No

(l) Give details of your current and previous occupations during the last five years.

From	To	Occupation	Employer
<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"/>

8 Occupation and income details (continued)

(m) Give details of your current and previous occupations during the last five years.

From	To	Occupation	Employer

(n) Annual earned income details

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	\$

(o) Annual unearned income details

Interest	\$
Rental	\$
Dividend	\$
Annuity	\$
Other (Please specify)	\$
Total unearned income	\$
Less Related Expenses	\$
Net unearned income	\$
Net income (earned and unearned)	\$

(p) 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)?

Notes

[illegible]

Notes

[illegible]

Notes

[illegible]

Notes

[illegible]

9 Declaration and consent

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

Your Duty of Disclosure - Important Notice

Before you enter into this contract of Insurance ('Insurance') 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. You have the same duty to disclose those matters to Sovereign before you apply to vary or reinstate the Insurance. If you fail 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 and avoid the Insurance from inception.

The below-named Life to be Assured and Policy Owner(s) declare and agree that:

- (a) The above answers have/have not been entered by me/us in this Application ('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.
- (b) 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.
- (c) I/We have read the notice explaining my/our duty of disclosure and all the statements contained in this Application are true and complete to the best of my/our knowledge.
- (d) 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 take to accept this Application.
- (e) 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 between me/us and Sovereign contract.
- (f) 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.
- (g) I/We authorise Sovereign to debit the nominated credit card amount 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 account, Sovereign may also debit the 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.
- (h) 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 commencement 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.
- (i) I/We acknowledge that my/our adviser receives commission from Sovereign.
- (j) 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.
- (k) I/We consent to the use of the personal information provided in this Application by Sovereign and/or any related companies, their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application for Insurance, for the processing of this Application and administration of the Insurance and any claims, and for promotion of insurance and investment services to me/us. I/We understand that the personal information collected will be held at Sovereign's Head Office, 74 Taharoto Road, Takapuna. I/We understand access to and correction of my/our personal information may be requested by me/us.
- (l) I/We 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.
- (m) 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 we provide to the Telephone Underwriter will form part of my/our Application for Insurance.
- (n) I/We consent to 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:
 - Registered Medical Practitioners and specialists
 - Dentists
 - Employers (whether current or not)
 - Insurers (whether public or private)
 - Medical laboratories
 - Banks and other financial institutions
 - Accountants and other financial advisers
 - Counsellors, psychologists and therapists
 - Accident Compensation Corporation
 - Government departments, agencies, organisations and enterprises
- (o) 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.

Declaration and consent (continued)

Please print full name of Life to be Assured

Signature of Life to be Assured

Date

/ /

Signature of Policy Owner(s)
(If other than Life to be Assured and as named in section 2 of this application form).

Date

/ /

Date

/ /

Date

/ /

Date

/ /

THIS SECTION MUST BE COMPLETED



Authority to accept Direct Debits

(Not to operate as an assignment or agreement)

Please complete shaded areas.

Sovereign House
74 Taharoto Road
Takapuna, North Shore City 0622
Private Bag Sovereign
Auckland Mail Centre 1142

Telephone +64 9 487 9000
Facsimile +64 9 487 8003
Freephone 0800 500 108
Freefax 0800 329 768
enquire@sovereign.co.nz
www.sovereign.co.nz

To the Manager

Bank
Branch
PO Box
Town/City

Authorisation Code	1	2	0	0	3	6	5
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Full name of policy owner		
Residential phone no.	Business phone no.	Mobile phone no.
Email		

If this debit relates to an existing policy please note policy number(s):
Date of first payment: (Between 1st and 28th of the month)

Account details

Customer to complete details
of account to be debited.
(Please print in BLOCK CAPITALS)

Name of account														
Bank		Branch number				Account number						Suffix		

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

Authorisation

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.

The following will appear on my/our bank statement

(My/our policy number will print under payer reference.)

Payer particulars	Payer code	Payer reference
S O V E R E I G N		

Authorised signature(s) – your signature must appear here

	Date: / /
--	--------------

For bank use only

Approved <hr/> 0036 <hr/> 02 02	Date Received <hr/>	Recorded By: <hr/>	Checked By: <hr/>	Bank Stamp
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3647-09/07

Conditions of this Authority

1. The Initiator:

10-Day Advance Notice of Each Direct Debit

- (a) Has agreed to give advance notice of the net amount of each Direct Debit and the due date of debiting at least 10 calendar days before (but not more than 2 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 notice to the Customer 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 Customer 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 (c) 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.

Advice on Replacement Business

A separate form is to be completed for each existing contract/policy/plan to be replaced.

The original of this form should be held by the policy owner, and a copy sent to the company issuing the new contract, policy or plan.

Details of new contract/policy/plan		
Name(s) of policy owner(s)		
Type of contract/policy/plan		Annual premium or contribution \$
Is initial commission being received in relation to the new contract?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is renewal commission being taken as an alternative form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Details of contract/policy/plan being replaced		
Name(s) of policy owner(s)		
Name of insurer		
Type of contract/policy/plan no.(s)		Annual premium or contribution \$
Details of replacement – statement by adviser/intermediary		
(a) The specific reasons for the replacement of this existing contract/policy/plan are		
(b) The policy to be replaced cannot adequately fulfil the owner's objectives because		
(c) The following death/disability risks/medical costs or procedures (delete those not applicable) are NOT covered by the new contract/policy/plan which WERE covered by the old contract/policy/plan		
Name of adviser/intermediary		
Address of adviser/intermediary		
Sovereign adviser code		Telephone ()
Adviser's signature		Date / /

Advice to policy owner(s)

You might find this advice helpful in deciding whether to replace an existing contract/policy/plan. This includes all situations where a new contract/policy/plan is being issued within a period of six months after an existing one has been discontinued, or six months before an existing contract/policy/plan is planned to be discontinued, and

1. The lives assured (or one of the lives assured) is the same, or
2. The policy owner (or one of the policy owners) is known to be the same, or
3. The premium payer (or one of the premium payers) is known to be the same.

Advice on replacement business (continued)

I/We acknowledge there may be advantages and disadvantages involved in replacing an existing contract/policy/plan such as:

1. There are sometimes establishment costs in setting up a contract/policy/plan. Replacing it with a new contract/policy/plan may involve further establishment costs
2. If the policy which is being replaced was purchased on the life to be assured at a younger age, the same or similar benefits in the new policy may now cost more
3. A change in health, pastimes or occupation of the life to be assured may affect insurability and the new policy may contain restriction limitations, and/or be more costly
4. In a new policy the Suicide Exclusion Clause may recommence
5. Conditions or benefits may be more (or less) favourable under the contract/policy/plan which is being replaced, for example, the contract duration, wording and/or benefit definitions may differ
6. If the purchase of the new contract/policy/plan involved using or borrowing against cash values of any existing policy(ies) or plan(s), these monies may be beyond the policy owners(s) future ability or intention to repay. This may mean a loss or reduction of the benefits under the policy(ies) or plan(s).

I/We also acknowledge that this information was provided and explained before I/we signed this Application for the new contract policy/plan.

I am/We are aware that I/we may cancel this application, in writing, within the 'free-look' period of 15 days from the date the new contract/policy/plan is received. In this event, Sovereign Assurance Company Limited will refund any premium, deposit or other payment made in respect of the new contract/policy/plan.

Name(s) of policy owner(s)
(please print)

Signature(s) of policy owner(s)

Date

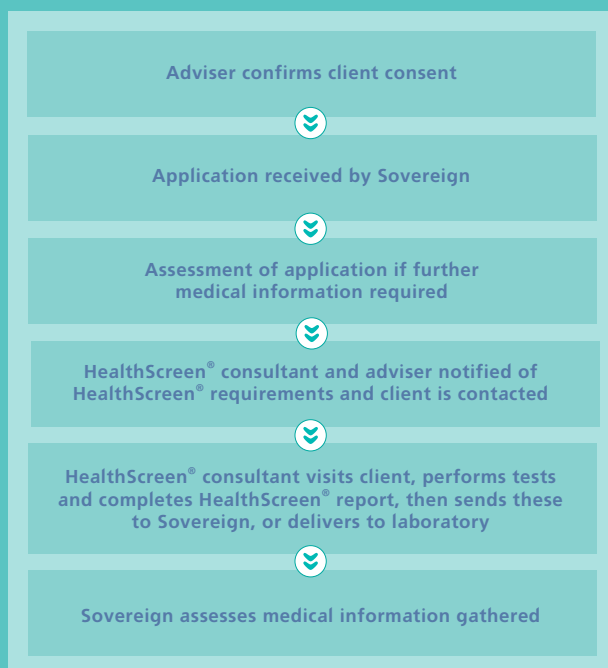


4032-09/07



HealthScreen®

How it works



Note: A copy of blood results is sent to client's doctor.

HealthScreen® is a free service 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 designated specialist, is responsible for providing this service and the necessary documentation.

Now, HealthScreen® provides an easier, more efficient way of gathering this information.

Key features of the service

- Confidentiality and discretion are assured
- You are notified of the required tests prior to consultation
- Tests are carried out at your convenience – at your home or office
- Service is personalised
- The processing time for your insurance application is shortened
- Available in most areas (Whangarei, Warkworth, Auckland, Hamilton, Tauranga, Rotorua, Taupo, Turangi, Taumarunui, Gisborne, Hawke's Bay, New Plymouth, Palmerston North, Wanganui, Wellington, Nelson, Blenheim, Christchurch, Dunedin, Invercargill and surrounding districts), and Queenstown.



HealthScreen®

Who are we?

HealthScreen® consultants are experienced, registered nurses who may ask you a series of detailed questions. These will include questions about:

- Your medical history; and
- Any medications you are taking now, or have taken in the past (including names and dosage).

If an appointment is necessary, you will receive a call from a HealthScreen® consultant. If, at any time, you need to reschedule an appointment, please contact the HealthScreen® consultant directly, as soon as possible.

Once all information has been gathered, the relevant documentation will be sent to Sovereign Assurance Company Limited ('Sovereign') for assessment.

HealthScreen® will complete most medical tests. Where they don't, your adviser will let you know the required tests needed by your doctor or specialist.

Should you not wish to use the HealthScreen® service, you are free to see your own doctor.

Sovereign Group Limited • Sovereign Limited • Sovereign Assurance Company Limited • Sovereign Financial Services Limited • Sovereign Services Limited • Sovereign Superannuation Trustees Limited • Franchise Services (NZ) Limited • The Colonial Mutual Life Assurance Society Limited ACN 004 021 809 Incorporated in Australia

HealthScreen®

Key features of the service

Confidentiality and discretion are assured



Tests are done at your convenience – at your home or office



Service is personalised



You are notified of the required tests prior to consultation



The processing time for your insurance application is shortened



Available in most areas (Whangarei, Warkworth, Auckland, Hamilton, Tauranga, Rotorua, Taupo, Turangi, Taumarunui, Gisborne, Hawke's Bay, New Plymouth, Palmerston North, Wanganui, Wellington, Nelson, Blenheim, Christchurch, Dunedin, Invercargill and surrounding districts), and Queenstown.

NOTE: HealthScreen® is solely a medical information gathering service. All material and applications are handled in the strictest of confidence and in accordance with medical standards and ethics. HealthScreen® is not an underwriting service. HealthScreen® consultants are based in the centres where the service operates. All administration is handled by Sovereign's head office in Auckland. Full details of HealthScreen® can be obtained by contacting the Chief Underwriter, Sovereign Assurance Company Limited. Alternatively, please discuss this service with your adviser.

What happens now?

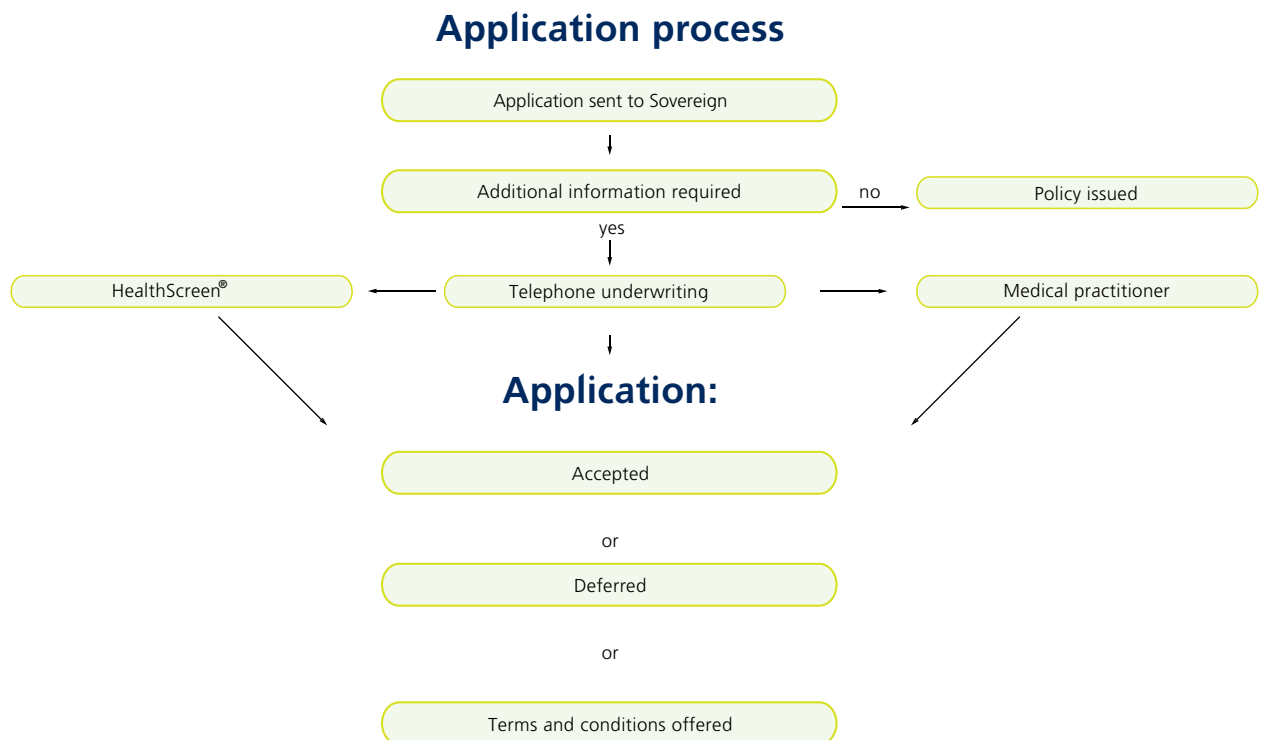
The underwriting and new business process

When you apply for insurance our aim is to make the process as simple as possible.

We review your application to ensure that you are charged the correct premium and that you qualify for the cover you have applied for. The questions you have answered in your application usually provide us with sufficient information but sometimes we may need to obtain further details.

In some instances this may require you to either see your doctor, meet with one of our HealthScreen® nurses or provide additional information by utilising our telephone underwriting service. Additionally we may write to your doctor to obtain further medical history.

We have outlined the application process below; please take time to read it as this information is important. If you have any questions please contact your adviser or call Sovereign on **0800 500 108**.



What is telephone underwriting and how does it work?

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 most convenient to you. They may ask you questions about your health, your occupation or your hazardous pursuits so we can process your application. We use this additional information to assess the acceptance terms for your application.

The information you provide will be taken down and a copy of the questions and your answers will be posted to you. We ask that you check that the details are correct and advise us of any amendments, if necessary, within seven days of receiving this information.

Will there be any further information required once the telephone underwriting has been completed?

In most cases we will have all the information we require; however in some cases we may need to call again. We may also need to collect more information from other sources such as your GP or specialist. We will keep you informed if this becomes necessary.

When will you be contacted?

We will only contact you if we require essential information not provided on your application.

Our service operates between 8:00am to 6:00pm, Monday to Friday and we will contact you at the time and place you specify on your application.

Is the information you provide over the telephone confidential?

All information provided to Sovereign is kept strictly confidential and will not be disclosed to any other parties without your authority.

Sovereign Assurance Company Limited

Sovereign House
74 Taharoto Road
Takapuna, North Shore City 0622

Private Bag Sovereign
Auckland Mail Centre 1142

Telephone +64 9 487 9000
Facsimile +64 9 487 8003
Freephone 0800 500 108
Freefax 0800 329 768
enquire@sovereign.co.nz
www.sovereign.co.nz



Your accredited Sovereign adviser