HEALTHIER, LONGER,
BETTER LIVES

CORPORATE SOLUTIONS PERSONAL STATEMENT

Welcome to AIA New Zealand.

If you prefer, you can complete this form in private and post it directly to:
Private Bag 92499, Victoria Street West, Auckland 1142

If you need extra space to provide any response, please use the notes on pages 14 and 15 and write **'refer to notes'** next to the original question.

DUTY OF DISCLOSURE: WHAT YOU NEED TO TELL US

The purpose of this Personal Statement is to prompt you to provide information we may consider relevant to the assessment of your application ("Application") for insurance.

We understand that the questions we ask in this form may be sensitive and completing the form may take time, but it is very important that you give us all the information asked for, as this may affect your Application for insurance.

It is important that you understand your **duty to provide truthful, complete and correct information** about yourself, including your health and medical history.

This means you should:

- Always tell the truth (including if your circumstances change after you have completed this Personal Statement but before the policy is issued);
- Answer questions as fully as you can, including as much detail relating to your current and past circumstances as possible;
- Include all information, even if you're unsure it is relevant;
- Tell us if you don't know the answer to any question; and
- Ask questions if there is anything you're not sure of.

At claims time, we will look further into your personal history. If we discover that you haven't told us something material, we may either alter the terms of the insurance issued in relation to your Application (which might affect your claim) or we may avoid the insurance issued in relation to your Application from its inception which means that you would not be able to make a claim, as no policy would exist. It does not matter if the new information is about a condition unrelated to your claim.

What happens next:

Once you have completed this Personal Statement form it will be sent to AIA and an Underwriter will assess the information you have provided. We may require further information from you or your GP to complete our assessment. Typically the more information you provide on the Personal Statement form the faster we are able to process your Application, so please provide as much detailed information in the General Health Questions as you can.

After the assessment has been made:

You will be advised in writing of the outcome of your Application, whether it has been accepted and if any terms have been applied.

If you are unsure of anything, don't be afraid to ask the Plan's financial adviser or AIA for help. Contact your Plan Adviser or phone us on **0800 500 108.**

1 Plan details

Employer name

Policy Number (if known)

2 Life to be assured

Mr/Mrs/Miss/Ms/Mx

Last name | First names

Previous name (if changed)

Mailing address

Street

Suburb | Town/City | Postcode

Home address (if different)

Contact details

Home phone ( ) | Business phone ( ) | Mobile ( )

Email

Date of birth (dd/mm/yyyy) / /

Place of birth

☐ Male ☐ Female ☐ X

In the last 12 months, have you smoked tabacco or any other substance and/or used smoking alternatives (e.g. e-cigarettes, vaping, nicotine gum or patches)?

☐ Yes ☐ No If Yes, please give details of each substance including date started (or stopped) and quantity per day:

Occupation
(please include duties)

3 Your Insurance Details

(a) Has any insurance you currently have, or have applied for (eg Life, Income Protection), ever been declined, deferred or modified including any loadings or exclusions? ☐ Yes ☐ No

If YES, please give details below:

DATE	INSURANCE COMPANY	TYPE OF INSURANCE	DECLINED	DEFERRED	SPECIAL TERMS	REASON

(b) Have you ever claimed benefits from ACC, WINZ or an insurer due to sickness, injury or treatment for injury (eg physiotherapy)? ☐ Yes ☐ No

If YES, please give details below, and give details of the condition in the **General Health Questionnaire** in SECTION 5

CLAIM DATE	TYPE OF CLAIM	REASON/CONDITION

4 Personal Statement

(a) Please indicate your New Zealand residency status

☐ Citizen/ Permanent resident ☐ Resident Visa / Work Permit (please enclose a copy) ☐ Long-term business visa and permit (please enclose a copy) ☐ Other (please enclose a copy)

How long have you resided in New Zealand?

Years Months

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

☐ Yes ☐ No If YES, please tick purpose and give details below ☐ Live ☐ Work ☐ Travel

Country | Start date | Duration

(c) Do you participate, intend to participate, or in the last three years have you participated, in any hazardous occupation or pursuit (e.g. motor racing, aviation, martial arts, parachuting, scuba diving, or motor boat racing)? ☐ Yes ☐ No

If YES, please give details:

PASTIME/PURSUIT	NO. OF YEARS PARTICIPATED AND DETAIL OF EXPERIENCE	FREQUENCY OF PARTICIPATION PER ANNUM	MAXIMUM HEIGHT, DEPTH, SPEED, RECORD ATTEMPTS	GEOGRAPHIC LOCATION	EQUIPMENT DETAILS

(d) What is your height and weight?

cm/feet/inches | kg/stone/lb

(e) In the last 12 months, has your weight varied by more than 10 kg?

☐ Yes ☐ No If YES, please give full details

(f) Do you drink alcohol?

☐ Yes ☐ No If YES, please give full details

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

(g) Have you ever used any drug not prescribed by a doctor, or used over the counter medications not in accordance with the manufacturer's directions, or received medical advice, counselling or treatment for the use of alcohol, drugs or gambling?

☐ Yes ☐ No If YES, please give full details

(h) **Family history**

Has any parent, sister or brother (blood relative) before the age of 60, received treatment or been diagnosed with one of the conditions in the following table? ☐ Yes ☐ No

If yes, please complete this table.

**For Cancer please specify type*

CONDITION	RELATIONSHIP TO YOU	Current state of health	AGE when diagnosed	Current AGE	If deceased, AGE at death
Diabetes					
Stroke					
Mental illness					
Dementia					
Kidney disease					
Heart disease					
Cancer*					
Huntington's disease					
Polycystic kidney					
Multiple Sclerosis					
Any other hereditary or familial disease					

(i) **Doctor's details**

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

Medical professional and clinic

Doctors name

Does this professional hold your records? ☐ Yes ☐ No

Clinic name

Business phone ( )

Clinic address

Years attended

Medical professional and clinic

Doctors name

Does this professional hold your records? ☐ Yes ☐ No

Clinic name

Business phone ( )

Clinic address

Years attended

HealthScreen®

HealthScreen® has been developed to provide you with an efficient, convenient and professional means of gathering medical information required for processing your Application for insurance.

Depending on your amount of cover and/or your medical history, different tests or medical questionnaires may be necessary. Usually your doctor or a specialist is responsible for providing this service and the necessary documentation. HealthScreen® provides an easier, more efficient way of gathering this information.

This is a completely confidential service provided free of charge. It enables a medical assessment to be conducted by a Registered Nurse at a time and place that is convenient for you.

Telephone Underwriting

Telephone Underwriting is a service that helps us process your Application quickly and simply. If we require further information, an AIA Underwriter will phone you. They may ask you questions about your health, your occupation or hazardous pursuits so we can process your Application. We use this additional information to assess the acceptance terms of your Application.

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

(j) If we require further information to process your Application quickly, would you use our Telephone Underwriting and HealthScreen services? ☐ Yes ☐ No

(k) Have you ever had any signs or symptoms of, or been tested or treated for, or diagnosed with any of the following?

If YES, please complete the **General Health Questionnaire** in SECTION 5. If your symptom is underlined, please refer to the questionnaire specific to that condition.

1	Brain or neurological disorders (e.g. stroke, paralysis, epilepsy, Multiple Sclerosis, Motor Neurone Disease, Bell's palsy, cerebral palsy, any migraine or frequent headaches)	☐ YES	☐ NO
2	Nervous or mental disorders/illness, stress, depression, fatigue, anxiety, low mood, phobia, sustained poor sleep or lack of energy	☐ YES please complete **questionnaire i**	☐ NO
3	Any disease or disorder of the eyes, ears, nose or throat (eg sinusitis, rhinitis, tonsillitis or ear infections, loss of sight, hearing or speech etc.)	☐ YES	☐ NO
4	Thyroid disorder or any other glandular condition	☐ YES	☐ NO
5	Respiratory disorder (eg asthma, bronchitis, bronchiolitis, sleep apnoea, shortness of breath, breathing problems etc.)	☐ YES please complete **questionnaire ii**	☐ NO
6	Heart complaint, chest pain, heart murmur, high blood pressure, high cholesterol, irregular heart beat, hole in the heart	☐ YES	☐ NO
7	Any condition of the gastrointestinal tract or bowel (eg irritable bowel, Crohn's disease, ulcers, colitis, reflux)	☐ YES please complete **questionnaire iii**	☐ NO
8	Obesity treatment (eg bariatric surgery, prescribed diet)	☐ YES	☐ NO
9	Liver disease or disorder (eg hepatitis, fatty liver, abnormal liver function test)	☐ YES	☐ NO
10	Diabetes or abnormal blood sugar level	☐ YES	☐ NO
11	Kidney, bladder, or urinary problems (eg kidney reflux, kidney stones, urinary incontinence)	☐ YES	☐ NO
12	Cancer, tumour, cyst, breast lump, abnormal moles, or any other lesion	☐ YES please complete **questionnaire iv**	☐ NO
13	Skin disorder (ie a part of the skin that has an abnormal growth or appearance) or any other skin condition (eg eczema, dermatitis)	☐ YES	☐ NO
14	Any injury, disease or disorder of your muscle(s), joint(s) or bone(s) (including arthritis, rheumatism, gout)	☐ YES please complete **questionnaire v**	☐ NO
15	Blood disorders (eg leukemia, anaemia, blood clots, bleeding tendencies) or varicose veins	☐ YES	☐ NO
16	Disease or disorder of the immune system (eg systemic lupus erythematous/ SLE, rheumatoid and/or psoriatic arthritis, AIDS or HIV antibodies)	☐ YES	☐ NO
17	Disease or disorder of the reproductive tract (eg hydrocele, testicular lump, prostate enlargement, abnormal test, torsion, phimosis, endometriosis, fibroids, abnormal smears, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and/or abnormal periods)	☐ YES	☐ NO
18	Any other illness or condition not listed above (please state)	☐ YES	☐ NO

(l) In the last five years, have you had any medical examinations by a doctor or specialist, specialist tests, blood tests or X-rays?

☐ Yes ☐ No **If YES, please give details in the General Health Questionnaire in SECTION 5**

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

☐ Yes ☐ No **If YES, please give details in the General Health Questionnaire in SECTION 5**

(n) Are you experiencing any health problems or are you receiving or considering seeking medical advice, counselling, specialist tests, blood tests, treatment or an operation from a health professional or awaiting any screening or tests results?

☐ Yes ☐ No **If YES, please give details in the General Health Questionnaire in SECTION 5**

5 General Health Questionnaire

Please complete this section if you answered YES to any of the selected questions in SECTION 3 and 4. If you need extra space to provide your response, please use the NOTES on pages 14 and 15 and write 'refer to notes' next to the original question.

	CONDITION 1	CONDITION 2
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

	CONDITION 3	CONDITION 4
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

5 General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on pages 14 and 15 and write 'refer to notes' next to the original question.

	CONDITION 5	CONDITION 6
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

5 General Health Questionnaire (continued)

i. Mental health questionnaire

Please complete this section if you answered YES for **Nervous or mental disorders/illness, stress, depression, fatigue, anxiety, low mood, phobia, sustained poor sleep or lack of energy**.

(a) Do you have, or have you ever had any signs or symptoms of, been on treatment for, or had medical tests or prescribed medication for, or have you ever been advised by a medical practitioner that you have, one of the following:

- ☐ Anxiety
- ☐ Compulsive disorder
- ☐ Headaches
- ☐ Irritability
- ☐ Stress
- ☐ Fear or phobia
- ☐ Hyperventilation
- ☐ Depression
- ☐ Fatigue
- ☐ Sleeplessness
- ☐ Post-traumatic stress disorder
- ☐ Other

If OTHER, please give name of condition

(b) How long ago were the first symptoms? ☐ Years ☐ Months

(c) How long ago were the last symptoms? ☐ Years ☐ Months

(d) Have you had any recurrence of the symptoms? ☐ Yes ☐ No If YES, please give details

(e) Have you ever been hospitalised or had time off work or school as a result of this condition? ☐ Yes ☐ No If YES, please give details

(f) Have you ever had any suicidal thoughts or attempts of suicide or self-harm? ☐ Yes ☐ No If YES, please give details

(g) Have you ever been recommended, prescribed or received treatment for any of the conditions or symptoms listed above eg medication or counselling? ☐ Yes ☐ No If YES, please give details

Treatment period: Date started Day / Month / Year Date ceased Day / Month / Year

(h) Have you ever been assessed by a psychiatrist or a psychologist? ☐ Yes ☐ No If YES, please give details

ii. Respiratory questionnaire

Please complete this section if you answered YES for **Respiratory disorder (eg asthma, bronchitis, bronchiolitis, sleep apnoea, shortness of breath, breathing problems etc.)**

(a) Frequency of symptoms in the last five years (please tick the appropriate box)

- ☐ Daily
- ☐ Weekly
- ☐ Occasionally
- ☐ One-off episode
- ☐ None – childhood only

(b) Severity of symptoms in the last five years (please tick the appropriate box)

- ☐ Nil symptoms – childhood only
- ☐ Mild, eg exercise-induced only, seasonal (related to hayfever allergy, colds or flu)
- ☐ Moderate, eg all year around, no specific triggers
- ☐ Severe, eg constant, reduced lung capacity, restriction of lifestyle or work duties

(c) Have you, over the last two years, required: (please tick the appropriate boxes)

- ☐ YES ☐ NO Daily preventative inhalers, eg ventolin
- ☐ YES ☐ NO Occasional use of a nebuliser or oral steroid medication eg prednisolone
- ☐ YES ☐ NO Hospitalisation/ emergency treatment

(d) Maximum number of consecutive days off work / school you have had over the last two years due to this condition ☐ Days

5 General Health Questionnaire (continued)

iii. Gastrointestinal tract/bowel questionnaire

Please complete this section if you answered YES for **Any condition of the gastrointestinal tract or bowel (eg irritable bowel, Crohn's disease, ulcers, colitis, reflux)**

(a) Do you have, or have you ever had any signs or symptoms of, been on treatment for, or had surgery or medical tests or prescribed medication for, or have you ever been advised by a medical practitioner that you have, one of the following:

- ☐ Indigestion
- ☐ Heartburn
- ☐ Gastro-oesophageal reflux
- ☐ Hiatus hernia
- ☐ Gastritis
- ☐ Ulcer
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Irritable bowel syndrome
- ☐ Other

If OTHER, please give name of condition

(b) Have you ever consulted a specialist about symptoms of any of the above? ☐ Yes ☐ No

(c) Are you on continuous medication? ☐ Yes ☐ No If YES, is your medication prescribed by your GP/specialist? ☐ Yes ☐ No

(d) Have you ever had any investigations of the gastrointestinal tract? ☐ Yes ☐ No If YES, please give details below

Name of investigation	Result: Normal	Abnormal	Unknown
	☐	☐	☐

Name of investigation	Result: Normal	Abnormal	Unknown
	☐	☐	☐

(e) How often do you experience any symptoms? ____ times per year

(f) When were your last symptoms? Day / Month / Year

iv. Tumour questionnaire

Please complete this section if you answered YES for **cancer, tumour, cyst, breast lump, abnormal moles, or any other lesion.**

(a) What was the site of the tumour?

(b) Histology of the tumour if known ☐ Benign ☐ Malignant or pre-malignant ☐ Unknown

(c) How long ago was the initial diagnosis made? ____ Years ____ Months

(d) Have you received treatment within the last three years? ☐ Yes ☐ No If YES, please give details

(e) Has there been any recurrence? ☐ Yes ☐ No If YES, please give details

(f) Are you undergoing any ongoing follow-up or have you been advised that follow-up treatment is required? ☐ Yes ☐ No If YES, please give details

(g) Date of last cervical smear, mammogram or other routine screening? Day / Month / Year

Result

5 General Health Questionnaire (continued)

v. Musculoskeletal questionnaire

Please complete this section if you answered YES for **Any injury, disease or disorder of your muscle(s), joint(s) or bone(s) (including arthritis, rheumatism, gout)**

		CONDITION 1	CONDITION 2
(a)	Name of condition		
	Areas affected (eg left shoulder, right knee)		
(b)	How long ago did you first have any signs or symptoms of, or receive any advice or treatment for this condition/pain/discomfort/injury?	☐ Years ☐ Months	☐ Years ☐ Months
(c)	How long did these symptoms last?	☐ Years ☐ Months ☐ Weeks	☐ Years ☐ Months ☐ Weeks
(d)	Has this condition occurred more than once?	☐ YES – please give full details at (k) ☐ NO	☐ YES – please give full details at (k) ☐ NO
(e)	Have you had any special investigations or surgery?	☐ YES – please give full details at (k) ☐ NO	☐ YES – please give full details at (k) ☐ NO
(f)	Have you had any time off work or school as a result of this condition?	☐ YES – please give full details at (k) ☐ NO	☐ YES – please give full details at (k) ☐ NO
(g)	Are you currently receiving treatment?	☐ YES – please give full details at (k) ☐ NO	☐ YES – please give full details at (k) ☐ NO
(h)	Did you have any metalware inserted?	☐ YES – please give full details at (k) ☐ NO	☐ YES – please give full details at (k) ☐ NO
	If yes, has it been removed?	☐ YES – please give date it was removed ☐ NO Day Month Year / /	☐ YES – please give date it was removed ☐ NO Day Month Year / /
(i)	Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery may be required?	☐ YES – please give full details at (k) ☐ NO	☐ YES – please give full details at (k) ☐ NO
(j)	Do you have any residual, ongoing effects or restrictions as a result of this condition?	☐ YES – please give full details at (k) ☐ NO	☐ YES – please give full details at (k) ☐ NO
(k)	Please give full details if you have answered YES to question (d), (e), (f), (g), (h), (i) or (j) above		

6 Declaration and consent

Please read your duty of disclosure and declaration carefully, then complete the disclosure check boxes and sign the bottom of page 13 to show your acceptance of these terms. Failure to make the following declaration truthfully may invalidate any insurance issued in relation to your Application.

Important Notice: Your duty of disclosure

When you apply for insurance with AIA New Zealand Limited ("AIA"), and whenever you apply to vary or reinstate it, you have a duty to disclose 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 any insurance issued in relation to your Application from the beginning, which means any claim will not be paid.

I acknowledge that in issuing insurance related to this Personal Statement form, that AIA is relying on all disclosures made by the Policy Owner, or by or on behalf of me ("life to be assured") on any application relating to the related Corporate Solutions Plan ("Plan"), this includes any application for a policy or policies issued by ("related company or companies") Sovereign Assurance Company Limited ("Sovereign") or AIA International Limited, New Zealand Branch ("AIA Intl"), and that all such disclosures were true and correct to the best of my knowledge at the time they were made.

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.

Life assured:

I understand the importance of full disclosure of all information required in this Personal Statement form, and have read the "Disclosure" section below. ☐ Yes

I consent to AIA obtaining my medical records from my doctor and other medical providers and have read the "My personal information" section below. ☐ Yes

I authorize AIA to disclose all personal information relating to this Personal Statement form to the Plan's financial adviser, pursuant to clause (q) under the "My personal information" section below. ☐ Yes

The below named life assured declares and agrees as follows:

Disclosure:

a. I have read the notice explaining my duty of disclosure and all the statements contained in this Personal Statement form are true and complete to the best of my knowledge.
b. Should I undergo any alteration in mental or physical health or have a change of occupation between the date of this Personal Statement form and the issue of the insurance, I agree to notify AIA immediately as this information is relevant to any decision AIA may make about issuing the insurance.
c. I understand that statements made in this Personal Statement form, and any other application relating to the Plan including statements made by me to any medical examiner or made by any medical examiner on my behalf, form the entire basis of the AIA insurance contract.
d. I understand that irrespective of whether I have been insured with AIA before, that AIA will rely on the accuracy and completeness of my answers given in this Personal Statement form and I must not assume AIA has any prior knowledge of my history.

Underwriting

e. I will be bound by the standard conditions applicable to the proposed insurance upon AIA's acceptance of my Application. I understand that my Application requires underwriting, and that special terms (including special conditions, premium loadings, exclusions or maximums) may be applied. I understand that any special terms will apply from the risk commencement date of my insurance.
f. I understand that if additional information is required to process my Application, I may be telephoned by an Underwriter. The information that I provide to the Underwriter will form part of my Application.
g. I understand that if I do not consent to AIA collecting personal information on this Personal Statement form and from the sources listed in clause (r) 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.
h. I understand the insurance proposed in my Application shall not commence until my Application has been accepted by AIA.

My Personal Information

i. I understand that any personal information that I provide in this Personal Statement form will be collected, used, stored and disclosed in accordance with AIA's privacy statement, available at www.aia.co.nz/privacy
j. I acknowledge and consent that except in relation to "health information" (as that term is defined in the Health Information Privacy Code 2020) personal information provided in this Personal Statement form to AIA, or obtained by AIA from the sources listed in clause (r) may be used, held, stored and/or disclosed by AIA and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their Plan Advisers and reinsurers:
   - to assess and process my 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 Personal Statement form;
   - 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 my 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 other information or promotional material that we think may be of interest to you;

6 Declaration and consent (continued)

- 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; and
- as otherwise specified in this declaration.

k. I acknowledge and consent that health information provided in this Personal Statement form to AIA, or obtained by AIA from the sources listed in clause (r) may be used, held, stored and/or disclosed by AIA and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their Plan Advisers and reinsurers:
   - to assess and process my 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 Personal Statement form;
   - where disclosure is required by law; and
   - in accordance with clauses (l), (m) and (n) below.

l. All personal information (including health information) may be collected, held and/or stored by AIA and may be made available to AIA related companies, local and overseas (and in this regard I consent to the transfer of my information outside New Zealand) and to any agent, contractor or third party who provides technology, administrative or other services to AIA or any member of the AIA Group.

m. 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 about me 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.

n. I authorise AIA to obtain my full medical history where this Personal Statement form contains:
   - ongoing medical conditions
   - partial or incomplete medical history
   - multiple medical conditions
   - a referral to a medical provider

o. I understand that all of my personal information (including health information) will be stored by AIA at 74 Taharoto Road, Takapuna, Auckland, 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.

p. I understand that access to and correction of my personal information (including health information) may be requested by me.

q. I authorise AIA to disclose all personal information (including health information) relating to my Application to the Plan's financial adviser for the purposes of providing me with advice regarding the underwriting of my Application by AIA. This authority is limited to my 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 my Application.

r. I consent and give authority to AIA and/or any of its related companies to seek from, and for all and any of the following, their officers and employees, to disclose to AIA and/or any of its related companies, their advisers, reinsurers, and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me:
   - any doctor or other registered medical practitioner or specialist, counsellor, psychologist, therapist, dentist, clinic, hospital or medical laboratory;
   - the Accident Compensation Corporation;
   - any bank, financial institution, accountant or financial adviser;
   - any of my current or former employers;
   - insurers or reinsurers (whether public or private); and
   - any government department, agency, organisation or enterprise.

s. I understand that the supply of the information gathered from the above sources is voluntary and that AIA and/or any of its related companies 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.

t. I understand that in collecting information that is relevant to my Application AIA may also receive/collect information that is not relevant to the assessment of my 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.

Correspondence by Email:

u. Where I have provided my email address in this Personal Statement, I consent to AIA corresponding with me by email for the purposes set out in clause (j) above.

v. Such correspondence can be sent to the email address(es) detailed in this Personal Statement or subsequent email addresses I provide to AIA.

w. I am responsible for the security of the information sent to and held in my email account and the access that others have to this account e.g. the access other family members/colleagues may have to my emails.

Insurance Policy:

x. I have checked the information that the Plan's financial adviser has entered on this Personal Statement form.

y. At the date of my Application, no statement affecting my Application has been made to any representative of AIA that has not been recorded in this Personal Statement form.

z. I am aware that a copy of the Plan's Policy Document can be requested from the Policy Owner and the financial statements of AIA are available to me on request from AIA's Head Office.

Full names of Life to be Assured			
Signature of Life to be Assured	X	Date (dd/mm/yyyy)	/ /

Notes

Notes

X00190 007a 2209

0800 500 108
Monday - Friday, 8am - 6pm

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Disclaimer

AIA New Zealand has made all reasonable efforts to ensure that the information is correct at date of printing. Please note the information contained in this guide is a summary only and should not be regarded as a full explanation of the contract. Please contact AIA New Zealand or refer to the terms and conditions of the policy document for full details of the contract and the limitations and exclusions that apply.

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