FIDELITY Life
THE NEW ZEALAND LIFE COMPANY

Fidelity Life Risk Application Form

Fidelity Life Assurance Company Limited

Revised: December 2008

Please read these instructions before completing the application →

Important information

This application is scanned and data is input electronically. Please follow these instructions carefully so there are no delays in processing.

- Please do not write on this page or inside the perforated section of the spine, as the front page and spine are detached and discarded for processing purposes when received by Fidelity.
- Any notes should be included on the "Notes" page (refer page 17).
- Use a black pen where possible printing in BLOCK CAPITALS within the spaces provided, e.g.

C	H	R	I	S		J	O	N	E	S

- Do not leave empty boxes at the start of lines containing words, but leave a space between words.
- Always attach a quote.
- Remember to complete all questions in the required sections. Any alterations made must be initialled by the Life to be Insured and Policy Owner where applicable.

Ensure the following sections are completed

For all applications

- Please complete Sections 1 to 4 (Section 3.1 not required if no credit card payment).

If any of the benefits listed below are included, please complete...

Sections 5 to 12 for

- Life Assurance
- Family Income Plan/Survivor's Income
- Critical Care/Life Care/Trauma

Sections 5 to 13 for

- Income Protection/Disability Income/Business Disability Insurance
- Total & Permanent Disability
- Waiver of Premium
- Accidental Death Benefit

Sections 5 to 14 for

- Business Overheads/Business Expenses
- Locum Cover

Please provide any additional details relating to this Product Application in the Notes section on page 17.

December 2008

Application number

1. LIFE TO BE INSURED

Title Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other ◯

Surname

First name(s)

Residential address

Postcode

Mailing address, if different from above

Postcode

Marital status Male ◯ Female ◯ Date of birth D D M M Y Y

Previous surname (if applicable)

Telephone numbers *Home – Daytime* ◯ *After hours* ◯ *Work – Daytime* ◯ *After hours* ◯ *Mobile – Daytime* ◯ *After hours* ◯

( ) ( ) ( )

Do you wish to be sent mail by – Post ◯ Email ◯ or to both ◯ Email

Occupation Industry

Average Gross Annual Earnings (net of expenses) $ Is Life to be Insured a Policy Owner? Yes ◯ No ◯

2. POLICY OWNER(S)

Policy Owner (1)

Title Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other ◯

Surname (or company name)

First name(s)

Residential address

Postcode

Mailing address, if different from above

Postcode

Relationship to Life to be Insured Male ◯ Female ◯ Date of birth D D M M Y Y

Telephone numbers *Home – Daytime* ◯ *After hours* ◯ *Work – Daytime* ◯ *After hours* ◯ *Mobile – Daytime* ◯ *After hours* ◯

( ) ( ) ( )

Do you wish to be sent mail by Post ◯ Email ◯ or to both ◯ Email

Policy Owner (2)

Title Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other ◯

Surname (or company name)

First name(s)

Residential address

Postcode

Mailing address, if different from above

Postcode

Relationship to Life to be Insured Male ◯ Female ◯ Date of birth D D M M Y Y

Telephone numbers *Home – Daytime* ◯ *After hours* ◯ *Work – Daytime* ◯ *After hours* ◯ *Mobile – Daytime* ◯ *After hours* ◯

( ) ( ) ( )

Do you wish to be sent mail by Post ◯ Email ◯ or to both ◯ Email

Select mailing address to be used – Life to be Insured if Policy Owner ◯ Policy Owner (1) ◯ Policy Owner (2) ◯

3. ADVISER TO COMPLETE

	Adviser name	Adviser number	I/C % split	R/C% split
1.			%	%
2.			%	%

See attached quote

Amount collected $

Commencement date for Direct Debits only – monthly 1st to 28th

– fortnightly 1st to 31st Day of week Month Year

To speed up the acceptance of this application, if we need further information we will contact your client directly (e.g. via email or telephone) unless you indicate otherwise. ◯ No, please do not contact my client ◯ If 'Yes', when is the best time? am/pm

Phone number to be used ( )

Joint Life Applications – where the policy comprises more than one life, do you wish the policy to be issued on acceptance of any one life? Yes ◯ No ◯

Is this application to amend an existing policy? Yes ◯ No ◯

- If 'Yes', please give policy number and complete Policy Alteration Form (on page 20)

Is this application dependent on completion of any other arrangement? Yes ◯ No ◯

- If 'Yes' please give details in Notes Section Page 17.

3.1 CREDIT CARD PAYMENT

Please note

1. Credit card payments will be accepted for all annual, bi-annual, initial monthly premiums and advance payment of risk premiums only.
2. Fidelity Life does not accept credit card payments for regular monthly premiums, overdue premiums, savings or investment premiums (including annual or bi-annual).

Name of cardholder

Amount $ Credit card number

Card type Visa ◯ Mastercard ◯ Expiry date /

Signature

Date D D M M Y Y

4. PURPOSE OF THIS APPLICATION

◯ Family Protection ◯ Retirement Provision ◯ Income Protection

◯ Business/Loan Guarantee Insurance ◯ Mortgage Protection ◯ Key Person Insurance

◯ Partnership/Share Protection ◯ Other, please give details

Duty of Disclosure – please read BEFORE completing application

Your Duty of Disclosure for the Life to be Insured and Policy Owner(s)

Before you enter a contract of insurance you have a duty to disclose to Fidelity Life every matter that you know or could reasonably be expected to know is relevant to its decision whether to accept the risk of insurance and if so on what terms. You have the same duty to disclose those matters to Fidelity Life that occur after signing this application and before your contract of insurance commences. If you fail to comply with your duty of disclosure, Fidelity Life may cancel your policy from inception. In that event, all premiums paid may be forfeited.

5. OTHER INSURANCE ARRANGEMENTS

Note: *Please complete the "Advice on Replacement Business" if this application replaces any of the insurances listed here, or any insurance cancelled within the last 6 months.*

a. Are you currently proposing to any other company? Yes ◯ No ◯
b. Has an application ever been declined, deferred, withdrawn or loaded, or had an exclusion? Yes ◯ No ◯
c. Do you have any life or critical care/trauma insurance? Yes ◯ No ◯
d. Do you have any disability insurance? Yes ◯ No ◯
e. Is this application replacing an existing policy, or a policy discontinued within the last 6 months, with Fidelity Life or any other company? Yes ◯ No ◯
f. Have you ever had a disability, health or critical care/trauma claim? (Including ACC claims). If 'Yes', please give date and reason Yes ◯ No ◯

If 'Yes' to questions a. to e., please give details

Company	Year issued	Type	Sum Insured	Indicate Normal terms, Declined, Deferred, Loaded (indicate reasons)

6. RESIDENCE AND TRAVEL

a. Are you a citizen or permanent resident of New Zealand?* Yes ◯ No ◯

If 'No', please give details

* Please note for persons without permanent residence, generally life cover only will be available.

b. Do you intend to travel to (other than on holidays) or live in another country? Yes ◯ No ◯

If 'Yes', please give details

Destination	Purpose	Duration

7. HAZARDOUS PURSUITS AND ACTIVITIES

If answer to any of these questions is 'Yes', please complete the section noted

Do you participate or intend to participate in any of the following	Section		
a. Aviation (other than as a fare-paying passenger)	(15.1)	Yes ◯	No ◯
b. Hang-gliding/kiting	(15.2)	Yes ◯	No ◯
c. Motor sport – any form, including off-road activities or power boat racing	(15.3)	Yes ◯	No ◯
d. Scuba diving	(15.4)	Yes ◯	No ◯
e. Mountaineering, rock climbing, abseiling or caving	(15.5)	Yes ◯	No ◯
f. Parachuting	(15.6)	Yes ◯	No ◯
g. Any other hazardous sports/pastimes/activities (e.g. martial arts, competitive horse riding, hunting, etc.)	(15.6)	Yes ◯	No ◯

8. MEDICAL RECORDS/LIFETEST

Doctor's details

a. Please give details of your usual doctor below

Name ______________________ Phone ( )

Address ______________________

b. How long have you been with your usual doctor? [|] Years [|] Months

c. Please advise date of, reason for and outcome of your last consultation D D M M Y Y

Reason

Outcome

d. Are your medical records held under the same name as shown in Section a. above. Yes ◯ No ◯

Please give details of the doctor who holds your records, if different from above

Name ______________________ Phone ( )

Address ______________________

LIFETEST

- ***Lifetest (a medical service company) provides a convenient way for you to supply Fidelity Life with personal medical information sometimes required for insurance cover.***
- ***The service uses qualified nurses to conduct medical assessments and/or blood tests for Fidelity Life.***
- ***It is available for applications which are over non-medical limits, or outside our normal build range.***

Are you happy for Lifetest to contact you if we need more information? Yes ◯ No ◯

9. YOUR PERSONAL INFORMATION

Name

Date of birth D D M M Y Y Place of birth

a. What is your height? cm ft ins What is your weight? kg lbs

b. Has your weight changed in the last year? Yes ◯ No ◯ If 'Yes', did your weight **increase** by kg/lbs or **decrease** by kg/lbs

If any weight change, please provide reason

c. Do you smoke tobacco or any other substance? Yes ◯ No ◯ If 'Yes', what? how much?

d. Have you ever smoked? Yes ◯ No ◯ If 'Yes', date last smoked D D M M Y Y

e. Have you used marijuana, heroin, cocaine, narcotics, barbiturates, or any other recreational, non-prescription drugs, or psychoactive drugs? *If 'Yes', please give details below* Yes ◯ No ◯

f. Do you drink alcohol? Yes ◯ No ◯ If 'Yes', number of standard drinks* per day week month

*a standard drink = 1 nip of spirits or 1 glass of wine or 1 glass of beer.

g. Have you ever been advised by a medical practitioner to reduce your alcohol consumption? *If 'Yes', please give details* Yes ◯ No ◯

h. Have you ever been treated for addiction to or abuse of alcohol and/or drugs? *If 'Yes', please give details* Yes ◯ No ◯

10. YOUR HEALTH HISTORY

Are you currently being treated for, or have you **EVER** been treated for, suffered from or diagnosed with any of the following?

(If you have answered 'Yes' to any of these questions then either complete the Section indicated OR give full details in the space provided below)

a. Asthma .... (Complete Section 16) Yes ◯ No ◯
b. Bronchitis, emphysema, sleep apnoea or any other respiratory disorder .... Yes ◯ No ◯
c. High blood pressure or high cholesterol .... Yes ◯ No ◯
d. Chest pains, heart attack, angina, palpitations, coronary artery disease or any other heart condition .... Yes ◯ No ◯
e. Gastric or duodenal ulcer, reflux, frequent indigestion or thyroid disorder .... Yes ◯ No ◯
f. Stomach or bowel disorders, colitis or any other internal organ disorder .... Yes ◯ No ◯
g. Depression, breakdown, stress or anxiety disorder, panic attack, sleeplessness, post traumatic stress disorder or any other mental health or nervous disorder .... (Complete Section 21) Yes ◯ No ◯
h. Liver disease or disorder e.g. hepatitis A, B or C or cirrhosis .... Yes ◯ No ◯
i. Kidney or bladder disease .... Yes ◯ No ◯
j. Bleeding from lung, bowel or kidney .... Yes ◯ No ◯
k. Sexually transmitted disease or virus .... Yes ◯ No ◯
l. Diabetes .... (Complete Section 17) Yes ◯ No ◯
m. Back or neck problems, spinal condition, sciatica, whiplash, OOS/RSI or any kind of joint problem (state which limb, "l" or "r") .... (Complete Section 19) Yes ◯ No ◯
n. Recurrent or chronic allergy or skin disease .... Yes ◯ No ◯
o. Cancer or tumour including skin growths or lesions, moles, cysts or growths of any kind .... (Complete Section 18) Yes ◯ No ◯
p. Arthritic disorders, gout, rheumatism, osteoarthritis or rheumatoid arthritis .... (Complete Section 19) Yes ◯ No ◯
q. Disorder of the reproductive or genito-urinary system including prostate or gynaecological disorders .... Yes ◯ No ◯
r. Any brain or neurological disorder e.g. epilepsy, dizziness, stroke, migraines, paralysis or multiple sclerosis .... (Complete Section 20) Yes ◯ No ◯
s. Anaemia, haemophilia, leukaemia, haemochromatosis or any other blood disorder(s) .... Yes ◯ No ◯
t. Any other condition or disorder not mentioned above, apart from colds, flu or contraception .... Yes ◯ No ◯

If 'Yes', to any of the previous questions, please give details here. Please use Additional Information page (page 17) if you require more space.

Question	Condition	Date first started	Date of last symptoms	Full details of investigation/treatment	Degree of recovery	Full name of doctor or hospital
d. EXAMPLE ONLY	*Chest pain*	*01/05/05*	*04/05/05*	*Blood tests, ECG, No treatment given*	*100%*	*Auckland Hospital*

11. YOUR MEDICAL INFORMATION

In addition to the conditions you have already mentioned in this Application *(it is not necessary to repeat information you have already provided in Question 10).*

a. In the past 5 years have you ever taken regular medication or had any medical procedure, operation, consultation, investigation or test or are you currently considering seeking medical advice? .... Yes ◯ No ◯

b. In the past 5 years have you had consultations with other Health Professionals including chiropractors, physiotherapists, naturopaths, osteopaths, counsellors etc? .... Yes ◯ No ◯

c. Do you suffer from a disability of any kind? .... Yes ◯ No ◯

d. In the past 5 years have you ever had more than 5 consecutive days off work due to any illness or injury? .... Yes ◯ No ◯

e. Have you or your sexual partner(s)
   i. Received or do you expect to receive any medical treatment, advice, counselling or blood tests in connection with AIDS or an AIDS related condition? .... Yes ◯ No ◯
   ii. Engaged in sexual activity with person(s) whose previous or current sexual behaviour involves homosexual activity or puts them at risk of HIV? .... Yes ◯ No ◯

f. **Females only**
   i. Have you had an abnormal pap smear or mammogram or any breast lump (even if you have not seen a doctor about it)? .... Yes ◯ No ◯
   ii. Are you currently pregnant? .... Yes ◯ No ◯
   If 'Yes', please give estimated date of delivery .... D D M M Y Y
   iii. If currently pregnant, have you had any complications with this or past pregnancies? .... Yes ◯ No ◯

If 'Yes', to any of questions a. to f. please give details

Question	Reason	Date first started	Duration	Time off work	Full details of treatment including degree of recovery	Full name of doctor or hospital
d. f. j.	*Pneumonia*	*3/06*	*2 Weeks*	*3 Weeks*	*Antibiotics, 100% recovery*	*Dr A Jones/Auckland Hospital*
f. h. EXAMPLE ONLY	*Deafness*	*1/04*	*Ongoing*	*Nil*	*Hearing aid, 60% hearing loss in right ear*	*Dr A Jones*

If you prefer not to disclose any **particular** medical condition on this application due to its personal or sensitive nature and you wish Fidelity Life to contact your doctor who has the information, **please indicate here** ◯

12. YOUR FAMILY HISTORY

Has any blood-related immediate family member (father, mother, brother, sister) had or been diagnosed with:

a. Diabetes, high blood pressure, heart disease, stroke, high cholesterol, kidney disease, mental health condition (including depression), breast, cervical, ovarian, colon or other cancer? Yes ◯ No ◯

b. Multiple Sclerosis, muscular dystrophy, motor neurone disease, cystic fibrosis, familial polyposis, haemochromatosis, Huntington's chorea or any familial disease or inherited disorder? Yes ◯ No ◯

If 'Yes', to either 'a' or 'b' above, please complete the table below

Relation	List ALL conditions and cause of death if applicable (if cancer, please give type and site)	Age at diagnosis	Current age OR	Age at death (if applicable)
Mother				
Father				
Brothers				
Sisters				

Declaration by Doctor

Note: Where a Medical Examination is required the following Declaration is to be completed by the examining Doctor.

Declaration by Doctor – I have sighted this person's medical file and confirm the information on the Personal Statement section (pages 05 and 06) of this application is complete and accurate. (Please delete if not applicable.)

Name

Signature   Date D D M M Y Y

13. YOUR OCCUPATION

For Income Protection/Disability Income and Business Overheads/Business Expense/Business Disability Insurance complete questions 13a. to 13x.
For all Agreed Value, and any Indemnity Value policies with a benefit in excess of $8,000 per month, evidence of income is required as follows;

1. For self-employed persons please provide evidence of the last 3 years income e.g. copy of accounts.
2. For wage or salary earners please provide a copy of a recent wage/salary advice or copy of employment contract.
3. Bonus – to ascertain whether eligible for inclusion please refer to Underwriting Dept.
4. For Total and Permanent Disablement and Waiver of Premium, complete questions 13a to 13r.
5. For Accidental Death Benefit complete questions 13a to 13l.

a. What is your principal income-earning occupation?

b. What is your position?

c. Are you self-employed? Yes ○ No ○
or a shareholder-employee? Yes ○ No ○ If a shareholder-employee, % of shares owned ☐☐☐ %

d. What is the name of your employer?

e. What is the nature of the business?

f. How long have you been with this employer or in your current self-employment? ☐☐ years ☐☐ months
(if self-employed less than 12 months, please contact Underwriting Dept)

g. Please give details of your major duties (including details as applicable of heights, depth and locations at which you work, and chemicals, gases or any toxic substances used).

h. Please provide percentage of time on each major duty

Major Duty	%	Major Duty	%

i. What percentage of these duties require manual or physical work? (i.e. non-clerical or desk-based work)

Major Duty	%	Major Duty	%

j. Is your income derived from

Salaried employment		**Self-employment**		**If partnership**	
Full-time	○	Sole proprietor	○	Number of partners	☐☐☐
Part-time	○	Partnership	○	Profit Share entitlement	☐☐☐ %
Seasonal	○	Other	○	If other, please specify below (e.g. Trust, Directors fees)	

k. If self-employed, or shareholder with 20% or more shares, total number of employees? Full-time ☐☐☐ Part-time ☐☐☐

l. How many hours per week do you spend at your principal occupation? ☐☐☐

m. How long would your income (other than investment income) continue if you become disabled?

n. Please give details of specific qualifications (e.g. degree, trade certificate, etc)?

o. Do you work from your home? Yes ○ No ○

If 'Yes', please give full details of work activities performed away from home and average weekly hours of such activities

p. Do you have a second occupation or financial interest in any other business entity? Yes ◯ No ◯

If 'Yes', please give full details

q. Give details of your occupations during the past 5 years (attach separate sheet if necessary)

From (mm/yy)	To (mm/yy)	Occupation	Employer

r. Do you intend to change your occupation or duties? Yes ◯ No ◯

If 'Yes', please give full details

s. Annual income details (from personal exertion in principal occupation only)

Salary/Wages (excluding Fringe Benefits)	$	Bonus (see Note 3 at beginning of this Section)	$
Fringe Benefits (itemise) e.g. Company Car	$	Share of Profits (Losses)	$
	$	Other (please specify)	$
	$	Total Gross Income	$
	$	Less Business Expenses	$
Commission Income	$	Net Income – Before Tax	$

t. Is your income split for tax purposes with your spouse or partner? Yes ◯ No ◯

If 'Yes', please advise the percentage split and the hours and nature of work they do in the business

u. Do you receive other income which is not produced from personal exertion (not included in "s") and would continue if you became disabled? Yes ◯ No ◯

If 'Yes', please give details (i.e. rental income, share dividends, investment income, royalties, etc.)

v. Have you previously made any claim under Accident Compensation, sickness or accident policies or any other disability policies for a period of more than two weeks? Yes ◯ No ◯

If 'Yes', please give details

w. Have you ever been convicted of fraud or any criminal offence? Yes ◯ No ◯

If 'Yes', please give details

x. Have you ever been declared bankrupt? Yes ◯ No ◯

If 'Yes', please give date, details and discharge date, (if applicable)

14. BUSINESS OVERHEAD PROTECTION OR LOCUM COVER/BUSINESS EXPENSES

Name of business

When did the business commence? D D M M Y Y

How many people are employed in the business? Full-time Part-time

Business Expense Analysis (for 12-month period)	$
a. Rent or mortgage interest payments	
b. Rates, taxes and other government levies	
c. Electricity, gas, water, heating, telephone, cleaning and security	
d. Depreciation of plant and business equipment	
e. Non-income producing employees – position:	
f. Interest on Business Loans	
g. Lease payments on business vehicles and equipment	
h. Accountants and legal fees	
i. Insurance premiums	
j. Other fixed costs usually incurred in your business (please detail)	
k. Total business expenses	
l. Percentage of total business expense for which you are responsible	%
m. Estimated cost of locum	

Approved Business Expenses do not include personal income, repayments of mortgage principal, cost of goods or merchandise, cost of implements of profession and salaries of employees who would continue to produce revenue during the disability of the life assured or cost of goods, merchandise, furniture or depreciation of items acquired after commencement of disability.

Note: *In the event of a claim,* ***either*** *the Expenses* ***or*** *the Locum cover shall be paid, but not both.*

15. HAZARDOUS PURSUITS AND ACTIVITIES

15.1 AVIATION

a. What type of licence do you hold?

b. What type of aircraft do you fly?

c. Please indicate number of hours flown Total ____ This year ____ Last year ____ Expected next year ____

d. Please provide details of type(s) of aviation you are involved in (eg. Private, commercial/agricultural, aero club, helicopter, microlite, ballooning, gliding or paragliding.)

e. Please give details of routes/areas flown

f. Number of years flying?

g. Do you have any definite plans to upgrade or change your licence or the nature of your present flying? *If 'Yes', please give details* Yes ◯ No ◯

h. Do you always use recognised airfields? *If 'No', please give details* Yes ◯ No ◯

i. Have you had any previous flying accident(s) and/or charges relating to violating Civil Aviation Regulations? *If 'Yes', please give details* Yes ◯ No ◯

15.2 HANG-GLIDING/KITING

a. What heights do you attain?

b. Geographical location

c. Are you towed? Yes ◯ No ◯

d. How often do you participate in this activity?

e. Do you go over water? Yes ◯ No ◯

f. Have you ever had a hang-gliding/kiting accident or injury? *If 'Yes', please give details* Yes ◯ No ◯

15.3 MOTORSPORT (LAND OR WATER)

a. What category of motorsport do you participate in?

b. What type of vehicle do you race?

c. What is the engine capacity?

d. What is the maximum speed attained?

e. Frequency/number of events in the **last** 12 months

f. Frequency/number of events in the **next** 12 months

g. Are you a professional or amateur driver?

h. Have you ever had a motorsport accident or injury? Yes ◯ No ◯

If 'Yes', please give details

15.4 SCUBA DIVING

a. How long have you been scuba diving? months ____ years ____

b. Number of dives per year? ____

c. Average depth of dives? ____ m ____ ft

d. Maximum depth of dives? ____ m ____ ft

How many times have you dived to this depth? ____

e. Where do you dive?

f. What qualifications do you hold?

g. Do you dive alone or in company?

h. Have you ever required medical attention following a dive? *If 'Yes', please give details* Yes ○ No ○

15.5 MOUNTAINEERING/CLIMBING/ABSEILING/CAVING

a. How long have you been involved in this activity? months ____ years ____

b. Which countries and geographic locations do you climb in?

c. What heights/depths do you climb to? ____ m ____ ft

d. On average how many times a year do you climb? ____

e. Do you belong to a mountaineering club? Yes ○ No ○

f. What type of equipment do you use?

g. Do you climb alone or in a party?

h. Have you ever had an injury or accident while participating in this activity? *If 'Yes', please give details* Yes ○ No ○

15.6 OTHER SPORTS, PASTIMES (INCLUDING PARACHUTING)

Describe activity (please give full details)

a. How long have you been doing this? months ____ years ____

b. How many times a year do you do this activity? ____

c. How often do you intend to participate in the future?

d. Where do you participate in this activity and what equipment is used?

e. Are you, or do you intend to become a professional? *If 'Yes', please give details* Yes ○ No ○

f. If heights are involved, please advise details ____ m ____ ft

g. Do you travel outside New Zealand for this activity? *If 'Yes', please give details* Yes ○ No ○

h. Have you ever had an accident or injury from participating in this activity? *If 'Yes', please give details* Yes ○ No ○

16. ASTHMA

a. When did you first develop asthma?

b. When did you last experience symptoms?

c. How frequently did those symptoms occur in the last 2 years?

d. What is your present treatment (please give names of inhalers and/or tablets and dosage)?

e. How many inhalers do you use in a year?

f. Have you ever been admitted to a hospital for asthma treatment? Yes ◯ No ◯

If 'Yes', please give details

g. Have you had treatment with cortisone or prednisone in the last 5 years? Yes ◯ No ◯

If 'Yes', please give details

h. How much time have you lost from work in the last 5 years due to asthma?

17. DIABETES

a. When was diabetes diagnosed?

b. How often do you see your doctor for diabetic supervision?

c. State date of last visit D D M M Y Y

d. How often does your doctor carry out blood tests for control of diabetes?

e. If taking insulin or tablets, please give name, dose and frequency

Name	Dose	Frequency

f. Do you take your own blood sugar readings? Yes ◯ No ◯

g. If 'Yes', how often, and what is the usual range?

h. Have you suffered a diabetic or insulin coma? Yes ◯ No ◯

i. Have you suffered any complication of diabetes affecting your circulation, heart, vision or kidney function? Yes ◯ No ◯

If 'Yes' to h. or i. please give details

18. CANCER, TUMOUR OR SKIN GROWTH/LESION

a. Please state the nature of cancer or lesion including location and date(s) diagnosed

b. If cancer or lesion has been treated, please give details of treatment and diagnosis

c. Was the cancer or lesion benign, pre-malignant or malignant?

d. Have any follow up checks or treatment been required? Yes ○ No ○

e. If 'Yes', please provide dates, further details, results (if known) and name and full address of attending Doctor/Specialist

19. MUSCULOSKELETAL QUESTIONNAIRE

(Please complete this section for disorder, disease or injury to muscles, bones or joints, including hips, shoulders, back, neck, knees, wrists or arthritis, gout, rheumatism, OOS)

a. When did you first suffer from any of the above problems? D D M M Y Y

b. Please state – i) the cause

ii) the symptoms/exact nature of the problems

c. Please indicate the area or joint involved and specify which side (if applicable)

cervical spine (neck) ○ knee joint L ○ R ○ Other, please specify L ○ R ○

lumbar spine (low back) ○ hip joint L ○ R ○

thoracic spine (mid back) ○

d. What was the severity of the pain? Mild ○ Moderate ○ Severe ○

e. How many recurrences have you had of the problems? When? Duration of episode(s)

f. Are you now free of all symptoms? (e.g. no pain or stiffness) Yes ○ No ○

i) If 'Yes', for how long?

ii) If 'No', what is the current severity of pain?

g. How much time have you lost from work as a result of the above problems?

h. Please describe the treatment(s) received

i. If you are still undergoing treatment, please give details

j. If treatment has ceased, please give date D D M M Y Y

k. Please advise diagnosis (e.g. slipped disc, arthritis, etc.)

l. Have you ever had any associated depression? Yes ○ No ○

m. Please give the dates, names and address of doctor(s) or other health provider(s) or adviser(s) consulted for these problems

20. SPECIFIC HEALTH QUESTIONNAIRE

1. Please describe your particular health condition

2. When did this condition first occur?

3. Please describe the location on the body and the severity and nature of symptoms, eg. left leg.

4. When were the most recent symptoms?

5. Have you had time off work as a result? Yes ○ No ○
If 'Yes', when and for how long?

6. Have you ever been hospitalised or attended a clinic as a result of this condition? Yes ○ No ○
If 'Yes', when and for how long?

7. Please advise full details of treatment, medication, tests, investigations and advice you have had for this condition, eg. x-rays, ECGs, physio, etc.

Please name any drugs and dosage

8. Which doctors or health professional(s) did you consult and on what dates?

9. On what date did you last receive treatment/medication for this condition? D D M M Y Y

10. Has further treatment been recommended? Yes ○ No ○
If 'Yes', please give details

11. Have you fully recovered from this condition? Yes ○ No ○

If 'Yes', please advise date D D M M Y Y

If 'No', please give details below of ongoing issues

21. MENTAL HEALTH QUESTIONNAIRE

a. Please indicate the nature of the complaint.

Depression ◯ Stress ◯ Anxiety disorder ◯ Panic attack ◯ Phobia ◯ Compulsive Disorder ◯ Chronic Fatigue ◯

Other (please specify)

b. Date of onset or dates if you have suffered more than one episode

c. Did this complaint arise as a result of particular circumstances? Yes ◯ No ◯

If 'Yes', please outline those circumstances

d. Has your condition ever led you to intentionally or unintentionally consider harming yourself or have you ever had suicidal thoughts? Yes ◯ No ◯

If 'Yes', please give details

e. Please provide the name of any doctor(s) or health provider you have consulted regarding your symptoms.

f. Please give details of any drugs or treatment prescribed, date(s) and duration(s).

g. Are you still on treatment for this complaint? Yes ◯ No ◯

If 'Yes', please give details. If 'No' please give date of cessation of treatment

h. How much time have you had off work for this complaint?

i. Date(s) of last symptoms (if applicable) D D M M Y Y

DECLARATION

Your Duty of Disclosure for the Life to be Insured and Policy Owner(s)

Before you enter a contract of insurance you have a duty to disclose to Fidelity Life every matter that you know or could reasonably be expected to know is relevant to Fidelity Life's decision whether to accept the risk of insurance and if so on what terms. You have the same duty to disclose those matters to Fidelity Life that occur after signing this application and before your contract of insurance commences. You also have the same duty to disclose those matters to Fidelity Life before you apply to increase or re-instate your insurance. If you fail to comply with your duty of disclosure, **Fidelity Life may cancel your policy from inception**, alter the amounts and terms of the insurance or decline to consider any claim/s. If Fidelity Life cancels your policy from inception, all premiums paid may be forfeited.

Privacy Act 1993 and The Health Information Privacy Code 1994

- This application collects personal information about you, **the Life to be Insured and Policy Owner(s)**. You have the right of access to, and correction of, this information.
- The personal information and any additional information obtained, (including medical and financial information) will be used by Fidelity Life, its subsidiaries, its officers, its advisers, reinsurers and other companies for processing on Fidelity Life's behalf, to calculate and administer the insurance you apply for and for the purposes and promotion of insurance and investment services to you. The information may also be used for statistical purposes provided you are not identified.
- The information is securely held by Fidelity Life Assurance Company Limited at 81 Carlton Gore Road, Newmarket, Auckland.
- The information may be disclosed outside of Fidelity Life group of companies where the disclosure is necessary for one or more purposes for which the personal information was collected, to the adviser named on this application (or allocated to your business), where required by law, to the policy owner and with your consent.
- If blood tests are required in connection to this application, results will be provided to your general practitioner named in this application.

Declaration and Authority by Life to be Insured and Policy Owner(s)

- I/we have read the notice explaining my/our duty of disclosure. I/we have completed the sections in this application required to be completed. If I/we have not done this, I/we declare that I/we have read the completed application and the information given (including any personal statement) is true, accurate and complete. I/we have not withheld or misstated any material fact.
- No statement affecting this insurance has been made to any representative of Fidelity Life that is not recorded in this application.
- I/we acknowledge that the information I/we have provided and the information provided by anyone else on my/our behalf in this application will form the basis of the contract of insurance between me/us and Fidelity Life.
- I/we understand if additional information is required to process my/our application for insurance, I/we may be telephoned by an underwriter. The information that I/we provide to the underwriter will form part of my/our application for insurance.
- I/we will immediately notify Fidelity Life of any circumstances affecting the risk that may occur after signing this application and before the contract of insurance commences.
- I/we understand that the contract of insurance with Fidelity Life will not commence until this application has been accepted by Fidelity Life, acceptance terms have been agreed to by the policy owner(s) and received by Fidelity Life and until payment of the premium is received, or receipt of a valid direct debit to operate within 30 days.
- I/we shall be bound by the standard terms and conditions in the policy to be issued to me by Fidelity Life.
- If I/we have provided my/our email address in this application, or if I/we provide it at some stage in the future, I/we consent to receive emails from Fidelity Life in respect of Fidelity Life and any further services.
- I/we have read and understand the sections in this application headed Privacy Act 1993 and The Health Information Privacy Code 1994, and Statement of Consent by life to be insured. I/we authorise Fidelity Life to disclose any personal information that it holds about me, to any person where the disclosure is necessary for one or more purposes for which the personal information was collected.

Statement of Consent by Life to be Insured

- I/we authorise Fidelity Life to obtain any information about me from any person and/or entity including, but not limited to, any and all health treatment providers (i.e. medical practitioner, specialist, hospital, clinic, counsellor, psychologist, therapist, dentist), insurers, Accident Compensation Corporation, employers (whether current or not), accountants, consultants, financial advisers, banks, financial institutions, any credit rating agencies and public authorities.
- I/we authorise any person and/or entity, including any of those listed above, to give any information about me to Fidelity Life.
- I/we agree that a photocopy of this statement of consent shall be as valid as an original and is sufficient evidence of my consent and authority to the disclosure of my information.

14-day Free Look

I/we understand that my/our contract of insurance can be cancelled during the 14-day Free Look period and all premiums refunded to me/us.

Signature of Life to be Insured

Date D D M M Y Y

Signature of parent/guardian/employer for person under age 18

Date D D M M Y Y

Signature of Policy Owner(s), if not the Life to be Insured
(If company-owned, authorised signatory must sign and indicate they are signing on behalf of the Company and their position in the Company.)

1.

Date D D M M Y Y

2.

Date D D M M Y Y

3.

Date D D M M Y Y

ADVICE ON REPLACEMENT BUSINESS

The completion of this form is a requirement of the ISI Standard for Term Life and Disability products. (A separate form is to be completed for each existing contract or policy to be replaced.) A copy of this form will be given to the Applicant(s) by the Adviser and the original held by the Company issuing the new contract or policy.

Details of new contract/policy

Name of client

Name of company FIDELITY LIFE ASSURANCE COMPANY LIMITED

Type of contract/policy Annual Premium $

Is initial commission being received in relation to the new contract? Yes ◯ No ◯

Is instalment commission being taken as an alternative form? Yes ◯ No ◯

Details of contract/policy being replaced

Name of client

Name of company

Contract/Policy No(s).	Annual Premium
	$
	$
	$
	$

Details of Replacement – Statement by Adviser

a. The specific reasons for the replacement of the existing contract/policy are

b. The policy to be replaced cannot adequately fulfil the owner's objectives because

c. The following risks are **not** covered by the new contract/policy which **were** covered by the old contract/policy

Name of Adviser

Address of Adviser

Telephone ( )

Adviser signature

Date D D M M Y Y

ADVICE TO APPLICANTS

You might find this advice helpful in deciding whether to replace an existing contract or policy. This includes all situations where a new contract or policy is being issued within a period of six (6) months after an existing one has been discontinued, or six (6) months before an existing contract or policy is planned to be discontinued; and

1. the insured (or one of the insureds) is the same, or
2. the applicant (or one of the applicants) is known to be the same, or
3. the premium payer (or one of the premium payers) is known to be the same.

APPLICANT ACKNOWLEDGEMENT

I/We acknowledge there may be advantages and disadvantages involved in replacing an existing contract/policy such as:

1. there are sometimes establishment costs (including commission) in setting up a contract/policy. Replacing it with a new contract/policy may involve further establishment costs;
2. if the policy which is being replaced was purchased on the life assured at a younger age, the same or similar benefits in the new policy may now cost more;
3. a change in health, pastimes or occupation of the life assured may affect insurability and the new policy may contain restrictions, limitations, and/or be more costly;
4. in a new policy the Suicide Exclusion clause will recommence
5. conditions or benefits may be more (or less) favourable under the contract/policy which is being replaced, for example, the contract duration, wordings, and/or benefit definitions may differ.

I/We also acknowledge that this information was provided and explained before I/we signed the application for the new contract/policy.
I am/We are aware I/we may withdraw this application in writing within the “free look” period of fourteen (14) days from the date the new contract/policy is received.

Name of the Applicant(s) (please print)

1.

2.

3.

Signature of Applicant(s)

1. Date D D M M Y Y

2. Date D D M M Y Y

3. Date D D M M Y Y

FIDELITY Life
THE NEW ZEALAND LIFE COMPANY

Alteration Advice

Policy number

Please attach this form to appropriate support documentation

Life Insured

Surname

First name(s)

Surname

First name(s)

Policy Owner(s)

Surname

First name(s)

Surname

First name(s)

I/We request that the policy be altered as follows (please tick which action is required)

Increase/addition ○

Decrease ○

Other ○

Benefit...	Change from...	to...

With effect from D D M M Y Y

New total premium $

Payable Monthly ○ Half yearly ○ Annual ○ or Other ○

Paying by Direct Debit Existing ○ New ○ (attached)

I understand and agree that:

- this application, together with the proposal shall be the basis of the contract for the altered insurance.
- any endorsement, and/or terms and conditions on the current policy benefits will also apply to any change in those benefits unless advised otherwise by Fidelity Life Assurance Company Limited.

Life Assured signature(s)

Policy Owner signature(s)

Date D D M M Y Y

FIDELITY Life
THE NEW ZEALAND LIFE COMPANY

Direct Debit Authority

Please complete in full and return original to Fidelity Life Assurance Company Limited, PO Box 37-275 Parnell, Auckland 1151
Phone 09 373 4914 **Fax** 09 308 9953

Policy number(s)

Contact phone number ( )

Please put name on your bank account below (same as on your deposit slip or cheque account)

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

Please provide your Bank/Branch number, account number and suffix of the account to be debited in the spaces below.

Bank/Branch number

Account number

Suffix

To The Manager (Please print clearly)

Bank/Branch

Branch Address

Town/City

AUTHORISATION CODE
0 6 0 4 9 0 2
(user number)

I/We authorise you until further notice in writing to debit my/our account with all amounts which Fidelity Life Assurance Company Limited (hereinafter referred to as the Initiator) the registered Initiator of the above Authorisation Code, may initiate by Direct Debit. I/We acknowledge and accept that the bank accepts this Authority only upon the conditions listed overleaf.

Information to appear on my/our bank statement

Payer particulars
F I D E L I T Y

Payer code

Payer reference

Name of authorised signatory

Name of authorised signatory

Authorised signature

Authorised signature

Date D D M M Y Y

For bank use only

Approved	Date received	Recorded by	Checked by	Bank stamp
0490 09 2002				

DDFM

Conditions of this authority to accept Direct Debits

1. The Initiator ...

(a) undertakes to give written notice to me/us of the commencement date, frequency and amount of Direct Debit at least 10 calendar days before the first Direct Debit is drawn (but no more than 2 calendar months). Where the Direct Debit System is used for the collection of payments which are regular as to frequency, but variable as to amounts, the Initiator undertakes to provide me/us with a schedule detailing each payment amount and each payment date.
In the event of any subsequent change to the frequency or amount of the Direct Debit, the initiator has agreed to give written advance notice at least 30 days before the change comes into effect.

(b) 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 this 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 both the Bank and 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 clause 1(a), 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 a 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 any 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 lie between me/us and the Initiator.

(d) the Bank accepts no responsibility or liability for the accurancy of information about Direct Debits on Bank Statements.

(e) the Bank is not responsible for, or under any liability in respect of
- any variations between notices given by the Initiator and the amounts of Direct Debits.
- 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.

(f) notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.

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.

FIDELITY Life
THE NEW ZEALAND LIFE COMPANY

Free Accident Cover & Our Commitment of Service

Life/Lives Insured

1.

2.

We welcome your application and will endeavour to give you quality service. As our client we intend to give you the service expected for the length of your contract. Please contact us if you have any questions.

Introduction to Fidelity Life

Fidelity Life is a New Zealand-owned life assurance company and a member of the Investment Savings and Insurance Association of New Zealand Inc.

Being one of the few life assurance companies making use of independent investment managers, we are able to secure the best available investment advice on behalf of our policyholders. Our protection benefits are enhanced through an international network of leading reinsurance companies, securing a top-ranking risk management programme where most of the insurance risk is shared by the reinsurers.

Importance of Proposal

The application and accompanying documents form an integral part of the contract between you and Fidelity Life. As soon as the application is received by us we will check all the information.

If the application is approved on the terms requested by you, we will advise you in writing that the application is accepted and when the Direct Debit Order (if any) is due to start. The resulting contract (policy document) will be sent to you 7 to 10 days following the above letter.

Insurance

Life and disability cover requested under the application needs to be assessed carefully to determine the terms on which it can be provided. By completing a full assessment at this stage, delays can be avoided when a claim is made. We ask your co-operation in providing us with as much information as possible. We will contact your adviser/broker if further information is required.

If your application is acceptable on terms that differ from those originally requested by you, your adviser/broker will contact you for approval of any changes.

You will be notified in writing when the application is accepted. The insurance for which you applied will take effect from that day or the date of commencement, whichever is the later. Please notify us if anything happens which may have an effect on your application for insurance before your policy is issued. Any failure to inform us may jeopardise a claim at a later stage.

FIDELITY Life
THE NEW ZEALAND LIFE COMPANY

Certificate of Free Accident Cover

(to be kept by Policy Owner)

Free accident cover

Fidelity Life grants free Accident Cover on the Life to be insured at no additional cost while this application is being assessed provided the first premium has been paid or a valid payment instruction has been received. The Accident Cover under this application is payable, upon submission of this duly completed Certificate, if the Life to be Insured under this application dies or is diagnosed with one of the critical illness conditions below, solely as a result of accidental bodily injury, prior to the earliest of:

- the expiry of 60 days from the date you signed the application
- the date on which you are notified that the insurance in terms of this application is accepted, rejected or accepted subject to modification of the terms of acceptance
- the date the policy applied for under this application is issued
- the date of cancellation of this application at your request
- the date on which Fidelity Life seeks facultative reinsurance in respect of the life assurance applied for in order to secure better terms for the Life to be Insured.

Terms and conditions

There is no free accident cover

- if the Life to be Insured is over the age of 65.
- if the Life to be Insured has in the past had an insurance application refused or deferred by any life company
- if the Life to be Insured has in the past been assessed as non-standard by any life company
- if we believe that cover for the Life to be Insured would have been refused anyway
- if a similar application has been accepted and a policy issued by another company since this application was completed

Critical illness conditions covered are

Blindness, coma, deafness, severe burns, major head trauma, paralysis and total and permanent loss of the use of two limbs

Benefit

Irrespective of the number of Certificates issued for any one Life to be Insured, the Accident Cover is equal to the sums insured proposed with a maximum of $500,000 for death and $250,000 for critical illness. If there was no application for life insurance or critical illness, the Accident Cover is $5,000 for death only for any one Life to be Insured. In terms of this Certificate and other concurrent Certificates, no benefit is payable if any proposed life insurance becomes payable.

Accident

Accident in terms of this Certificate means death or critical illness which is the result of external or internal bodily injury caused directly or solely by violent external and visible means, not attributable to any other event. It excludes death or critical illness caused by or resulting from

- A self-inflicted act, whether sane or insane
- Taking drugs, alcohol or any intoxicating substance
- Participation in a criminal activity
- Aviation other than as a fare paying passenger on a recognised airline
- Taking part in risks or occupation which would exclude him or her from insurance cover for death or critical illness
- Any accident which took place before or on the date of this application

Adviser signature

Date D D M M Y Y