Application/Policy No.

Application for Reinstatement

To be completed by the Life Assured
Please state full particulars in reply to each question, using an additional sheet if necessary.
Please use a separate form for each Life Assured.

1. Life Assured

Title | **First Names** | **Surname**

Street Address

Postal Address (if different)

Phone No. Business ( ) Home ( ) Mobile ( )

Occupation | **Email**

Date of Birth / / | **Place of Birth** | **Male** | **Female**

Previous Name (if changed) | **Nationality**

2. Policy Owner(s)

If different from Life Assured.

Policy Owner (1)

Title | **First Names** | **Surname**

Street Address

Postal Address (if different)

Phone No. Business ( ) Home ( ) Mobile ( )

Occupation | **Email**

Date of Birth / / | **Place of Birth** | **Male** | **Female**

Previous Name (if changed) | **Nationality**

Additional Policy Owner (2)

Title | **First Names** | **Surname**

Street Address

Postal Address (if different)

Phone No. Business ( ) Home ( ) Mobile ( )

Occupation | **Email**

Date of Birth / / | **Place of Birth** | **Male** | **Female**

Previous Name (if changed) | **Nationality**

3. General Details

1. Have you ever been declined, deferred, or accepted at special terms under a life, accident, medical or other health-related insurance by any other insurance company? If yes, give details. Yes ☐ No ☐

2. Are you intending to travel or reside overseas? If yes, give details. Yes ☐ No ☐

3. Do you engage in motor sports, climbing, scuba diving, hang gliding and aviation other than as a fare paying passenger on a regularly scheduled airline of travel overseas other than for vacation or holiday or participate in any other hazardous activities or hobbies. If yes, give details. Yes ☐ No ☐

4. Health and Medical History

1. What is your height? ______ inches/cms What is your weight? ______ stone/kg

2. What is the name and address of your current doctor?

3. How long have you been a patient of your current doctor?

4. Are you in good health and do you normally enjoy good health? If no, give details. Yes ☐ No ☐

5. Since applying for the above policy have you had any of the following?

a. Any heart conditions e.g. rheumatic fever, chest pain, coronary artery disease, angina Yes ☐ No ☐

b. High blood pressure and/or high cholesterol Yes ☐ No ☐

c. Brain or neurological conditions e.g. stroke, paralysis, epilepsy, headaches Yes ☐ No ☐

d. Cancer, tumour, cyst, mole or growth of any kind Yes ☐ No ☐

e. Skin disorders Yes ☐ No ☐

f. Liver disorders e.g. hepatitis Yes ☐ No ☐

g. Kidney, bladder or prostate disorders e.g. colic, stones, prostatitis Yes ☐ No ☐

h. Lung disease e.g. asthma Yes ☐ No ☐

i. Impaired speech, hearing or vision (e.g. wearing glasses), ear or nose or throat disorders, or teeth or gum problems Yes ☐ No ☐

j. Gastric ulcers or any stomach or bowel disorders e.g. indigestion, crohns disease, ulcerative colitis Yes ☐ No ☐

k. Diabetes or thyroid disorders Yes ☐ No ☐

l. Blood disorders e.g. anaemia, haemophilia, leukaemia Yes ☐ No ☐

m. Disorders of spine, joints, muscles e.g. arthritis, back pain, gout Yes ☐ No ☐

n. Mental or nervous disorders e.g. depression, stress, fatigue, anxiety Yes ☐ No ☐

o. Haemorrhoids, varicose veins, hernias Yes ☐ No ☐

p. Any disorder of the reproductive system or sexually transmitted disease Yes ☐ No ☐

q. Do you have any symptoms or conditions for which you intend to visit a doctor in the future Yes ☐ No ☐

r. Congenital conditions, illnesses or injuries not listed above Yes ☐ No ☐

s. Are you taking any drugs or medications on a regular basis, prescribed or otherwise Yes ☐ No ☐

Please turn over.

t. Tests, examinations, x-rays, surgery or hospitalisation Yes ☐ No ☐

To be answered by females only -

u. Disease or disorder of the Gynaecological Tract, including the Cervix, Uterus, Fallopian Tube(s), Ovary, Vulva, Vagina, abnormal smear test(s), Fibroids, irregular or heavy menstural bleeding or mid cycle pain, Breast Lumps, thickenings,Cancer or abnormal mammogram(s) and ultrasound(s)? Yes ☐ No ☐

v. Are you pregnant? If yes, due date / / Yes ☐ No ☐

If yes to any of the conditions above, please give full details.

Date	Nature of illness/test	Duration	Time off work	Treatment received	Name of doctor/hospital

6. Has there been any change in your family history since your previous statement? Yes ☐ No ☐
If yes, provide further details.

5. Aids Declaration

The following declaration should be made by the Life Assured if able to do so. Inability to make the declaration will not necessarily mean that insurance is not available. However, in that case, an HIV antibody test may be required.

I declare that the following statements are TRUE:

1. I have not been infected by the virus which is believed to cause AIDS (the Human Immunodeficiency Virus), I am not carrying antibodies to that virus. Yes ☐ No ☐

2. In connection with AIDS or AIDS related conditions, I have not sought, and I am not intending to seek a medical consultation, treatment or investigation. Yes ☐ No ☐

3. To my knowledge, all my sexual partners since 1980 would be able to make the same declaration in relation to statements 1 and 2 above. Yes ☐ No ☐

If you have answered NO to any of the above statements, please provide details.

6. Occupation

Questions 1-2 must be completed for ALL benefits.

1. Current Occupations: Principal ______ Industry ______
Secondary ______ Industry ______

2. Describe fully your normal duties and state any hazardous or manual aspects.

State percentage of work that is manual. ______ %

Complete questions 3-11 only if you are applying for reinstatement of Total and Permanent Disability, Income Protection, Vital Income Protection, Mortgage Income Protection, Business Overheads, Locum Cover, Key Person Benefit or Waiver of Premium.

3. Hours worked per week? ______

4. How long have you been in your current occupation? ______ years/months

5. Annual income? $ ______

6. Is your occupation: ☐ Full time ☐ Part time ☐ Seasonal

7. Do you work from home? Yes ☐ No ☐ % of time ______ %

8. Who is your current employer? ______

Please turn over.

9. What qualifications and training do you hold for your present occupation?

10. What was your previous occupation? ______

11. Are you about to change your occupation or duties? Yes ☐ No ☐
If yes, give details.

7. Duty of Disclosure

Your duty of disclosure:
When you apply for insurance with AIA New Zealand, you have a legal duty of disclosure to AIA New Zealand.
This means that:

1. All the statements you make to AIA New Zealand (both written and oral) including the answers in this application, must be true and correct.
2. You must disclose everything that you know, or could reasonably be expected to know, that is relevant to AIA New Zealand's decision whether:
   - to accept your application for insurance; and
   - if AIA New Zealand accepts your application, then on what terms AIA New Zealand will accept it and how much it will cost.
3. This duty of disclosure continues from the time you complete this application until either:
   - the commencement date of this policy or the date AIA New Zealand accepts your application for insurance, whichever is the later; or
   - AIA New Zealand declines your application for insurance.
4. You also have the same duty of disclosure to AIA New Zealand at the time you extend, vary or reinstate your insurance.

Important
If you do not comply with your duty of disclosure, and AIA New Zealand would not have accepted your application for insurance on the same terms or at the same premium if you had made full disclosure, then legally AIA New Zealand may:

- **decline any claim that you make; and/or**
- **retain all premiums paid and recover any benefits paid; and/or**
- **alter the terms of any benefits under the policy; and/or**
- **remove any benefits under the policy; and/or**
- **avoid your insurance from inception.**

IF YOU ARE NOT SURE WHETHER YOU NEED TO DISCLOSE A PARTICULAR FACT, PLEASE ASK AIA NEW ZEALAND OR YOUR INSURANCE ADVISER.

8. Declaration and Medical Authority

I declare that the information above is true and complete.
I hereby authorise any doctor, hospital, clinic, ACC or insurance company who has been or may hereafter be consulted to disclose to AIA New Zealand any and all information concerning my medical history. A photocopy of this authorisation shall be valid as the original.

I agree to meet any costs including medical expenses associated with obtaining this information.

Full Name of Life Assured	Signature of Life Assured	Date
		/ /

Full Name of Policy Owner (1) ______
(if different from Life Assured)
Signature of Policy Owner (1) ______ **Date** / /

Full Name of Policy Owner (2) ______
(if different from Life Assured)
Signature of Policy Owner (2) ______ **Date** / /

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