



AIA Real and Superior Health Supplementary Child Application form

This application should only be used to add a child* of a life assured to their existing REAL or SUPERIOR Health Policy ('existing policy') issued by AIA International Limited, New Zealand Branch ("AIA International"). Policy ownership and payment details must be the same as the existing policy.

* For a child aged 16 years and over please complete an AIA Living Application form.

1 Existing policy details

Life assured	<input type="text" value="Title"/>		
First name(s)	<input type="text"/>	Surname	<input type="text"/>
Policy owner	<input type="text" value="Title"/>		
First name(s)	<input type="text"/>	Surname	<input type="text"/>
Policy number	<input type="text"/>		

2 Child details

First name(s)	<input type="text"/>	Surname	<input type="text"/>
Gender	<input type="text" value="male/female"/>	Date of birth	<input type="text" value="Day / Month / Year"/>
Height	<input type="text" value="cm/ft/inches"/>	Weight	<input type="text" value="kg/stone/lb"/>

1. Is this policy to replace any existing insurance? Yes No If yes, please attach a completed Replacement Policy Advice form.

2. Has the child ever had any Insurance deferred, declined or issued on special terms with AIA or any other Insurance company? Yes No If yes, please give details below.

Date	<input type="text" value="Day / Month / Year"/>		
Insurance company	<input type="text"/>	Type of insurance	<input type="text"/>
Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No	Deferred	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special terms	<input type="text"/>		
Reason	<input type="text"/>		

Child details continued...

3. Is the child a permanent resident of New Zealand?

Yes No If no, please provide details

4. Name, address and phone number of the child's current doctor and doctor holding their records

First name(s) Phone number

Address

5. When did the child last visit a doctor and what was the reason?

Date of visit Day / Month / Year

Reason for visit

Treatment

Outcome

6. Has the child ever had a trauma, disability, or health insurance claim or an ACC claim?

Yes No If yes, please provide details

Claim date Day / Month / Year

Reason

Claim date Day / Month / Year

Reason

7. Has the child 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 Yes No
- b. Diabetes or heart disease or disorders of the blood, rheumatic disorders including heart murmur Yes No
- c. Ear disorders or infection or deafness, vision disorders (including wearing glasses), nose or throat disorders or infection, impaired speech, or wisdom teeth Yes No
- d. Musculoskeletal disorders; injury or disease of the back, joints, muscles or bones, juvenile arthritis Yes No
- e. Cancer, tumour, hepatitis A, B or C, umbilical hernia, colitis or any other disease or disorder of the gastrointestinal tract or renal system Yes No
- f. Neurological disorders including epilepsy, recurring ailments, or congenital conditions not already disclosed Yes No
- g. Has the child 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? Yes No

Child details continued...

If you answered yes to any of questions (7 a-g), please provide details here

Question	<input type="checkbox"/>	Date	<input type="text" value="Day / Month / Year"/>
Name of illness/test	<input type="text"/>		Duration <input type="text"/>
Treatment/received/ diagnosis/results	<input type="text"/>		
Any recurrences	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please provide details here		
	<input type="text"/>		
Date of last symptoms	<input type="text" value="Day / Month / Year"/>		
Name and address of doctor/hospital	<input type="text"/>		
Question	<input type="checkbox"/>	Date	<input type="text" value="Day / Month / Year"/>
Name of illness/test	<input type="text"/>		Duration <input type="text"/>
Treatment/received/ diagnosis/results	<input type="text"/>		
Any recurrences	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please provide details here		
	<input type="text"/>		
Date of last symptoms	<input type="text" value="Day / Month / Year"/>		
Name and address of doctor/hospital	<input type="text"/>		
Question	<input type="checkbox"/>	Date	<input type="text" value="Day / Month / Year"/>
Name of illness/test	<input type="text"/>		Duration <input type="text"/>
Treatment/received/ diagnosis/results	<input type="text"/>		
Any recurrences	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please provide details here		
	<input type="text"/>		
Date of last symptoms	<input type="text" value="Day / Month / Year"/>		
Name and address of doctor/hospital	<input type="text"/>		
Question	<input type="checkbox"/>	Date	<input type="text" value="Day / Month / Year"/>
Name of illness/test	<input type="text"/>		Duration <input type="text"/>
Treatment/received/ diagnosis/results	<input type="text"/>		
Any recurrences	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please provide details here		
	<input type="text"/>		
Date of last symptoms	<input type="text" value="Day / Month / Year"/>		
Name and address of doctor/hospital	<input type="text"/>		

4 Declaration

Declaration and consent to be completed by the policy owner

Please read your duty of disclosure and declaration carefully and sign the bottom of the page to show your acceptance of these terms.

Failure to make the following declaration truthfully may invalidate your insurance.

The below named policy owner declares and agrees that:

Disclosure:

1. I have read the notice explaining my duty of disclosure and all the statements contained in this Supplementary Child Application form ('Child Application') are true and complete to the best of my knowledge.
2. Should the Child to be Assured ('Child') undergo any alteration in mental or physical health between the date of this Application and the issue of the insurance, I agree to notify AIA immediately as this information is relevant to any decision AIA may make to accept this Application.
3. I understand that statements made in the original application for my existing policy set out in Section 1 above and in this application, including statements made by me to any medical examiner or made by any medical examiner on my behalf, forms the entire basis of the insurance contract between me and AIA.
4. I acknowledge that my Adviser receives commission from AIA.
5. I acknowledge that I am signing on behalf of the Child and declare that I have disclosed all health information, including any pre-existing conditions, for the Child.

Underwriting:

7. I will be bound by the standard conditions applicable to the proposed insurance upon AIA's acceptance of this Application. I understand that if my Application requires underwriting, then special terms (including special conditions, premium loadings, exclusions or maximums) may be applied to my policy in respect of the child.
8. I understand if additional information is required to process my Application, I may be telephoned by a Telephone Underwriter. The information that I provide to the Telephone Underwriter will form part of my Application.
9. I understand that if I do not consent to AIA collecting personal information on this Application and from the sources listed in paragraph (20) AIA may not be able to undertake a full underwriting assessment which may result in AIA declining to offer cover or offering cover on less favourable terms than I may otherwise be offered.
10. I understand that financial information may be required as part of the Illustration (quoting) process, and that any such information, if requested, will form part of my Application.

My personal information:

11. I understand that any personal information that I provide in this Application will be collected, used, stored and disclosed in accordance with AIA's privacy statement, available on www.aia.co.nz/en/index/privacy-statement.html.
12. I acknowledge and consent that personal information, including "health information" (as that term is defined in the Health Information Privacy Code 2020), provided in this Application to AIA, or obtained by AIA from the sources listed in clause (20) may be used, held, stored and/or disclosed by AIA or a related company to:
 - > assess and process this Application and any other application for insurance I make to AIA;
 - > for the purposes of assessing any claim(s), including assessing if I have met my duty of disclosure under this Application;
 - > to design new, or enhance existing, products and services provided by AIA, including research/direct marketing firms engaged by AIA or its related companies to seek my views on products or services offered by AIA or its related companies (whether or not I choose to proceed with this Application);
 - > to communicate with me, including to send me administrative communications about any policy I may have with AIA;
 - > to third parties for the purposes of such parties providing AIA with technology services
 - > for statistical or actuarial research undertaken by AIA;
 - > unless I tell AIA otherwise or opt out, to tell me about other products and services that are offered by AIA, or by reputable organisations with whom AIA contracts, or to send me/us other information or promotional material that we think may be of interest to you;

- > to assist AIA to work with other reputable organisations with whom AIA contracts, whether in New Zealand or overseas, that offer products or services (including loyalty programmes) connected with any of the services that AIA provides. Such assistance may include undertaking data matching exercises both internally within AIA and with such organisations in order to identify products and services that I might be interested in;
 - > for internal business and administrative purposes;
 - > where disclosure is required by law;
 - > as otherwise specified in this declaration.
13. I acknowledge and consent that health information provided in this Application to AIA, or obtained by AIA from the sources listed in clause (20) may be used, held, stored and/or disclosed by AIA
 - > to assess and process this Application and any other application for insurance I make to AIA; for internal business and administrative purposes;
 - > for the purposes of assessing any claim(s), including assessing if I have met my/our duty of disclosure under this Application;
 - > where disclosure is required by law;
 - > in accordance with clauses (14), (15) and (16) below.
 14. All personal information (including health information) may be collected, held and/or stored by AIA and may be made available to AIA or a related company and to any agent, contractor or third party who provides technology, administrative or other services to AIA or any member of the AIA Group.
 15. I understand that AIA is a member of the Health Funds Association of New Zealand (HFANZ). I agree that AIA is authorised to collect, use, store and disclose personal information and health information collected in this Application for the purposes of the HFANZ Integrity Registry. I authorise disclosure of personal and health information to HFANZ or its agents, and HFANZ Members, for that purpose.
 16. I authorise AIA to obtain the Child's full medical history where the application form contains:
 - > ongoing medical conditions where disclosure is required by law;
 - > partial or incomplete medical history
 - > multiple medical conditions
 - > a referral to a medical provider
 17. I understand that all personal information (including health information) will be stored by AIA at, 74 Taharoto Road, Takapuna, New Zealand, and may also be held by AIA's data storage providers, including cloud-based data storage providers (in New Zealand or elsewhere). I understand that AIA will take reasonable steps to keep such information secure.
 18. I understand access to and correction of personal information (including health information) may be requested by me.
 19. I authorise AIA to disclose all personal information (including health information) relating to this Application to my financial adviser for the purposes of 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 and until an outcome is reached. I acknowledge that the personal information which may be disclosed includes, but is not limited to, health information, vocational, occupational and financial information relevant to the assessment of this Application.
 20. I consent and give authority to AIA or a related company to seek from, and for all and any of the following, their officers and employees, to disclose to AIA and/or any of their advisers, reinsurers, and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of the Child:
 - > any doctor or other registered medical practitioner or specialist, counsellor, psychologist, therapist, dentist, clinic, hospital or medical laboratory;
 - > the Accident Compensation
 - > any bank, financial institution, accountant or financial adviser;
 - > insurers or reinsurers (whether public or private); and
 - > any government department, agency, organisation or enterprise.

21. I understand that the supply of the information gathered from the above sources is voluntary and that AIA or a related company, may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my insurance.

22. I understand that in collecting information that is relevant to this Application AIA may also receive/collect information that is not relevant to the assessment of this Application or the assessment and administration of my claim and AIA will not use this non-relevant information for any purpose other than as permitted under the Privacy Act.

IMPORTANT NOTICE: Your Duty of Disclosure and Personal Information

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

Please note, AIA may request a copy of your entire medical file from your General Practitioner and other medical providers.
IF IN DOUBT - DISCLOSE. WE TREAT ALL INFORMATION CONFIDENTIALLY.

Please complete the below Check boxes to confirm that each life assured understands and accepts the following:

I/We understand the importance of full disclosure of all information required in this application for Insurance and have read the “Disclosure” section above..... Yes
I/We understand that AIA may require access to my/our medical records, other sensitive financial information or other personal information from my/our medical providers and other agencies. I/We give consent to AIA to do so pursuant to clause (20) under the “My personal information” section above..... Yes
I/We authorise AIA to disclose **all** personal information relating to this application for insurance to my/our financial adviser pursuant to clause (19) under the “My personal information” section above..... Yes

Please print full name of Child to be Assured.

Signature of Policy Owner

Date Day / Month / Year

PLEASE COMPLETE

Parent’s consent where Life/Child to be Assured is less than 16 years of age

I consent to this Application for Insurance and certify that the answers to the questions in the application are true and complete to the best of my knowledge.

Relationship (please tick) Parent Guardian

Signature of parent or guardian of Life/Child to be Assured

Date Day / Month / Year

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

Where deceased minor is under the age of 10 years

Upon the death of a minor who is under the age of 10 years, payment is limited to a return of the total premiums paid on the life of the minor together with interest calculated in accordance with Schedule 2 of the Interest on Money Claims Act 2016, plus the amount that, when added to any other sum permitted to be paid by any other company or friendly society, equals \$2,000 (or such larger sum as may be specified by Order in Council).

Where deceased minor is under the age of 16 years

AIA is prohibited from paying on the death of a minor under the age of 16 years, any sum under any policy issued on or after the 1st day of April 1986 to any person other than:

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

AIA New Zealand Limited

AIA House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag 92499
Victoria Street West
Auckland 1142

Phone (Int.): +64 9 487 9963
Freephone (NZ): 0800 500 108
Email: enquireNZ@aia.com
Web: aia.co.nz

AIANB-002-15 03/21