Email completed form to enquireNZ@aia.com

Declaration Of Continued Good Health

1 Purpose of declaration

Policy reinstatement ☐

Pending application ☐

New 'top-up' cover application ☐

Date policy lapsed/cancelled — Day / Month / Year

Date original application's declaration and consent signed — Day / Month / Year

Date original application's declaration and consent signed (only available within 12 months of original application being signed) — Day / Month / Year

2 Life to be assured

Policy number(s)

Mr/Mrs/Miss/Ms/Mx — Last name — First names

Previous name (if changed)

Home address — Street

Suburb — Town/City — Postcode

Mailing address (if different)

Contact details — Home phone — Business phone — Mobile

Email

Date of birth — Day / Month / Year

☐ Male ☐ Female ☐ X

Preferred language

Occupation — Industry

In the last 12 months have you smoked tobacco or any other substance and/or used smoking alternatives (eg 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

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

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.

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 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.

Please give the details of the medical professional and clinic that hold your medical records.

Name of Medical Professional

Name and address of clinic

Financial Strength Rating: AIA New Zealand Limited, has been given an **AA (Very Strong)** insurer financial strength rating by Fitch Ratings, an approved ratings agency. A rating of AA means AIA New Zealand Limited has a very strong capacity to meet policyholder and contractual obligations.

Ratings scale: AAA – Exceptionally Strong **AA – Very Strong** A – Strong BBB – Good BB – Moderately Weak B – Weak CCC – Very Weak CC – Extremely Weak C – Distressed

Note: "+" or "-" may be appended to a rating to indicate the relative position of a credit within the rating category. Such suffixes are not added to ratings in the AAA category or to ratings below the CCC category.

3 Personal statement

1) What is your height? cm / feet & inches

What is your weight? kg / lb

2) In the last 12 months, has your weight varied by more than 10 kg? ☐ Yes ☐ No If yes, please provide brief details

3) 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

4) Since the date provided in SECTION 1, have you:

a) Experienced any health problems, been referred for, receiving or are you considering seeking any medical advice, counselling, specialist tests, blood tests, treatment or an operation from a health professional or awaiting any screen or test results? ☐ Yes ☐ No If yes, please provide brief details

Condition

Date of first symptoms / / Date of last symptoms / /

Details (including treatment, tests results, time off work, reoccurence, current status, follow-up)

Please attach additional pages if extra space is required.

b) Ever participated, or do you participate, or intend to participate in any hazardous occupation or pursuit? (e.g. motor racing, aviation, martial arts, parachuting, scuba diving, motor boat racing) ☐ Yes ☐ No If yes, please provide brief details

c) Had any insurance application declined, deferred or accepted with special terms (e.g. exclusions and/or loadings)? ☐ Yes ☐ No If yes, please provide brief details

5) Are you currently, have you ever been, or are you on notice that you are likely to be adjudged bankrupt, or placed under receivership or administration? ☐ Yes ☐ No If yes, please provide brief details

6) Have you ever been convicted of fraud or any offence involving dishonesty? ☐ Yes ☐ No If yes, please provide brief details

4 Occupation and income details

Please complete this section if you are applying for Income Protection (IP), Total and Permanent Disablement (TPD), Waiver of Premium (WOP).

1) Since the date provided in SECTION 1, has your occupation or duties changed? ☐ Yes ☐ No If yes, please provide brief details

	First recent change	Second recent change
Occupation		
Name of Employer or Business (please also state if self employed)		
Exact duties and % time on each duty		
Hours worked per week		
Date of employment from		
Date of employment to		

4 Occupation details continued...

2) What is your annual income before tax?

$

Please tick source of income:

☐ Salary wage ☐ Fringe benefits ☐ Bonus

☐ Share of profit ☐ Regular commission income ☐ Other (Please specify)

3) Have you ever claimed benefits from ACC, WINZ or an insurer due to sickness, injury or treatment for injury?

☐ Yes ☐ No If yes, please provide brief details

4) Has there been ANY change in ANY other circumstances since completing your application dated above that could affect any decision AIA may make regarding your cover?

☐ Yes ☐ No If yes, please provide brief details

5 Declaration and consent to be completed by the life to be assured

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 LIFE TO BE ASSURED DECLARES AND AGREES THAT:

Disclosure:

(1) I have read the notice explaining my duty of disclosure and all the statements contained in this Declaration of Continued Good Health ('DOCGH') are true and complete to the best of my knowledge.

(2) Should the Life to be Assured undergo any alteration in mental or physical health or have a change of occupation between the date of this DOCGH 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 DOCGH.

(3) I understand that statements made in the original application dated above and in this DOCGH, 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/ASB Bank Limited ("the Bank") receives commission from AIA.

(5) I acknowledge that I am signing on behalf of any children and declare that I have disclosed all health information, including any pre-existing conditions, for such children and ourselves.

(6) I understand that irrespective of whether I have been insured with AIA or a "related company" before, that AIA will rely on the accuracy and completeness of my answers given in this DOCGH and I must not assume AIA has any prior knowledge of my history.

Underwriting:

(7) I will be bound by the standard conditions applicable to the proposed insurance upon AIA's acceptance of this DOCGH. I understand that if my DOCGH requires underwriting, then special terms (including special conditions, premium loadings, exclusions or maximums) may be applied to my policy. I understand that any special terms will apply from the risk commencement date of my insurance.
I understand that the special terms will be set out in the schedule to my policy document and will form part of my insurance contract. I will accept the special terms if I either make a premium payment after the policy free look period or agree to the special terms in writing.

(8) I understand if additional information is required to process my DOCGH, I may be telephoned by a Telephone Underwriter. The information that I provide to the Telephone Underwriter will form part of my DOCGH.

(9) I understand that if I do not consent to AIA/the Bank collecting personal information on this DOCGH 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 DOCGH.

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 except in relation to "health information" (as that term is defined in the Health Information Privacy Code 2020) personal 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 and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers:
- 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 and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers:
- 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/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 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.

(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 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.

(16) I authorise AIA to obtain my full medical history where the application form contains:
- ongoing medical conditions
- partial or incomplete medical history
- multiple medical conditions
- a referral to a medical provider

(17) I understand that all of my 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) and by the Bank at, ASB Bank Limited, 12 Jellicoe Street, Auckland if you have ASB insurance underwritten by AIA. I understand that AIA and the Bank will take reasonable steps to keep such information secure.

(18) I understand access to and correction of my 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 or the Bank 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 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;

5 Declaration and consent continued...

- 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.

(21) 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.

(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.

Correspondence by e-mail:

(23) Where I have provided my email address in this DOCGH, I consent to AIA corresponding with me by email for the purposes set out in clause (12) above.

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

(25) I am responsible for advising AIA if my email address(es) change.

(26) 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.

IMPORTANT NOTICE: Your Duty of Disclosure

When you apply for your insurance, and when 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. I acknowledge that in issuing my policy which related to this DOCGH, that AIA is relying on all disclosures made by or on behalf of me and any life to be assured on the original application, 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 to be assured

I understand the importance of full disclosure of all information required in this Declaration of Continued Good Health (DOCGH) and have read the "Disclosure" section above. ☐ Yes

I understand that AIA may require access to my medical records, other sensitive financial information or other personal information from my medical providers and other agencies. I give consent to AIA to do so pursuant to clause (20) under the "My personal information" section above. ☐ Yes

I have read the "My personal information" section above. ☐ Yes

Please print full name of Life to be Assured

Signature of Life to be Assured X Date Day / Month / Year

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

I consent to this DOCGH for Insurance and certify that the answers to the questions in the DOCGH 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 X Date Day / Month / Year

6 ASB details (if applicable)

Accepted by Name and Branch | Introduced by Name and Branch | Onyx number

7 Adviser details (if applicable)

Credit this case to adviser code | FSPR number or FAP name

Group Voluntary Code | Percentage split Initial Renewal

Adviser's company | Adviser name

(please ✓ one option) ☐ Variable % ☐ Pendulum % ☐ As earned

Second Adviser (if applicable)

Credit this case to adviser code | FSPR number or FAP name

Group Voluntary Code | Percentage split Initial Renewal

Adviser's company | Adviser name

(please ✓ one option) ☐ Variable % ☐ Pendulum % ☐ As earned

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