AIA New Zealand
Application for Insurance

Application for Insurance for:

Client Name:

Have you applied for insurance cover with AIA in the last 10 years? ☐ Y ☐ N

If yes, did that application proceed? ☐ Y ☐ N

Adviser Name:

aia.co.nz

WE'RE FOR LIFE

AIANB-002-16
11/17

Welcome to AIA New Zealand and thanks for choosing us...

With this application you can apply for just about every type of insurance with us.

We have a range of insurances to make life easier if something should happen to you. It means you can rest assured that you and your family will be financially protected, no matter what life may bring.

DUTY OF DISCLOSURE – please read BEFORE completing application

WHAT YOU NEED TO TELL US

1. ANSWER ALL QUESTIONS COMPLETELY – You must answer all questions as fully as you can. This will include any detail relating to your current and past circumstances. We must have all the information we need to be able to make a decision on whether to insure you and your family and on what terms.

2. ALWAYS BE HONEST – You must be truthful on your application for insurance. You must answer the questions truthfully and complete and correct any information, including your health or medical history. If you or your family are diagnosed with a medical condition after the date of your application, you must let us know before we agree to the terms of cover we may offer you. If we offer to cover your family, you will all be insured on the basis of the information you have provided us with.

3. TELL US, IF YOU DON'T KNOW SOMETHING – If you don't know something then please put this on your application for insurance. We may need to obtain the information from somewhere else. By signing this declaration and consent, you give us your consent to get this information.

4. UNDERSTAND WHAT YOU ARE SIGNING – When you sign this declaration form you are telling us that you understand the questions and you have answered the questions truthfully and to the best of your knowledge. Your answers may influence our decision about your policy. If you are unsure about any of your answers that may influence our decision about your policy, you must ask your adviser or us before signing this declaration.

5. IF YOU ARE UNSURE, TELL US – The law does not distinguish between innocent or deliberate non-disclosure. If you are unsure as to whether to tell us about any information, please include it on the form as it may be important to us. If you are completing this form on behalf of someone else, it is important that you check the information is correct and nothing has been left out.

6. UNDERSTAND WHAT YOU ARE CONSENTING TO – We are only able to request information that we need to assess your application for insurance or for payment of a claim. You have the right to access any information we hold about you, and if it is wrong, correct it. You can do this at any time.

7. UNDERSTAND HOW NON-DISCLOSURE AFFECTS CLAIMS – We will look further into your personal history when you make a claim. If we find out that you have not provided us with correct or material information, we may choose to void your policy and decline your claim at our discretion. We may also choose to change the terms of your insurance policy. The new information does not have to be related to your claim for us to choose to void your policy from inception. If we void your policy from its inception, this means that you would not be able to make a claim as no policy would exist. In addition, all premiums will be forfeited.

8. PROVIDE US WITH MORE INFORMATION AT CLAIM TIME – We might need to get more information from you or another party if you make a claim. We may need to call you, ask you to fill out another form, or ask you to have 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 this consent form, you give us your consent to do this.

9. DON'T BE AFRAID TO ASK US – If there is anything you are not sure of, don't be afraid to ask us or correct it. Contact your adviser, or phone AIA New Zealand on 0800 800 242.

Section 1: Personal Details

1. Life Assured (please complete a separate application for each Life Assured)

Title

First name

Gender (Please tick) ☐ M ☐ F

Surname

Middle name(s)

Name(s) known as

Previous name(s)

Physical address

Unit/apartment/building/floor
Street
Suburb
Town/city | Postcode
Region/state | Country

Postal address (if different from physical address)

PO Box/private bag number
Street
Suburb
Town/city | Postcode
Region/state | Country

Home Phone

( )

Business phone

( )

Mobile phone

( )

Email

Enquiries

Please state a convenient time for our underwriter to contact you if necessary. Information you provide to our underwriter will form part of your application for insurance.

Best Contact ☐ Phone ☐ Email

Preferred Time

Date of birth ☐☐ ☐☐ ☐☐☐☐

Country of birth

Nationality

(a) Are you a permanent resident of New Zealand? ☐ Y ☐ N

If no, please advise your country of residence and whether you have applied for residency status in New Zealand

(b) Are you planning to work, live or travel overseas (other than for holidays)? ☐ Y ☐ N

If yes, please provide details of the country(s) you intend to travel to including date, duration and purpose

(c) Occupation

I/We authorise AIA to disclose all personal information relating to this Application to my financial adviser. The information is to be provided for the purposes of my financial adviser providing me with advice regarding the underwriting of this Application by AIA. This authority is limited to this Application, and is only valid for the period of the assessment of this Application until an outcome on this Application is reached. I/we acknowledge that the personal information which may be disclosed includes, but is not limited to, medical, vocational, occupational and financial information relevant to the assessment of this Application.

Signature of Life Assured _____ Date ☐☐ ☐☐ ☐☐☐☐

Free accidental cover

At AIA New Zealand we know how important it is to protect what you've worked so hard for. So, while your application is being processed, we'll give you free accidental cover for up to 90 days*. **It's just one of the ways we say thanks for choosing us.**

*Refer to the Interim Accidental Cover certificate enclosed.

2. Insurances

(a) Have you ever had insurance deferred, declined or issued on special terms with AIA or any other insurance company? If yes, please provide details below ☐ Y ☐ N

Date	Insurance Company	Type of insurance	Declined	Deferred	Special Terms	Reason

(b) Do you have, or are you applying for, any other Insurance cover with other companies? If yes, please provide details ☐ Y ☐ N

Company	Type of insurance	Start date	Benefit amount	Applied for	Existing / in force	To be replaced

NOTE: If this policy is to replace existing insurance, PLEASE COMPLETE AN ADVICE ON REPLACEMENT BUSINESS FORM.

(c) Have you ever had a trauma, disability or health insurance claim or an ACC claim? If yes, please provide details ☐ Y ☐ N

Claim date	Type of claim	Reason

3. Personal Information

(a) Height cm / ft-in _____ Weight kg / st-lb _____

(b) Have you smoked (or chewed) tobacco or used nicotine replacement or smoked any other substance during the last 12 months? If yes, what type(s) and daily quantity? ☐ Y ☐ N

(c) Do you drink alcohol? If yes, what type and how many standard* drinks per week? ☐ Y ☐ N
*1 standard drink = 1 glass (330mls) of ordinary strength beer OR 1 glass (100mls) of wine / fortified wine OR 1 pub measure (30mls) of spirits

(d) Have you ever used by mouth, injection or inhalation any drug not prescribed by a doctor other than medicines purchased at a chemist? If yes, please provide details ☐ Y ☐ N

(e) Have you ever received medical advice, counselling or treatment for the use of alcohol or drugs? If yes, please provide details ☐ Y ☐ N

(f) Have you ever been convicted of fraud or any other offence? If yes, please provide details ☐ Y ☐ N

(g) Have you been declared bankrupt in the past seven years? If yes, please provide date, details and discharge date ☐ Y ☐ N

Date ☐☐ ☐☐ ☐☐☐☐ **Details** _____ **Discharge Date** ☐☐ ☐☐ ☐☐☐☐

4. Family History

(a) Has your mother, father, sister(s) or brother(s) suffered from diabetes, heart disease, stroke, mental illness, dementia, haemophilia, kidney disease, high blood pressure, cancer (specify type), Huntington's Chorea, polycystic kidney disease, muscular dystrophy, cystic fibrosis, motor neuron disease or any hereditary or familial disease or disorder? If yes, please complete the table ☐ Y ☐ N

Relationship to you	Condition suffered	Current health	Age at diagnosis	Current age	Age at death (if applicable)

5. Activities

If you are only applying for REAL Health Cover, go to section 6.

Have you engaged in the last three years or do you intend to engage in abseiling, aviation (other than as a passenger on a recognised airline), long distance sailing, hang gliding, scuba diving, motor racing (all vehicles), parachuting, power boat racing, mountaineering, martial arts or any other hazardous activities? ☐ Y ☐ N

If yes, please complete the following questions:

(a) Please describe the activity or pursuit

(b) How many times do you engage in this activity per year?

(c) How many of the actual activities did you participate in over the last 12 months?

☐ events ☐ hours ☐ trips ☐ flights ☐ dives ☐ climbs ☐ jumps ☐ other (please specify number) ☐

(d) Please advise full details including the engine size and model for any cars, motorbikes, boats, planes, or other equipment used

(e) What qualifications, certificates, licences, associations and club memberships do you hold?

(f) How long have you been involved in this activity? Years | Months

(g) Where do you engage in this activity and at what locations? Please list New Zealand locations and, if applicable overseas locations

(h) Do you ever engage in this activity alone, or are you always with a group? ☐ alone ☐ group

(i) Do you compete in this activity? If yes, please advise the level of competition and the names of any events ☐ Y ☐ N

(j) Do you receive any reward, prizes sponsorships or payments for your involvement in this activity? If yes, please provide details ☐ Y ☐ N

(k) Please describe the maximum heights, speeds and depths or distances the activity involves

(l) Are any of the details above likely to change over the next two years? If yes, please advise full details ☐ Y ☐ N

(m) Are you or have you been involved in any record attempts? If yes, please advise full details ☐ Y ☐ N

(n) Are all recognised / standard safety measures and precautions followed? ☐ Y ☐ N

(o) Please provide any additional details

6. Doctor's Details

Doctor's name

Practice name

Address

Unit/apartment/building/floor | Street

Suburb | Town/city | Postcode

Business phone ( )

Fax number ( )

Email

(a) Does your doctor hold your medical records? If no, please provide details of who holds your medical records ☐ Y ☐ N

(b) How long have you been a patient of your doctor? Years | Months

(c) When did you last visit a doctor? ☐☐ ☐☐ ☐☐☐☐

(d) What was the reason(s) for your last visit to a doctor?

(e) What was the outcome of the visit?

7. Paramedical Service

If medical and / or blood tests are needed, would you like to use our mobile paramedical service if it's available in your area? ☐ Y ☐ N

Section 2: Medical Details and History

1. Medical Details and History

Personal medical information (Please complete all questions in this section)
Have you ever had, or been diagnosed with, had symptoms for / of and / or are you currently being treated for, or expecting to receive treatment in the future, or have you consulted a doctor for any of the following:

(a)	Heart conditions, heart disease or vascular disorders, eg. rheumatic fever, heart murmur, chest pains, palpitations, coronary artery disease, heart attack or angina	☐ Y ☐ N
(b)	Brain or neurological disorders e.g. stroke, paralysis, epilepsy, any migraine or frequent headaches	☐ Y ☐ N
(c)	Skin disorders	☐ Y ☐ N
(d)	Liver disorders e.g hepatitis A,B, or C, or cirrhosis	☐ Y ☐ N
(e)	Kidney, bladder or prostate disorders	☐ Y ☐ N
(f)	Gastric ulcers, stomach or bowel disorders, hernias, indigestion, gallbladder, or thyroid disorders	☐ Y ☐ N
(g)	Blood disorders e.g anaemia, haemophilia, leukaemia	☐ Y ☐ N
(h)	Ear disorders or infection or deafness, vision disorders (including wearing glasses), nose or throat disorders or infection, impaired speech or wisdom teeth	☐ Y ☐ N
(i)	Varicose veins or haemorrhoids	☐ Y ☐ N
(j)	Have you ever been refused as a blood donor?	☐ Y ☐ N
(k)	Any disorder of the reproductive system	☐ Y ☐ N
(l)	Have you any congenital conditions?	☐ Y ☐ N
(m)	Within the last five years have you been exposed to the risk of AIDS or the HIV virus or antibodies to that virus?	☐ Y ☐ N
(n)	Do you have Acquired Immune Deficiency Syndrome (AIDS) or are you carrying the HIV virus or antibodies to that virus?	☐ Y ☐ N
(o)	Are you taking any drug or medication on a regular basis prescribed or otherwise?	☐ Y ☐ N
(p)	In the last five years have you had any other medical exams, tests or X-rays, or surgical procedures?	☐ Y ☐ N
(q)	Any health condition(s) / symptom(s) that could require hospitalisation and / or medical treatment in the future?	☐ Y ☐ N
(r)	Have you had any other illness or injuries not already listed?	☐ Y ☐ N

2. Females

(s)	Females: Are you pregnant? ☐ Y ☐ N	What was your pre-pregnancy weight (kg /st /lb)?
(t)	When is your due date? ☐☐ ☐☐ ☐☐☐☐	
(u)	Have you ever had any complications with any pregnancies? ☐ Y ☐ N	

3. Optional women's extended cancer benefit and / or REAL Health and / or Cancer Treatment Benefit

Are you experiencing or have ever experienced, or are you considering seeking advice, tests, treatment or an operation from a health professional for any of the following:

(v)	Any symptoms, disease / disorder or investigation of the breast, including cancer, tumour, cyst, lumps or thickening, abnormal mammogram or ultrasound? If yes, please complete the table on page 7	☐ Y ☐ N
(w)	Any symptoms, disease / disorder or investigation of the gynaecological tract, including the cervix, uterus, fallopian tube(s), ovary, vulva, vagina, cervical Pap smear or colposcopy or irregular or heavy menstrual bleeding or mid-cycle pain? If yes, please complete the table on page 7	☐ Y ☐ N

If you have answered yes to any questions on Section 2, please complete the table on page 7

Please submit this page with the application form even if left blank

Question	Date	Nature of illness / test	Duration and time off work	Treatment received / diagnosis / results	Recovery: Ongoing or Full If full recovery, advise date of last symptoms	Name (and address) of doctor / hospital

4. Specific Medical Conditions

Have you ever had, or been diagnosed with, had symptoms for / of and / or are you currently being treated for, or expecting to receive treatment in the future, or have you consulted a doctor for any of the following:

(a)	High blood pressure	☐ Y	☐ N
(b)	High cholesterol	☐ Y	☐ N
(c)	Arthritic disorders, gout, osteoarthritis or rheumatoid arthritis	☐ Y	☐ N
(d)	Asthma, lung disorders or any other respiratory disorders	☐ Y	☐ N
(e)	Skin lesions, tumours, cancer, moles, cysts, or growths or any kind	☐ Y	☐ N
(f)	Nervous or mental disorders, stress, depression, fatigue, anxiety, low mood or lethargy	☐ Y	☐ N
(g)	Diabetes and / or raised blood sugar levels	☐ Y	☐ N
(h)	Musculo-skeletal disorders; injury or disease of the back, joints, muscles bones or neck; repetitive strain injury, occupational overuse syndrome	☐ Y	☐ N

If you have answered "yes" to any of the above eight questions, please provide details in the relevant sections.

Section A. High blood pressure

(a) What was the date when it was first noted? ☐☐ ☐☐ ☐☐☐☐

(b) What was the reading?

(c) What date did treatment commence?

(d) What medication are you currently taking?

(e) Has your treatment changed recently? If yes, please provide details ☐ Y ☐ N

(f) What was your most recent blood pressure reading?

(g) What date was it taken? ☐☐ ☐☐ ☐☐☐☐

(h) Have you been referred to a specialist for treatment or investigation? If yes, please complete the table ☐ Y ☐ N

Date	Treatment	Results (if known)	Name of Specialist	Full address

Section B. High cholesterol

(a) What was the date when it was first noted? ☐☐ ☐☐ ☐☐☐☐

(b) What was the reading?

(c) What date did treatment commence?

(d) What medication are you currently taking?

(e) Has your treatment changed recently? If yes, please provide details ☐ Y ☐ N

(f) What was your most recent cholesterol reading?

(g) What date was it taken? ☐☐ ☐☐ ☐☐☐☐

(h) Have you been referred to a specialist for treatment or investigation? If yes, please complete the table ☐ Y ☐ N

Date	Treatment	Results (if known)	Name of Specialist	Full address

Section C. Arthritic disorders, gout, osteoarthritis or rheumatoid arthritis

(a) What was the date when it was first noted?

(b) What was the diagnosis?

(c) Please describe symptoms and areas affected

(d) Are you currently receiving treatment of any kind? If yes, please provide details ☐ Y ☐ N

(e) Has the condition been investigated (or due to be) by a specialist? If yes, please complete the table ☐ Y ☐ N

Date	Treatment	Results (if known)	Name of Specialist	Full address

(f) What was the date of your last symptoms?

Section D. Asthma, lung disorders or any other respiratory disorders

(a) What is the nature of your disorder?

(b) How old were you when you first developed symptoms?

(c) Do you consider your breathing disorder to be ☐ Mild ☐ Moderate ☐ Severe

(d) What is the frequency and duration of attacks?

(e) What was the date of your last symptoms?

(f) What treatment are you receiving / how frequently has it been modified or changed significantly in the last 12 months?

Treatment	Changes

(g) Have you required any time off work in the past five years? If yes, please provide details ☐ Y ☐ N

(h) Please advise duration of time off work (in days, weeks, months, years)

(i) Have you ever been hospitalised because of this condition? If yes, please provide details ☐ Y ☐ N

(j) Have you ever required a course of oral steroids? If yes, please provide details ☐ Y ☐ N

(k) Have you had your peak flow measured in the past two years? If yes, please complete the table ☐ Y ☐ N

Date	Results (if known)	Name of Specialist / Doctor	Address

Section E. Skin lesions, tumours, cancer, moles, cysts or growths of any kind

(a) Was the lesion malignant? ☐ Y ☐ N **(b)** Have any follow-up checks been required? ☐ Y ☐ N

(c) Please provide details of lesion(s)

Date	Location on body	Treatment	Results (if known)	GP or Specialist

(d) Specialist name and contact details

Section F. Nervous or mental disorders, stress, depression, fatigue, anxiety, low mood or lethargy

(a) Please state the exact diagnosis

(b) Please state when the symptoms first occurred and all recurrences

(c) Please give the date of last episode, frequency and duration of symptoms

Date of last episode	Frequency	Duration of symptoms

(d) Has this condition been (or due to be) investigated by a specialist? If yes, please complete the table ☐ Y ☐ N

Date	Treatment	Results (if known)	Name of Specialist	Full address

(e) What treatment or medication was prescribed?

(f) Are you currently continuing on any medication? If yes, please provide details ☐ Y ☐ N

Details	Name(s) of drug(s)	Dosage

(g) Have you had any time off work? If yes, please advise duration of time off work (in days, weeks, months, years) ☐ Y ☐ N

(h) Have you ever had any suicidal thoughts or attempts of suicide or self-harm? If yes, please provide details ☐ Y ☐ N

Section G. Diabetes and / or raised blood sugar levels

(a) Please state the date of diagnosis ☐☐ ☐☐ ☐☐☐☐

(b) Are you on oral drug treatment or insulin? If yes, please state the medication and dosage ☐ Y ☐ N

Name of drug	Dosage

(c) Has the intake of insulin or oral drugs varied during the past two years? If yes, please provide details ☐ Y ☐ N

(d) Have you ever had a diabetic or insulin coma? If yes, please provide details ☐ Y ☐ N

(e) Do you take your own blood sugar readings? ☐ Y ☐ N

(f) How often do you take your blood sugar readings and what is the usual sugar range?

Frequency of readings	Usual sugar range

(g) Have you had any complication(s) relating to diabetes? If yes, please describe the nature of the complication(s)

Section H. Muscular-skeletal disorders; injury or disease of the back, joints, muscles, bones or neck; repetitive strain injury / occupational overuse syndrome

Condition 1.

Date	Diagnosis of injury / disorder / symptoms (please specify which side or area of the body affected)	Any recurrence since original injury? (if yes, please provide dates of all recurrences)	Duration / Time off work (if yes, please advise duration off work)	Date of Last Symptoms

(d) What type of treatment did you receive?

(e) Did you have any metal ware inserted? If yes, please provide details ☐ Y ☐ N

If yes, has it been removed? ☐ Y ☐ N The date it was removed ☐☐ ☐☐ ☐☐☐☐

(f) Are you still receiving medical treatment for the injury or disorder? If yes, please provide details ☐ Y ☐ N

(g) When did treatment cease? Please specify date ☐☐ ☐☐ ☐☐☐☐

(h) Do you need to use any mobility aids or is your mobility affected in anyway? If yes, please provide details ☐ Y ☐ N

(i) Does this injury or disorder cause a degree of disability in your occupation? If yes, please provide details ☐ Y ☐ N

(j) Have you ever had any (associated) depression? If yes, please provide dates, names and address of doctors or other health providers or advisers consulted ☐ Y ☐ N

Condition 2.

Date	Diagnosis of injury / disorder / symptoms (please specify which side or area of the body affected)	Any recurrence since original injury? (if yes, please provide dates of all recurrences)	Duration / Time off work (if yes, please advise duration off work)	Date of Last Symptoms

(d) What type of treatment did you receive?

(e) Did you have any metal ware inserted? If yes, please provide details ☐ Y ☐ N

If yes, has it been removed? ☐ Y ☐ N The date it was removed ☐☐ ☐☐ ☐☐☐☐

(f) Are you still receiving medical treatment for the injury or disorder? If yes, please provide details ☐ Y ☐ N

(g) When did treatment cease? Please specify date ☐☐ ☐☐ ☐☐☐☐

(h) Do you need to use any mobility aids or is your mobility affected in anyway? If yes, please provide details ☐ Y ☐ N

(i) Does this injury or disorder cause a degree of disability in your occupation? If yes, please provide details ☐ Y ☐ N

(j) Have you ever had any (associated) depression? If yes, please provide dates, names and address of doctors or other health providers or advisers consulted ☐ Y ☐ N

Section H. Muscular-skeletal disorders; injury or disease of the back, joints, muscles, bones or neck; repetitive strain injury / occupational overuse syndrome

Condition 3.

Date	Diagnosis of injury / disorder / symptoms (please specify which side or area of the body affected)	Any recurrence since original injury? (if yes, please provide dates of all recurrences)	Duration / Time off work (if yes, please advise duration off work)	Date of Last Symptoms

(d) What type of treatment did you receive?

(e) Did you have any metal ware inserted? If yes, please provide details ☐ Y ☐ N

If yes, has it been removed? ☐ Y ☐ N The date it was removed ☐☐ ☐☐ ☐☐☐☐

(f) Are you still receiving medical treatment for the injury or disorder? If yes, please provide details ☐ Y ☐ N

(g) When did treatment cease? Please specify date ☐☐ ☐☐ ☐☐☐☐

(h) Do you need to use any mobility aids or is your mobility affected in anyway? If yes, please provide details ☐ Y ☐ N

(i) Does this injury or disorder cause a degree of disability in your occupation? If yes, please provide details ☐ Y ☐ N

(j) Have you ever had any (associated) depression? If yes, please provide dates, names and address of doctors or other health providers or advisers consulted ☐ Y ☐ N

Condition 4.

Date	Diagnosis of injury / disorder / symptoms (please specify which side or area of the body affected)	Any recurrence since original injury? (if yes, please provide dates of all recurrences)	Duration / Time off work (if yes, please advise duration off work)	Date of Last Symptoms

(d) What type of treatment did you receive?

(e) Did you have any metal ware inserted? If yes, please provide details ☐ Y ☐ N

If yes, has it been removed? ☐ Y ☐ N The date it was removed ☐☐ ☐☐ ☐☐☐☐

(f) Are you still receiving medical treatment for the injury or disorder? If yes, please provide details ☐ Y ☐ N

(g) When did treatment cease? Please specify date ☐☐ ☐☐ ☐☐☐☐

(h) Do you need to use any mobility aids or is your mobility affected in anyway? If yes, please provide details ☐ Y ☐ N

(i) Does this injury or disorder cause a degree of disability in your occupation? If yes, please provide details ☐ Y ☐ N

(j) Have you ever had any (associated) depression? If yes, please provide dates, names and address of doctors or other health providers or advisers consulted ☐ Y ☐ N

Any Additional Information

(Please submit this page with the application form even if left blank)

(Please submit this page with the application form even if left blank)

SECTION 3: Occupation Details

1. Occupation Details

(a) What is your main occupation and the industry / sector?

(b) Do you have any other occupations? If yes, please provide details of the occupation and the industry /sector ☐ Y ☐ N

(c) For each occupation please complete the table regarding your occupational duties

Occupation	Main duties	Hours / Week	% Manual work	Hazardous Duties

(d) 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

(e) Are you about to change your occupation or duties? If yes, please provide details ☐ Y ☐ N

1a. For REAL Income Protection, REAL Total and Permanent Disability Cover, REAL Vital Income Protection, REAL Business Continuation Cover, REAL New to Business Cover, REAL Farmers' Revenue Protection Cover, REAL "Mortgage, Income and Rent Cover" (income option only).

(f) Who is your current employer?

(g) Is your occupation: ☐ Full-time ☐ Part-time ☐ Seasonal

(h) How long have you been in your current occupation? Years | Months

(i) What qualifications and training do you hold for your present occupation?

(j) What was your previous occupation and for how long? Years | Months

(k) Is your income split for tax purposes with your spouse or partner? If yes, please complete the table ☐ Y ☐ N

% of income split	Hours worked by partner / spouse in the business	Work your partner / spouse does in the business

(l) Will your income, or income you are entitled to receive, cease in the event of your disablement? ☐ Y ☐ N

(m) After what duration will your income cease?
Days / weeks / months / years or continue indefinitely

(n) Please provide details of your annual income before tax

Income type	Annual amount
Salary / wages excluding fringe benefits (e.g. company car)	$
Fringe benefits (e.g. company car, Kiwisaver, superannuation)	$
Commission income	$
Bonus (if consistent in the last 3 years)	$
Share of any profits	$
Net unearned income	$
Other (please specify)	$
Other (please specify)	$
Other (please specify)	$
Total gross income before tax	$ **0.00**
Less business expenses (if relevant)	-$
Net income before tax	$ **0.00**

1b. Self-employed or employee of your own company

If you are self-employed or an employee of your own company or applying for REAL Business Continuation Cover, REAL Farmers' Revenue Protection Cover, REAL New to Business Cover or REAL Mortgage, Income and rent Cover (income option only) please complete this section.

(o) What is your shareholding percentage? %

(p) How long have you been self-employed? Years | Months

(q) Are you an employee of your own company? ☐ Y ☐ N

(r) Total number of employees

Total no. employees	Full-time	Part-time	Non-income producing	Key people

(s) What amount of revenue is generated by the key person applying for this insurance? $

(t) What trading revenue (less costs of goods sold) is generated by the business? $

(u) What was the net profit of the business (before tax) for the current year? $

(v) Will your business continue to operate and generate income in the event of your disability? ☐ Y ☐ N

If yes, for how long can income be generated? Years | Months | Weeks

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

(w) Do you work from home? If yes, please complete the questions below ☐ Y ☐ N

(x) Hours worked at home

(y) Please provide details of changes you have made to your home as a work environment (i.e. physical changes such as separate entrance, separate telephone etc.)

(z) Are you required to leave your home to perform your occupation? ☐ Y ☐ N

(z.a) What percentage of time are you working away from home? %

If this application is for business, then please complete the following:

2. Business Cover Professional Options

Business increase option ☐ nil ☐ 2 ☐ 3 ☐ 4 ☐ 5

Specify your first review date ☐☐ ☐☐ ☐☐☐☐

☐ **Life Cover**

Cover amount made up of specific cover for:

Partnership/shareholder	$
Key person	$
Debt	$
Total sum assured	**$ 0.00**

☐ **Trauma Cover**

Cover amount made up of specific cover for:

Partnership/shareholder	$
Key person	$
Debt	$
Total sum assured	**$ 0.00**

☐ **TPD** ☐ Own ☐ Any

Cover amount made up of specific cover for:

Partnership/shareholder	$
Key person	$
Debt	$
Total sum assured	**$ 0.00**

3. For Mortgage Repayment Cover only

(a) What is the amount of mortgage debt that is being covered by this policy?

(b) Who is the lender of this mortgage?

(c) What is / was the mortgage advance date?

(d) What are your mortgage repayment commitments? $ Weekly Fortnightly Monthly

(e) Have you ever defaulted on mortgage payments (regardless of the reason for default)? If yes, please provide details Y N

Please attach three months of loan payments for existing mortgage or evidence of loan repayments for a new mortgage.

4. For Residential Rent Cover Only

(a) What is your current weekly residential rent payment? $

(b) What percentage of the residential rent payment are you liable for? %

(c) What frequency do you pay your residential rent payments? Weekly Fortnightly Monthly

(d) Is your residential rental agreement lodged with the tenancy board? Y N

If yes, please provide a copy of the signed tenancy agreement. If no, please provide the signed agreement you have with your current landlord

(e) Have you had any residential rent defaults that have gone through the tenancy tribunal? If yes, please provide full details Y N

Please attach evidence of three months of rent payments – (bank statements)

5. Redundancy (optional benefit – REAL Mortgage, Income and Rent Cover, REAL Income Protection and REAL Loss of Earnings Premier)

If you are applying for the optional Involuntary Redundancy Benefit, please complete the following question:

Are you aware or have you received written or verbal notification of any impending redundancy? If yes, please provide details Y N

Any Additional Information

(Please submit this page with the application form even if left blank)

(Please submit this page with the application form even if left blank)

6. Children's Details

Complete this section for Health cover (children under 16) and REAL Trauma Cover* (all children under 21)
Notes: *For the Child Trauma benefit, children will be covered from birth.

1(a) Complete this section for children under 16 years of age. (For children over the age of 16, please complete the adult application of Health cover.)

First name	Middle name(s)	Surname	Date of birth	Male/ Female	Trauma Cover Top-Up for this Child? (Please circle)	Height**	Weight**
					Yes / No		
					Yes / No		
					Yes / No		
					Yes / No		

** Complete for Health Cover + Trauma Cover with Cancer Treatment Benefit

Following to be completed for REAL Health Cover and Trauma Cover with Cancer Treatment Benefit

(b) Name, address and phone number of each child's current doctor and doctor holding their records

(c) When did each child last visit a doctor and what was the reason?

Name of Child	Date of visit	Reason for visit	Treatment	Outcome

(d) Have any of the children ever had a disability or health claim (including ACC) If yes, please complete the table ☐ Y ☐ N

Name of Child	Claim date	Reason

(e) Are the children permanent residents of New Zealand? If no, please provide details ☐ Y ☐ N

2) Have any of the children named on this application ever suffered from, been diagnosed with and / or had symptoms of, been investigated for, are currently being treated for or receiving medical advice for, or expect to receive treatment and / or medical advice in the future, or consulted a health professional, for any of the following?

(a)	Asthma or any other respiratory disease	☐ Y ☐ N
(b)	Diabetes or heart disease or disorders of the blood, rheumatic disorders including heart murmur	☐ Y ☐ N
(c)	Ear disorders or infection or deafness, vision disorders (including wearing glasses), nose or throat disorders or infection, impaired speech, or wisdom teeth	☐ Y ☐ N
(d)	Musculo-skeletal disorders; injury or disease of the back, joints, muscles or bones, juvenile arthritis	☐ Y ☐ N
(e)	Cancer, tumour, hepatitis A,B or C, umbilical hernia, colitis or any other disease or disorder of the gastrointestinal tract or renal system	☐ Y ☐ N
(f)	Neurological disorders including epilepsy, recurring ailments, or congenital conditions not already disclosed	☐ Y ☐ N
(g)	Have any of the children ever been hospitalised due to an emergency, or for special treatment or surgery, or suffered from any other problems that required or may require further investigation, tests, treatment or medication whether or not a doctor / dentist or specialist has been consulted?	☐ Y ☐ N

If you answered yes to questions 2 (a) – (g), please provide details here:

Question	Date	Name of child	Name of illness/test	Duration	Treatment received/ diagnosis/ results	Any recurrences (if yes, please give dates of all recurrences)	Date of last symptoms	Name (and address) of doctor/hospital

Application/policy no.

7. Policy Owner(s)

☐ Please tick if you wish the Life Assured to be the Policy Owner. For additional owners, please complete the below.

Policy Owner 1

Title | **First name** | **Gender** (Please tick) ☐ M ☐ F

Surname | **Middle name(s)**

Name(s) known as | **Previous name(s)**

Occupation | **Provider's customer number** (where applicable)

Physical address

Unit/apartment/building/floor
Street
Suburb
Town/city | Postcode
Region/state | Country

Postal address (if different from physical address)

PO Box/private bag number
Street
Suburb
Town/city | Postcode
Region/state | Country

Home Phone ( ) | **Business phone** ( )

Mobile phone ( ) | **Email**

Date of birth (DD MM YYYY) | **Country of birth** | **Nationality**

Policy Owner 2

Title | **First name** | **Gender** (Please tick) ☐ M ☐ F

Surname | **Middle name(s)**

Name(s) known as | **Previous name(s)**

Occupation | **Provider's customer number** (where applicable)

Physical address

Unit/apartment/building/floor
Street
Suburb
Town/city | Postcode
Region/state | Country

Postal address (if different from physical address)

PO Box/private bag number
Street
Suburb
Town/city | Postcode
Region/state | Country

Home Phone ( ) | **Business phone** ( )

Mobile phone ( ) | **Email**

Date of birth (DD MM YYYY) | **Country of birth** | **Nationality**

For more owners, please complete the supplementary ownership form.

Application/policy no.

8. Policy Owner – Business (please complete if the policy owner is a New Zealand registered company)

Name of organisation and trading name (if different)

Date of incorporation

Place of incorporation

Name of all directors / shareholders / partners / trustees / officers

Title	First name	Surname

If your business has multi-level ownership, please attach an organisation structure to this application.

Name of contact person

Position

Business phone

Contact person's phone (if different)

Contact person's mobile

Contact person's email

Business fax

Provider's customer number (where applicable)

Physical address (for principal place of business)

Unit/apartment/building/floor	
Street	
Suburb	
Town/city	Postcode
Region/state	Country

Physical address (for registered office) (if different)

Unit/apartment/building/floor	
Street	
Suburb	
Town/city	Postcode
Region/state	Country

Postal address (for principal place of business)

PO Box/private bag number	
Street	
Suburb	
Town/city	Postcode
Region/state	Country

9. Contact for Correspondence

Which policy owner's address should correspondence go to? (Please tick)

☐ Policy Owner 1 ☐ Policy Owner 2 ☐ Policy Owner – business

Application/policy no.

Section 4: Disclosures and Declarations

1. Parent's consent where the Life Assured is less than 16 years of age

Please note that Section 67B and 67C of the Life Insurance Act 1908 provide the following limitations in respect of payments able to be made by AIA New Zealand in the event of the death of a minor:

(a) Where the 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 equals $2,000 (or such larger sum as may be specified by Order in Council).

(b) Where the deceased minor is under the age of 16 years
AIA New Zealand 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 1996 to any person other than:

- the parents or guardians of the minor, or one of them; or
- a parent or guardian of the minor and the spouse of that parent or guardian jointly: or
- any person who had District Court approval to effect the policy on the minor;
- an executor or administrator of any of those persons; or
- a person to whom payment may be made under Section 65 (2) of the Administration Act 1969; or
- any person who is entitled to that sum by virtue of an assignment of policy approved by the District Court.

2. Declaration

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

Full name of Parent or Guardian of Life Assured

Signature of Parent or Guardian of Life Assured

Date ☐☐ ☐☐ ☐☐☐☐

3. 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 advisers 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 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 later of the commencement date of this policy or the date AIA New Zealand accepts your application for insurance; 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 or remove the terms of any benefits under the policy; and / or;**
- **void your insurance from inception.**

IF YOU ARE NOTE SURE WHETHER YOU NEED TO DISCLOSE A PARTICULAR FACT, PLEASE ASK AIA NEW ZEALAND OR YOUR INSURANCE ADVISER.

Application/policy no.

4. Declaration to AIA New Zealand

It is important for you to read and understand this declaration before signing the application, as these there are terms and conditions 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 further declare that the answers to the questions in this electronic application have been correctly entered at my / our dictation and read and approved by me/us.
5. 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.
6. 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.
7. I / We acknowledge that I / we are signing on behalf of any children under the age of 18 and declare that I / we have disclosed all health information, including any pre-existing conditions, for such children as well as myself / ourselves.
8. 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 account 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.
9. 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 purposes of assessing any claim; and
   - for the purposes of any legal proceedings.
10. I / We acknowledge that for the purposes set out in clause 9, personal information may be made available to our related 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.
11. I / We understand that AIA New Zealand is a member of the 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.
12. I / We authorise AIA New Zealand to obtain my full medical history where the application form contains:
    - ongoing medical conditions
    - multiple medical conditions
    - partial or incomplete medical history
    - a referral to a medical provider
13. 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.
14. 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.
15. 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
16. The AIA Group and its affiliates, including AIA New Zealand 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 Policy 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.
17. I / We agree that a photocopy of this authority shall be treated as an original.
18. If this application is to replace existing cover with another insurer, I / we have read, understood and signed an Advice on Replacement Business form.
19. 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.
20. I / We declare that I / we have disclosed all information around previous applications for insurance cover with AIA New Zealand.

Application/policy no.

4. Declaration to AIA New Zealand

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

I/We authorise AIA to disclose all personal information relating to this Application to my financial adviser. The information is to be provided for the purposes of my financial adviser providing me with advice regarding the underwriting of this Application by AIA. This authority is limited to this Application, and is only valid for the period of the assessment of this Application until an outcome on this Application is reached. I/we acknowledge that the personal information which may be disclosed includes, but is not limited to, medical, vocational, occupational and financial information relevant to the assessment of this Application.

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 18 years)

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**

Full name of Policy Owner (3)
(if different from Life Assured)

Signature of Policy Owner (3) **Date**

Full name of Policy Owner (4)
(if different from Life Assured)

Signature of Policy Owner (4) **Date**

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 and Poor's. A summary of the Standard and 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.

Application/policy no.

Section 5: Adviser Details

Adviser name	
Adviser number	
Agency name	
FSP/QFE no.	
If you are a part of a QFE, please provide the QFE name	
Commision split	
Commision code	
Is the client a family member?	☐ Y ☐ N

Checklist

Type of application

☐ New application ☐ Single Life ☐ Joint Life (please complete a separate application)

☐ Increase Policy no. ☐ Use existing DD ☐ Use new DD

☐ Amendment Policy no.

Application details

☐ All relevant sections completed and signature(s) obtained on the declaration

☐ The illustration is attached to this application

☐ A Business Cover Financial Report is completed (for AIA Business Cover applications)

Section 6: Payment Details

Payment Method

☐ Direct Debit ☐ Credit Card ☐ Cheque/manual payment ☐ quarterly ☐ half yearly ☐ annually ONLY

Payment Frequency:

☐ Monthly – deductions to be on the ☐☐ of every month (except 29, 30 & 31)

☐ Fortnightly – deductions to be on every second day starting on the ☐☐ ☐☐

☐ Quarterly – deductions to be made on the ☐☐ ☐☐ ☐☐☐☐

☐ Half Yearly – deductions to be made on the ☐☐ ☐☐ ☐☐☐☐

☐ Annually* – deductions to be made on the ☐☐ ☐☐ ☐☐☐☐

Preferred Policy Risk Commencement Date ☐☐ ☐☐ ☐☐☐☐

If not specified, we will start your cover in line with your preferred payment date.

If paying by credit card, please complete the following section.

* **A lower premium is charged if you select to pay a lump sum annual premium (rather than a fortnightly or monthly payment).**

Application/policy no.

Please ensure Section 6 is completed in conjunction with the following:

Authority to Accept Credit Cards

☐ Visa ☐ Mastercard

Card Number | | | | | | | | | | | | | | | | Expiry Date | | | | | | | | |

Cardholder's name

Cardholder's Signature

Date Signed | | | | | | | | |

This authority enables AIA New Zealand to debit your credit card as above until you advise AIA New Zealand in writing to cancel this authority. The amount debited may vary from time to time as a result of contractual increases or decreases which apply to your policy.

Authority to Accept Direct Debits

Daytime contact no. ( )

Name of account holder

Customer (acceptor) to complete bank / branch number & account number & suffix of account to be debited

Bank Branch number | Account number | Suffix

AUTHORITY TO ACCEPT DIRECT DEBITS
(Not to operate as an assignment or agreement)

AUTHORISATION CODE

0	3	1	8	8	2	7

(User number)

To: The manager

Bank

Branch

Address (PO Box)

Town / city

Date | | | | | | | | |

I / We authorise you until further notice in writing, to debit my / our account with all amounts which AIA New Zealand (hereinafter referred to as the Initiator) the registered Initiator of the above Authorised 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 on my / our bank statement (to be completed by the Initiator)

Payer particulars | Payer code – type of cover | Payer reference – policy no.

A	I	A		I	N	S	U	R	E															

Authorised signature/s:

AIANB-032-08
11/17

Application/policy no.

CONDITIONS OF THIS AUTHORITY TO ACCEPT DIRECT DEBITS

1. The initiator:

(a) Will not initiate a direct debit on my / our account unless 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.

(b) Has agreed to send notice of the net amount of each Direct Debit and the due date of debiting after receiving authorisation from me / us under clause 1 (a) but no later than the date the Direct Debit will be initiated. 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
The notice will include the following message:- "The amount $....., was direct debited to your Bank account on (initiating date)."

(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) 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 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 disputes lies between me / us and the Initiator.

(d) Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility in respect of:
- the accuracy of information about Direct Debits on Bank statements
- any variations between notices given by the Initiator and the amounts of Direct Debits

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

4. The bank may:-

(a) In its absolute discretion conclusively determine the order of priority of 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.

APPROVED	FOR BANK USE ONLY			BANK STAMP
1882 **07/10**	Date received:	Recorded by:	Checked by:	

Original – Retain at branch
Copy – Forward to initiator if requested

AIA New Zealand
Level 15, 5-7 Byron Avenue, Takapuna
Private Bag 300981, Albany, Auckland 0752, New Zealand
T: +64 9 488 8800
F: +64 9 488 8810

Application/policy no.

Advice on Replacement Business

This form must provide information for all contracts, plans or policies being replaced. The original of this form should be kept by the policy owner, and a copy held by the company issuing the new contract, plan or policy, and a record kept on the adviser's clients file(s).

Details of New Policy / Benefit(s)

Name(s) of Life Assured

Name(s) of Policy Owner

Name of Insurer(s)

Annual Premium $

Life Assured	Benefit Type	Sum Assured

Details of Policy / Benefit(s) Being Replaced

Name(s) of Life Assured

Name(s) of Policy Owner

Name of Insurer(s)

Annual Premium $

Life Assured	Policy Number	Benefit Type	Sum Assured	Commencement Date

Details of Replacement – Statement of Adviser / Intermediary

(a) Please state the specific reasons for the replacement of this existing policy / benefit(s) and reasons why the policy being replaced cannot adequately fulfil the owner's objectives:

1.

2.

3.

4.

(b) The following risks are not covered by the new policy / benefit(s) but were covered by the old policy / benefit(s):

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 and Poor's. A summary of the Standard and 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.

Application/policy no.

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
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 any benefit replacement, 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 many 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.

Benefit Definitions – There can be subtle differences in the definitions used between policies including medical conditions, employment, occupational and disablement etc. Take care to understand what your existing policy / benefit covers and what you will be covered for under the new policy / benefit.

Cost – If there have been changes to your personal situation since the original policy / benefit was taken out, the new policy / benefit may cost more to get the same or similar benefits. Alternatively, if your personal situation has improved or remained the same, the premiums for the new policy / benefit may be lower.

Important Information
In a new policy the Suicide Exclusion Clause may recommence or the waiting period for trauma condition benefits may recommence.
AIA New Zealand will not be on risk until the original insurance cover being replaced by this policy is cancelled.
When replacing one policy with another, it is imperative that the new insurer be provided with the opportunity to assess your application accurately. For that reason it is vital that you provide full and accurate information regarding your health, occupation and pastimes. Provided the above has been done, the new insurer will issue the new policy to the same levels of cover without the stand-down period or suicide exclusion, which would normally apply.

I am / We are also aware I / we may withdraw this application in writing within the 14 day "free look" period from the date the new policy is received. In this event, AIA New Zealand will refund any premium, deposit or other payment made in respect of the proposed replacement policy and the proposed replacement policy will be cancelled.

Full name of Life Assured

Signature of Life Assured _____ **Date** DD MM YYYY

Full name of Policy Owner (1)
(if different from Life Assured)

Signature of Policy Owner (1) _____ **Date** DD MM YYYY

Full name of Policy Owner (2)
(if different from Life Assured)

Signature of Policy Owner (2) _____ **Date** DD MM YYYY

Full name of Policy Owner (3)
(if different from Life Assured)

Signature of Policy Owner (3) _____ **Date** DD MM YYYY

Full name of Policy Owner (4)
(if different from Life Assured)

Signature of Policy Owner (4) _____ **Date** DD MM YYYY

Adviser Declaration

Your existing policies will remain in force and there will be no alteration to your existing cover, payment method or cancellation of your policy, until the terms and conditions of your new policy have been approved by yourself and you have instructed us to complete the replacement.

Full name of Adviser / Intermediary

Adviser / Intermediary Business Name

FSPR Number

Signature _____ **Date** DD MM YYYY

AIA New Zealand
Level 15, 5-7 Byron Avenue, Takapuna
Private Bag 300981, Albany, Auckland 0752, New Zealand
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aia.co.nz

AIANB-013-05
11/17

Application/policy no.

Certificate of Interim Accidental Cover

To be kept by the Policy Owner(s)

1. Life Assured

Title	First name	Middle name(s)	Surname

2. Policy Owner(s)

Title	First name	Middle name(s)	Surname

Date of application | | | | | | | | |

AIA New Zealand grants Interim Accidental Cover on the Life Assured named above at no additional cost, in accordance with the following terms and conditions:

1. When is a benefit payable?

1.1 Interim Accidental Cover only applies when the Application is for Life Cover, Total and Permanent Disability Cover, Trauma Cover only applies to the following events: Paralysis (quadriplegia, paraplegia, diplegia, hemiplegia), blindness, major burns, loss of use of limbs and sight of one eye, major head trauma, loss of independence or Income Protection Cover.

1.2 The maximum amount paid under a claim for Interim Accidental Cover will be the lesser of the sum applied for in the Application or the maximum amounts specified below:

Benefit type (please refer to the policy wordings of each benefit for the terms and conditions)	**Maximum payable** (being the lesser of the below amount or that applied for in the Application)
Life Cover	$500,000
Total and Permanent Disablement (TPD)	$200,000
Trauma Cover – limited to the events listed below: • Paralysis (quadraplegia, paraplegia, diplegia, hemiplegia) • Blindness • Major burns • Loss of use of limbs and sight of one eye • Major head trauma • Loss of independence	$200,000
Income Protection Cover	$4,000 monthly benefit with maximum payable of $24,000 over six months

Application/policy no.

1.3 A Life Benefit is payable on the death by accident of the Life Assured which is the result of external or internal bodily injury caused directly by violent external and visible means, not attributable to any other event.

1.4 A Total and Permanent Disability, Trauma or Income Protection Benefit is payable as a result of external or internal bodily injury caused directly by violent external and visible means, not attributable to any other event.

2. When is a benefit not payable?

2.1 No benefit is payable if, in AIA New Zealand's sole discretion, the application would not have been accepted without a premium loading, exclusion or any other special terms.

2.2 No benefit is payable if the application is not accompanied by payment of the first premium or provision of an active bank account or credit card details.

2.3 No benefit is payable if the death or injury occurs as a direct or indirect result of any of the following:

i. Any act of self injury; or
ii. suicide, whether sane or insane; or
iii. aviation other than as a fare-paying passenger on a recognised airline; or
iv. any accident which took place before or on the date of this application; or
v. pre-existing medical conditions contributing to an accident; or
vi. alcohol, drug or substance abuse; or
vii. participation in a criminal activity.

2.4 The Interim Accidental Cover expires on the earlier of:

i. 90 days after the date of the application; or
ii. the risk commencement date of the policy; or
iii. the date the application is withdrawn by the applicant; or
iv. the date AIA New Zealand defers or declines the application; or
v. the date one of the benefits proposed is paid.

3. General terms

3.1 All terms and conditions including, but not limited to, disclosure requirements applying to the application shall apply to this Interim Accidental Cover.

3.2 The application shall not be proceeded with if AIA New Zealand pays a claim under this Interim Accidental Cover.

3.3 AIA New Zealand will, under no circumstances, be required to pay a claim under the Interim Accidental Cover as well as a policy issued as a result of the application.

3.4 The maximum total amount that AIA New Zealand will pay under Interim Accidental Cover is $500,000 regardless of whether there is more than one claim.

Adviser signature _____ **Date** | | | | | | | | |

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 and Poor's. A summary of the Standard and 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.

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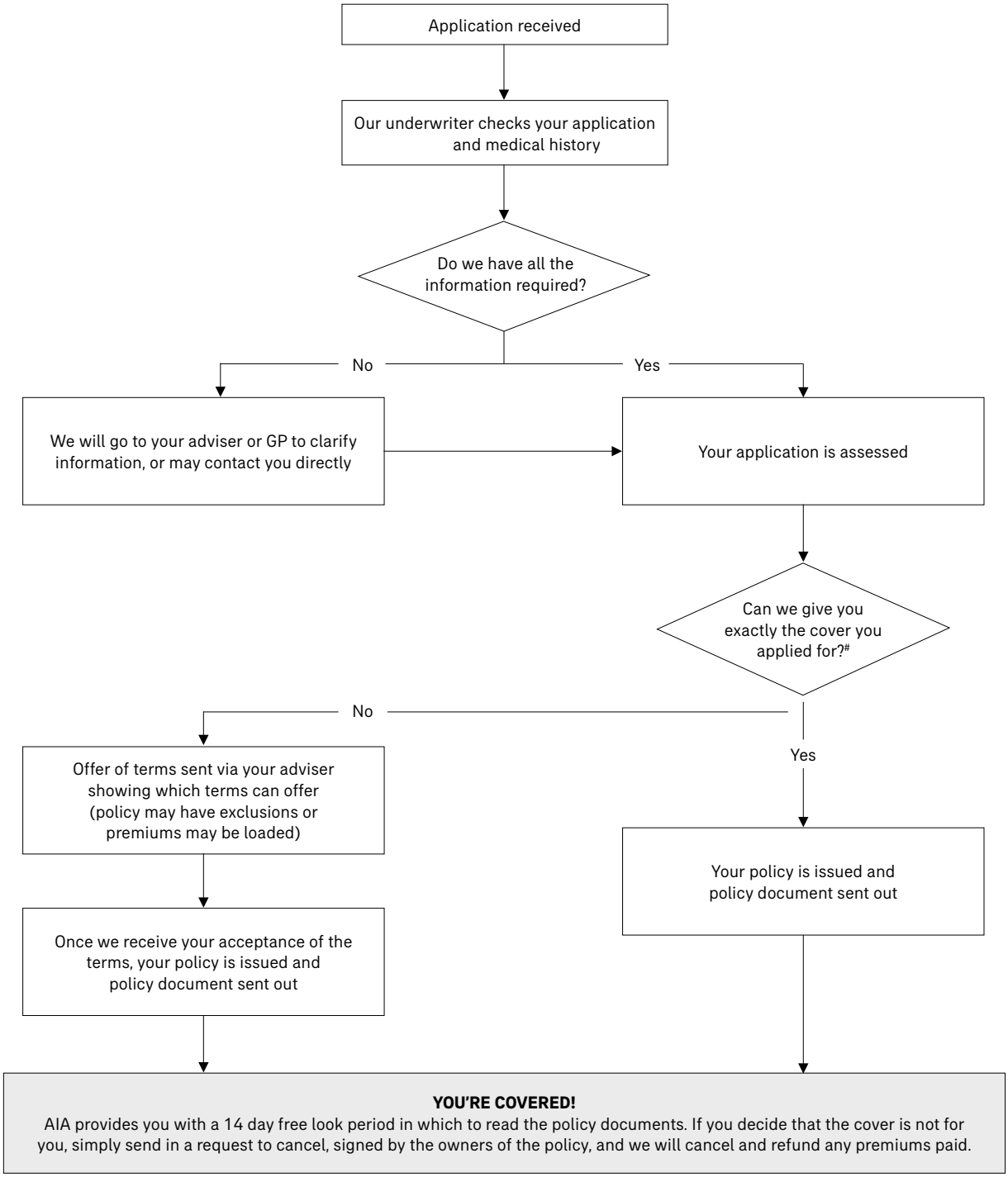
Application Process*



* This is a general outline of the standard process we take. Of course, everyone is different so, depending on your individual circumstances, the process may vary.

\# In some circumstances a policy may be deferred.

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AIA International Limited, trading as AIA New Zealand

AIANB-002-16
11/17