

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

Previous name (if changed)

Permanent residence address

Unit/apartment/building/floor	
Street	
Suburb	
Town / City	Postcode

Postal address (if different from permanent residence address)

P.O. Box / Private number	
Street	
Suburb	
Town / City	Postcode

Home Phone

Business phone

Mobile phone

Email

Date of birth

Gender (Please tick)

 M  F

Place of birth

Nationality

Occupation

### 2. Policy Owner(s) Please note, the Policy Owner(s) must be the same as at the time of the policy lapse.

#### Policy Owner 1 (if different from Life Assured)

Title

First names

Surname

Previous name (if changed)

Permanent residence address

Unit/apartment/building/floor	
Street	
Suburb	
Town / City	Postcode

Postal address (if different from permanent residence address)

P.O. Box / Private number	
Street	
Suburb	
Town / City	Postcode

Home Phone

Business phone

Mobile phone

Email

Date of birth

Gender (Please tick)

 M  F

Place of birth

Nationality

Occupation

## Policy Owner 2

<b>Title</b>	<b>First names</b>
<input type="text"/>	<input type="text"/>
<b>Surname</b>	<b>Previous name (if changed)</b>
<input type="text"/>	<input type="text"/>
<b>Permanent residence address</b>	<b>Postal address (if different from permanent residence address)</b>
<input type="text"/> Unit/apartment/building/floor	<input type="text"/> P.O. Box / Private number
<input type="text"/> Street	<input type="text"/> Street
<input type="text"/> Suburb	<input type="text"/> Suburb
<input type="text"/> Town / City	<input type="text"/> Town / City
<input type="text"/> Postcode	<input type="text"/> Postcode
<b>Home Phone</b>	<b>Business phone</b>
<input type="text"/> (    )	<input type="text"/> (    )
<b>Mobile phone</b>	<b>Email</b>
<input type="text"/> (    )	<input type="text"/>
<b>Date of birth</b>	<b>Gender (Please tick)</b>
<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="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>
<b>Nationality</b>	<b>Place of birth</b>
<input type="text"/>	<input type="text"/>
<b>Occupation</b>	
<input type="text"/>	

## 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, please provide details.  **Y**  **N**

2. Are you intending to travel or reside overseas? If yes, please provide details.  **Y**  **N**

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, please provide details.  **Y**  **N**

## 4. Health and Medical History

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

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

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

4. Are you in good health and do you normally enjoy good health? If no, please provide details.

 Y  N


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

(a) Heart conditions eg. rheumatic fever, chest pain, palpitations, coronary artery disease, angina

 Y  N

(b) High blood pressure and / or high cholesterol

 Y  N

(c) Brain or neurological conditions e.g. stroke, paralysis, epilepsy, headaches

 Y  N

(d) Cancer, tumour, cyst, mole or growth of any kind

 Y  N

(e) Skin disorders

 Y  N

(f) Liver disorders e.g. hepatitis

 Y  N

(g) Kidney, bladder or prostate disorders e.g. colic, stones, prostatitis

 Y  N

(h) Lung disease e.g. asthma

 Y  N

(i) Impaired speech, hearing or vision (e.g. wearing glasses), ear or nose or throat disorders, or teeth or gum problems

 Y  N

(j) Gastric ulcers, stomach or bowel disorders e.g. indigestion, Crohn's disease, ulcerative colitis

 Y  N

(k) Diabetes or thyroid disorders

 Y  N

(l) Blood disorders e.g. anaemia, haemophilia, leukaemia

 Y  N

(m) Disorders of spine, joints, muscles e.g. arthritis, back pain, gout

 Y  N

(n) Mental or nervous disorders e.g. depression, stress, fatigue, anxiety

 Y  N

(o) Haemorrhoids, varicose veins, hernias

 Y  N

(p) Any disorder of the reproductive system or sexually transmitted disease

 Y  N

(q) Do you have any symptoms or conditions for which you intend to visit a doctor in the future

 Y  N

(r) Congenital conditions, illnesses or injuries not listed above

 Y  N

(s) Are you taking any drugs or medications on a regular basis, prescribed or otherwise

 Y  N

(t) Tests, examinations, x-rays, surgery or hospitalisation

 Y  N

**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 menstrual bleeding or mid-cycle pain, breast lumps, thickening, cancer or abnormal mammogram(s) and ultrasounds(s)?

 Y  N

(v) Are you pregnant? If yes, due date

 Y  N

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

Date	Nature of illness / test	Duration	Time off work	Treatment received / diagnosis / results	Name (and address) of doctor / hospital

6. Has there been any change in your family history since your previous statement? If yes, please provide further details.  Y  N


### 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:

- 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.  Y  N
- 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.  Y  N
- 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.  Y  N

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.

- Current occupations:
 

**Principal**

  
 Industry   
**Secondary**  
  
 Industry

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


State % 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, New to Business, Business Continuation, 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?  Y  N % of time:  %

8. Who is your current employer?

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? If yes, please give details.  Y  N


**7. Business Continuation Cover**

1. Are you a key person in the business? If yes, please state why your position is key to the business and its revenue.  Y  N


2. Total number of employees

Total no. employees	Full-time	Part-time	Non-income producing	Total no. key persons

3. Amount of revenue generated by the key person applying for this insurance \$

4. Trading revenue (less cost of goods sold) generated by the business \$

5. Net profit of the business (before tax) for the current year \$

6. Will your company continue to operate and generate income in the event of your disability?  Y  N

If yes, for how long?  Years  Months

If yes, please quantify the potential loss of personal income to you.

## 8. Disclosure Information to AIA New Zealand

### Definition:

**AIA New Zealand** shall mean AIA International Limited, trading as AIA New Zealand, and / or any related companies and / or agents (including company officers acting in the scope of their authority) and AIA New Zealand's insurance adviser or reinsurers.

### You are not insured:

- until this application has been accepted by AIA New Zealand; and you have paid the first month's premium.
- AIA New Zealand may decline this application, or may accept this application subject to certain conditions and exclusions.

**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 be 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 a continuing duty of disclosure to AIA New Zealand at the time you extend, vary or reinstate your insurance.

### Important: Duty of Disclosure

**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 a 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 this policy; and / or;**
- **Remove any benefits under the policy; and / or**
- **Void your insurance from inception.**

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

## 9. Declaration to AIA New Zealand

**It is important for you to read and understand this declaration before signing the application, as there are terms and conditions that you may not be aware of and that will form part of your insurance if AIA New Zealand accepts your application.**

1. I / We declare that the statements made in this application are true and complete and that I / we have disclosed all information material to this insurance for myself / ourselves and on behalf of family members.
2. I / We agree that this application and any other written statements made in connection with the proposed insurance shall form the basis of the contract between myself / ourselves and AIA New Zealand.
3. I / We understand that AIA New Zealand reserves the right to recover any medical costs incurred in assessing this application should I / we decide to cancel this application.
4. I / We acknowledge that the illustration attached to this application, forms part of the application and sets out the insurance benefits I / we are applying for.
5. I / We acknowledge that if I / we undergo any alteration in my / our mental or physical health or have a change of occupation between the date of this application and the commencement date of this policy, or the date AIA New Zealand accepts this application for insurance, whichever is later, I / we agree to notify AIA New Zealand immediately.
6. I / We acknowledge that I / we are signing on behalf of any children under the age of 16 and declare that I / we have disclosed all health information, including any pre-existing conditions, for such children as well as myself / ourselves.
7. I / We authorise AIA New Zealand to debit my / our nominated credit card account with the premiums payable pursuant to the insurance. AIA New Zealand may debit the credit card account with an insurance premium even when there may be insufficient clear funds in the credit card account, but AIA New Zealand should not be obliged to do so. If there are insufficient funds in the account AIA New Zealand may also debit the credit card with any applicable fees and charges. If the insurance premium cannot be recovered from me / us, then AIA New Zealand may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and AIA New Zealand may be entitled to cancel the insurance in accordance with the insurance terms relating to non-payment of premiums.
8. I / We acknowledge that personal information collected or held by AIA New Zealand (whether contained in this application or otherwise obtained) is provided and may be held, used, and disclosed by AIA New Zealand to:
  - process this application and any other application for insurance I / we make to AIA New Zealand; and
  - for the purpose of assessing any claim; and
  - for the purposes of any legal proceedings.
9. I / We acknowledge that for the purposes set out in clause 8, personal information may be made available to our subsidiary and affiliated companies, local and overseas (and in this regard you consent to the transfer of your information outside New Zealand) and to any agent, contractor or third party who provides administrative or other services to AIA New Zealand or any member of the AIA Group.
10. I / We understand that AIA New Zealand is a member of Health Funds Association of New Zealand (HFANZ). I / We agree that AIA New Zealand is authorised to collect, use and disclose personal information and health information about me / us for the purposes of the Integrity Registry in relation to any AIA (REAL Health) policy. I / We authorise disclosure of personal and health information to HFANZ or its agents, and HFANZ Members, for the above purpose.
11. I / We authorise AIA New Zealand to obtain my full medical history where the application form contains:
  - on-going medical conditions
  - multiple medical conditions
  - partial or incomplete medical history
  - a referral to a medical provider
12. I / We acknowledge that if I / we fail to provide any information requested in this application, AIA New Zealand may be unable to process the application for insurance.
13. I / We understand that access to my / our personal information is available to me / us under the Privacy Act 1993 by writing to AIA New Zealand.

14. I / We authorise AIA New Zealand (or its agents) to obtain personal information held about me / us relevant to my / our application, my / our insurance, or any claim that I / we may make. This declaration shall constitute sufficient authority to the party that AIA New Zealand requests the information from and extends to personal information held about me / us by any government department, incorporated body or person, including (but not limited to) information held by:
- Accident Compensation Corporation
  - accountants and other financial advisers
  - banks and insurers
  - counsellors, psychologists and therapists
  - dentists
  - employers
  - government departments and bodies
  - medical laboratories
  - private and public hospitals
  - registered medical practitioners and specialists
15. The AIA Group and its affiliates, including AIA New Zealand (“the Group”) are required to comply with certain legal and regulatory requirements (the “Reporting Requirements”). As such, I / we provide our express consent that AIA New Zealand shall have the right to provide such personal data and information to any governmental authorities, regulatory bodies and / or any other person(s) in respect of the Reporting Requirements. I / We understand that such disclosures may involve the cross border transfer of personal data outside the jurisdiction and that such disclosures may be with respect to i) the personal data of the Owner, the Insured, and the Beneficiaries (“the Parties”), or any of them; ii) any information relating to this Policy; and iii) any information relating to any other policies held by the Parties or any of them. I / We understand that AIA New Zealand will not be able to sell any insurance product to me / us and provide any service if I / we refuse to give the said express consent.
16. I / We agree that a photocopy of this authority shall be treated as an original.
17. If this application is to replace existing cover with another insurer, I / we have read, understood and signed an Advice on Replacement Business form.
18. I / We have been advised that specimen policy wordings are available from my / our insurance adviser and that AIA New Zealand’s financial statements are available from AIA New Zealand’s head office.
19. I / We declare that I / we have disclosed all information around previous applications for insurance cover with AIA New Zealand.
20. I / We declare that I / we have read and understood the above declaration and agree to be bound by these terms and conditions.

**Note to U.S. citizens:**

**“I / We hereby declare and agree that, by purchasing this Policy and signing below, I / we represent that I / we are not a “U.S. person” for U.S. federal income tax purposes and that I / we are not acting for, on or behalf of, a U.S. person. I / We understand that the Company, believing this statement to be true, will rely on it and act on it. In the event this statement is false, any policy issued may be considered void in which case the Company shall notify me / us and repay any premiums less reasonable charges and policy withdrawals / the Company reserves the right and shall be entitled to cancel this Policy and pay reasonable compensation to me / us in consideration of such termination. I agree to notify AIA within thirty days of any change in my status as U.S. person for the purposes of U.S. federal income tax.”**

**IF YOU ARE APPLYING FOR SUPERIOR HEALTH COVER, PLEASE READ THIS CAREFULLY BEFORE SIGNING:**

If any claim arises from, or which is traceable to, or medically related to any pre-existing condition(s) within the first three years from the commencement date of the contract, AIA New Zealand will not pay the resulting claim. A pre-existing condition is any illness, injury or medical condition you or the Life Assured(s) were aware of; or which the direct indication you or the Life Assured(s) had that something was wrong; or for which you or the Life Assured(s) sought medical treatment or medical advice on or before the commencement date of the contract. This exclusion will apply to any person(s) added to this policy for the first three years from the date of their addition as a Life Assured under this contract. AIA New Zealand will not at any time pay a claim for any exclusion noted in the policy schedule.

**I / We declare that I / we have read and understood the above declaration and agree to be bound by these terms and conditions.**

To be signed below by every person to be covered by this insurance and all Policy Owners.  
(To be signed by the parent / legal guardian if the Life Assured is a child under 16 years)

<b>Full name of Life Assured</b>									
<b>Signature of Life Assured</b>		<b>Date</b>							
<b>Full name of Policy Owner (1)</b> <small>(if different from Life Assured)</small>		<b>Date</b>							
<b>Signature of Policy Owner (1)</b>		<b>Date</b>							
<b>Full name of Policy Owner (2)</b> <small>(if different from Life Assured)</small>		<b>Date</b>							
<b>Signature of Policy Owner (2)</b>		<b>Date</b>							

**AIA New Zealand Financial Strength Rating**

AIA International Limited, trading as AIA New Zealand, has a current insurer financial strength rating of **AA- (Very Strong)** from Standard & Poor’s. A summary of Standard & Poor’s rating scale is:  
 AAA – Extremely Strong **AA – Very Strong** A – Strong BBB – Good BB – Marginal B – Weak CCC – Very Weak CC – Extremely Weak  
 R – Regulatory Action D – Default NR – Not Rated  
 Plus (+) or Minus (-): The rating from ‘AA’ to ‘CCC’ may be modified by the addition of a plus or minus sign to show relative standings within the major rating categories.