Asteron Life

Application

SUNCORP

PART OF SUNCORP NEW ZEALAND

Guide to completing this application

- Most of this application needs to be completed by the person who is going to be insured. However there are some sections that the policy owner needs to answer, and these are clearly marked.
- When we refer to 'you' in this form, we mean the person to be insured unless we note otherwise.
- Please write in pen and use **BLOCK letters**.

What parts of the form do you need to complete?

There are two parts to this application form. You will only need to complete part 1, your adviser will compete part 2.

If you want to increase or replace an existing Asteron Life policy, please:

- Complete the Application for Increase (available from your Adviser) and/or
- Complete parts 1 and 2 of this application.

Do you need help?

Call us on 0800 737 101, or talk to your Adviser.

Important: Insurer Financial Strength Rating

The Insurance (Prudential Supervision) Act 2010 requires all licensed insurers to have a current financial strength rating that is given by an approved rating agency. **Asteron Life Limited** has been given an **AA-** Insurer Financial Strength Rating by Standard & Poor's. The rating scale is:

AAA Extremely Strong	**B** Weak
AA Very Strong	**CCC** Very Weak
A Strong	**CC** Extremely Weak
BBB Good	**SD** Selective Default
BB Marginal	**D** Default

Ratings from 'AA' to 'CCC' may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories.

The rating scale above is in summary form. The full version of this rating scale can be obtained from www.asteronlife.co.nz.

Privacy Statement

Asteron Life Limited ("Asteron Life") and the wider Suncorp Group complies with the Privacy Act when dealing with personal information.

Collection and Use of information

We confirm that we collect and use personal information about you and the insured person with Asteron Life for the following main purposes:

- To enable any application you make, or any policy you hold with Asteron Life or any other insurance office, to be processed, underwritten, reinsured and/or accepted.
- To enable any policy held with Asteron Life to be serviced and maintained, and to enable any claim you make against such a policy to be processed, including checking the validity of the policy.
- To enable Asteron Life and its authorised intermediaries to monitor and service your ongoing insurance requirements, including providing you with advice and information concerning life insurance, income protection insurance, or any other insurance products and services from us or our partners.

Disclosure of Information

We may disclose your personal information to third parties for the purpose of providing our services to you or in order to comply with legal requirements. This may include where we have introduced you to a new Adviser whom you appoint.

Storage, Access and Correction

Your personal information is stored securely with Asteron Life or other companies within the wider Suncorp Group. Your information may also be securely stored electronically on servers located in New Zealand or overseas, by third parties on our behalf. You have a right to request access to, and correction of, your personal information by contacting the Asteron Life Customer Service team on 0800 737 101, email them at contactus@asteronlife.co.nz or writing to PO Box 894, Wellington.

For further information about how we deal with your personal information, please refer to the "Asteron Life Privacy Statement". It is available at www.asteronlife.co.nz, by phoning 0800 737 101, or by writing to Asteron Life Limited, PO Box 894, Wellington 6140.

Why accurate information matters to us

To run an insurance business that is here for the long term, we need to predict what our future expenses will be so that we can minimise premiums for our customers, pay valid claims, meet the costs of running our business and encourage investment in our future. For these reasons, it is very important that you provide us with accurate information to help us assess the likelihood and potential cost of future claims under your policy.

Your duty of disclosure

Please read carefully

You have a duty to disclose to us all information about you, your personal circumstances and history to allow us to accurately assess the insurance we can provide to you. This is **material** information relevant to your application for insurance. **Material** information is information that might influence our decision to insure you and the terms and amount of premium of your insurance policy.

The information you need to tell us depends on what you are applying for. Typically, it includes information about your background, occupation, medical history and current health, personal habits and finances. There may be other types of **material** information about you which should also be disclosed. It is important that you tell us even if you have separately discussed something with your financial adviser.

You meet your duty of disclosure by providing us with complete and correct answers to all the questions that we ask, and by telling us anything else that might be **material**, even if we don't specifically ask you about it.

It is important that you answer all questions accurately in the application form, even if you need to go away and find the information from other sources.

This application for insurance forms part of your proposed insurance contract. The person to be insured and the policy owner(s) must answer all the questions asked of them accurately and disclose all **material** information, whether asked for in the application form or not.

The person to be insured and the policy owner(s) must also tell Asteron Life of any change in circumstances that is material to the application from the time the application form is submitted until the time the insurance policy is issued. This duty of disclosure also applies if in future you ask to extend or alter the policy or ask to reinstate it if it lapses for non-payment of premiums.

Risks to you from non-disclosure

If you don't provide us with accurate or complete information, even if you accidentally provide inaccurate information, you may be affected in the following ways:

- claims that you make under the policy may not be paid;
- your insurance policy may be cancelled or treated as if it never existed;
- you may not be able to obtain other insurance in the future;
- you could experience other financial hardship.

If you are unsure about whether you should disclose something it is always safer to include it in your application form or call our Customer Service Team on 0800 737 101 to check.

Replacement Business Risks

Although there may be good reasons for replacing an existing life insurance policy, you should also be aware of risks that may arise when doing so.

- benefits that you might have received under the existing policy may not be covered by the new policy.
- initial premiums in the new policy may appear lower but be higher over the long term.
- exclusions, limitations or increased premium in the new policy due to changes in health, lifestyle or occupation that have occurred since the existing policy was taken out.
- wait periods for benefits under the new policy which had already elapsed under the existing policy.
- non-disclosure may reduce claims payable or result in the new policy being treated as if it never existed.

Your financial adviser should be able to provide you with an analysis of these risks and ways to manage them.

PART 1: Insured person and policy holder details

Adviser Number ☐☐☐☐

Please attach AsteronConnect illustration(s) to front page

Please tick one of the following:

☐ New application
☐ Increase to policy
☐ Transfer or Upgrade to policy

1. Details of the person to be insured (Must be completed)

(If you are the person being insured under this policy, please complete this section)

Name of the person to be insured

Title
Family name
Given name(s)
Date of birth ☐ Male ☐ Female

Contact details

Home address
Post Code
Postal address
If different to home address
Post Code
Home phone
Work phone
Mobile
Email

Personal details

Smoker ☐ Non-smoker ☐
Height cms Weight kgs

Occupation and Income details

Occupation
Self-employed annual income
Employee annual income
Industry

Occupation code *Please tick one*

AM – Medical Health Prof. ☐ AA – Professional ☐
A1 – Clerical office work only ☐ A2 – Clerical mobile ☐
B – Light manual/skilled ☐ C – Heavy manual/skilled ☐
S – Special skills ☐

Existing Cover (Must be completed)

1. Do you have any of the following covers with us or another company, or are you currently applying for any of the following products (other than this application), any type of life, sickness, accident, trauma, lump sum disablement or disability insurance (including mortgage redundancy and bankruptcy cover)? Yes ☐ No ☐
   a. Is this with Asteron Life? Yes ☐ No ☐
   b. If you do have any type of insurance, is this being replaced? Yes ☐ No ☐

2. Details of the policy owners (Must be completed)

(If you are the owner of the policy, please complete this section)

1. Is the person to be insured also a policy owner? Yes ☐ No ☐
   If 'yes', which policy will they be the owner of?
   Personal Insurance ☐ Business Insurance ☐ Both ☐

If the person to be insured is the sole policy owner, please go to section 3, 'Doctor's details', and complete.

If the owner of the policy is a trust and the trustees are actual people, the trustees must individually apply as policy owners. Where the trustee(s) of the trust includes a corporate trustee, then its director(s) must individually sign as policy owners under 'Trustee Ownership section'. Where an owner of the policy is a limited liability company, the application form must be completed and signed by a director or authorised signatory of the company. If there are more than two policy owners, please attach an additional sheet with their details.

For personal ownership

Policy Owner 1

Title
Family name
Given name(s)
Date of birth
Relationship to the person to be insured
Postal address
Post Code
Preferred phone
Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

Policy Owner 2

Title
Family name
Given name(s)
Date of birth
Relationship to the person to be insured
Postal address
Post Code
Preferred phone
Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

Preferred contact person (Must be completed)

Please select the main contact to receive policy and general communications from Asteron Life.

Policy Owner 1 ☐ Policy Owner 2 ☐

For company ownership (at least one director/signatory required)

Company Name
Full name of Director or Authorised Signatory
Full name of Director 2 (if required)
Full name of Director 3 (if required)
Name of main contact person
Postal address
Post Code
Prefered phone
Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

For trustee ownership (all trustees required)

Full name of Trustee 1
Date of birth
Full name of Trustee 2
Date of birth
Full name of Trustee 3
Date of birth
Name of Trust
Name of main contact person
Postal address
Post Code
Prefered phone
Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

2. Do you intend to nominate beneficiaries for your insurance?
   If 'yes', please complete the 'Nominated Beneficiary Form.'

Yes ☐ No ☐

3. Doctor's details (Must be completed)

Name

Address

4. Paramedical service (Must be completed)

If medical and blood tests are needed, would you like to use our mobile paramedical services if available in your area? Yes ☐ No ☐

5. Kids Cover (Only complete if applying for Kids Cover)

Total number of children to be covered

Policy owners, please complete this section if you are applying for Kids Cover. If you would like cover for more than two children, please attach an additional Kids Cover application form with their details.

Child 1

Given name(s) and Surname

Date of birth Male ☐ Female ☐

If address of child is different from person to be insured

Home address

Post Code

Child 2

Given name(s) and Surname

Date of birth Male ☐ Female ☐

If address of child is different from person to be insured

Home address

Post Code

1. Are you the child's or children's parent? Yes ☐ No ☐
   If 'no', please provide details below.
2. Has any child ever attended a clinic, been admitted to a hospital, had any surgical procedure or blood transfusion (other than for normal growth and development checkups, immunisation, simple bone fractures or stitches)? Yes ☐ No ☐
   If 'yes', please complete details below.
3. Has any child ever had any abnormal blood tests or other abnormal investigation results? Yes ☐ No ☐
   If 'yes', please complete details below.
4. Does any child suffer from any medical condition or disability? Yes ☐ No ☐
   If 'yes', please complete details below.

Child 1

Name

Doctor

Doctor's address

Condition

Treatment

Tests

Results

Child 2

Name

Doctor

Doctor's address

Condition

Treatment

Tests

Results

5. Has any child's mother, father, brother or sister ever had:
   a. Breast, ovarian, colon or other cancer, familial adenomatous polyposis, diabetes, heart problems, stroke, haemochromatosis? Yes ☐ No ☐
   b. Huntington's disease, muscular dystrophy, polycystic kidney or any other hereditary disease? Yes ☐ No ☐
   If 'yes', please complete details below.

Family member *(relationship to child)*	**Condition/sickness** *(please specify cancer or heart disease and specify type of diabetes etc.)*	**Age at onset** *(approx.)*

IF YOU ARE ONLY APPLYING FOR LIFE, TRAUMA RECOVERY, MAJOR TRAUMA BENEFIT, CANCER, TPD, OR KIDS COVER, PLEASE DIRECTLY GO TO SECTION 10 – 'PAYMENT DETAILS' ON PAGE 8.

6. Financial Information

If applying for Mortgage and Living Cover based on annual income,Income Protection Cover, Workability Cover, Business Disability Cover, Farmers Disability Cover and/or Business Expenses Cover complete this section.

- If *also* applying for Mortgage and Living Cover based on monthly mortgage, Section 7 on page 7 must also be completed.
- If *only* applying for Mortgage and Living Cover based on monthly mortgage, proceed to Section 7 on page 7.

1. Employer name, or name of business if self employed

   Name of business

   Address

   Post Code

2. Income structure

   Employed ☐ Self-employed ☐ Employed by own company or trust ☐ Farmer ☐ Home duties ☐ Partnership ☐

3. Do you receive other income which is not produced from personal exertion? Yes ☐ No ☐

   If 'yes' please indicate the amount and details (i.e. interest, rental income, share dividends, annuity, investment income, royalties, etc.)

   Amount per annum Details

4. Do you have a trust or Loss Attributing Qualifying Company (LAQC) or Look Through Company (LTC)? Yes ☐ No ☐

   a. If 'yes' is this reducing your taxable income? Yes ☐ No ☐

   b. If this is trust, Loss Attributing Qualifying Company or Look Through Company is reducing your taxable income please give details.

5. Do you have a mortgage? Yes ☐ No ☐

PLEASE COMPLETE QUESTION 6 IF YOU ARE AN EMPLOYED PERSON

6. To be completed if you are an **employed person** only with no ownership or interest in a business.
   Please provide details of your personal earnings (as assessed for income tax) for the last two financial years.

Description	Year ended 31 March _____	Year ended 31 March _____
Wages and salary received	$	$
Car (up to $15,000 where salary sacrifice or up to $7,500 where tool of trade)	$	$
Other allowances, director's fees, fringe benefits etc	$	$
Superannuation (including Kiwisaver)	$	$
Bonus, commission and overtime	$	$
Other, please specify	$	$
Total	$	$

PLEASE COMPLETE QUESTION 7-13 IF YOU ARE A SELF-EMPLOYED PERSON

7. How many people do you employ (excluding you and your spouse)? Full time ☐ Part time ☐

8. What percentage of your work is freelance/contract? Freelance ☐ % Contract ☐ %

9. What percentage of the business do you own? ☐ %

10. Is your income split for tax purposes with your spouse or partner? Yes ☐ No ☐
If 'yes', please advise:

The percentage split ☐ %

The hours ☐ hours

Nature of work done by your spouse/partner in the business ☐ Work done

11. Are there any other businesses or related entities service or management companies other than the main operating entity? Yes ☐ No ☐
If 'yes', please provide details below.

Business name ☐

Relationship ☐

Principal function of related entity ☐

12. To be completed if you are a **self-employed person or if applying for Farmers Disability** (sole trader, partner or employee of own company/trust).

Please provide business income in the table below for the last two financial years for which tax returns, assessment notices and accounts are available.

Year ending	Gross income from business	Less all expenses incurred in earning that income	Equals net income before tax	Your share of net income	Total net earned income*
	$	$	$	%	$
	$	$	$	%	$
	$	$	$	%	$

**Note: Total net earned income is the income earned by your own personal exertion before tax which will cease if you are unable to work.*

13. In the last 12 months, has your business experienced a reduction in turnover of 20% or more? Yes ☐ No ☐
If yes, please explain why and provide YTD (year to date) figures in the table above.
If 'yes', please provide full details.

☐

7. Mortgage and Living Cover

(Only complete if applying for Mortgage and Living Cover **based on your monthly mortgage**)

You will also need to send proof of your mortgage with your application. This can be a copy of a recent bank statement or mortgage agreement.

a. Amount of mortgage ☐ $

b. Minimum monthly mortgage repayments ☐ $

c. Mortgage lender details ☐

d. Term of mortgage ☐

e. Is this dwelling owner occupied? Yes ☐ No ☐
If 'no', please provide full details.

☐

f. Has the mortgage for this dwelling that you live in been drawn down (activated)? Yes ☐ No ☐
If 'no', please provide full details.

☐

8. Business Disability Cover

(Only complete if applying for Business Disability Cover)

1. What is the position of the key person in the business?

2. What is the key person's total remuneration package? $

3. Why is the key person considered valuable?

4. What is the nature of the company's business and how long has it been in operation?

5. Key person details

Complete where key person is an employee	Complete where key person is also a shareholder	
Company's total salary bill	**Annual revenue of the company**	**% Shareholding (if applicable)**
$	$	

6. On what basis has the sum insured been calculated?

   Percentage of Profit ☐ Multiple of Salary ☐ Other (cost of replacement etc) ☐

   If "Multiple of Salary" or "Other" please provide details.

7. Who has given authorisation for the Business Disability Cover e.g. Board of Directors, key shareholder(s) etc?

8. Please provide details of the company succession plan.

9. Are there currently any other Key Person or Business Disability Cover insurance policies in place on other people in the company? Yes ☐ No ☐

   If 'yes', please provide full details.

9. Business Expenses Cover

(If applying for Business Expenses Cover, please complete the Business Expenses worksheet, available from your Adviser)

10. Payment details (Must be completed)

Please let us know how you would like to pay for the policy. We'll then validate your Temporary Cover Certificate.

1. What payment options would you like?

   a. Payment Frequency Yearly ☐ Half-yearly ☐ Quarterly ☐ Monthly ☐ Fortnightly ☐

   b. Payment Method Direct debit ☐ Credit card ☐

   c. If paying fortnightly, what day of the week (Monday-Friday) would you like to pay?

   d. What date would you like your first payment to be?

   If your policy is not issued before the date you've given, your first payment will be one month/fortnight after that date. Depending on how close the first payment date provided is to the date we issue your policy, your first payment might happen before you receive your policy documentation in the mail.

2. If you have chosen to pay by Direct Debit or Credit Card, please complete the relevant authority below.

Internal use
Client number

Credit Card Authority

I/we authorise Asteron Life to charge my credit card for all premiums due on this policy until further notice.

Please tick one Visa ☐ MasterCard ☐

Cardholder's name

First payment ☐ All payments ☐

Card number

Expiry date

Cardholder's signature

Sign here

Direct Debit Authority

Internal use
Policy number

Payer's details (Please use BLOCK LETTERS)

Title Family name Given name(s)

Authority to accept Direct Debits

Authorisation code

0 1 0 0 4 0 9

Name of account holder

Name of my bank

Approved

0040

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BANK BRANCH ACCOUNT NUMBER SUFFIX

From the acceptor (you) to your bank:

I authorise you to debit my account with the amounts of direct debits from Asteron Life Limited with the authorisation code specified on this authority in accordance with this authority until further notice.

I agree that this authority is subject to:

- The bank's terms and conditions that relate to my account, and
- The specific terms and conditions listed below.

Authorised signature

Sign here

Date

Specific direct debit conditions relating to notices and disputes

Asteron Life is required to give written notice of the amount and date of each direct debit in a series of direct debits no later than the date of the first direct debit. The notice is to include:

- the dates of the debits, and
- the amount of each direct debit.

I may ask my bank to reverse a direct debit up to 120 calendar days after the debit if:

- I don't receive a written confirmation of the amount and date of each direct debit from Asteron Life, or
- I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.

If I'm not reasonably satisfied that the authority authorised my bank to debit my account with the amount of the direct debit, I may ask my bank to reverse a direct debit up to 9 months after the date Asteron Life sent the first direct debit under the authority.

If the bank dishonours a direct debit but Asteron Life sends the direct debit again within 5 business days of the dishonour, Asteron Life is not required to give notice of the amount and date of the second direct debit.

If Asteron Life proposes to change an amount or date of a direct debit specified in the confirmation, they are required to give notice:

- no less than 30 calendar days before the change, or
- if Asteron Life's bank agrees, no less than 10 calendar days before the change.

I understand I can contact Asteron Life at any time and cancel or change this payment authority.

You will be sent confirmation of your payment details as part of your policy documentation within 5 working days of your policy being issued.

11. Contact times

If we need to clarify any of the information or answers provided in this application when will be the most suitable time to contact you?

Time ☐ Day ☐

12. Occupation (Must be completed)

1. Does your occupation involve any of the following:

   a. Using or handling dangerous substances, chemicals or explosives? Yes ☐ No ☐

   b. Working at heights above 10 metres, working offshore, working underground or working underwater? Yes ☐ No ☐

   c. Any other hazardous duties not listed? Yes ☐ No ☐

   If 'yes', to any of the above questions give details.

   ☐

Please complete Q2 – Q10 if you're applying for: Income Protection Cover, Workability Cover, Own or Any Occupation TPD option, All Mortgage and Living Cover, Business Disability Cover, Farmers Disability Cover, and Business Expenses Cover.

2. In the last 10 years have you, or any business with which you are associated with, been made bankrupt or placed in receivership, involuntary liquidation or under management? Yes ☐ No ☐

   If 'yes' when ☐ *Date of discharge* ☐ *Original amount owed* ☐

3. Over the last 12 month period:

   a. did you on average work between 30 and 55 hours per week? Yes ☐ No ☐

   b. has the business you work for changed your normal working arrangements e.g. reduced your working hours, changed your occupational duties, or reduced your pay? Yes ☐ No ☐

   If 'yes', please provide details.

   ☐

4. How long have you been in your current occupation?

   Less than 2 years ☐ 2-3 years ☐ 3-5 years ☐ Over 5 years ☐

   If less than 2 years, please provide details (e.g. previous occupation, date from and to, self-employed or employed).

   ☐

5. Do you have any other paid employment? Yes ☐ No ☐

   If 'yes', please provide details.

   ☐

6. In the immediate future, do you intend changing your occupation, work activities, hours or employment status (e.g. employed to self employed) or take extended leave? Yes ☐ No ☐

   If 'yes', please provide details including reason, date and duration.

   ☐

7. Do you spend more than 50% of your time working from home? Yes ☐ No ☐

   If 'yes', please provide details.

   % of time ☐ Duties performed at home ☐

8. Do you hold any tertiary qualification or trade licensing certification relevant to your occupation? Yes ☐ No ☐

9. Do you perform any manual work or physical labour in your occupation (e.g. lifting, packing, driving etc)? Yes ☐ No ☐

   If 'yes', are these duties normally associated with the occupation description/quoted? Yes ☐ No ☐

   If 'no', please provide details.

   ☐

PLEASE ONLY COMPLETE THIS QUESTION IF YOU'RE SELF-EMPLOYED

10. Will your business continue to operate if you are unable to work? Yes ☐ No ☐

    If 'yes', please provide details.

    Duration business can operate ☐

    Estimated amount of income you expect while you are unable to work ☐

13. Financial Information

(Only complete if applying for Mortgage and Living Cover **based on annual income**, Income Protection Cover, Workability Cover, Business Disability Cover, Farmers Disability Cover and Business Expenses Cover)

1. Would you continue to receive income if you were disabled? Yes ☐ No ☐
   If 'yes', please complete the following:
   a. How long would you continue to receive this? Duration _____ Amount _____
   b. What would be the source of the income (e.g. share dividends, retainers, ongoing profit or entitlements)?
   _____
   _____
   _____
   c. Is there an agreement in place (written or otherwise) that determines when this entitlement will cease? Yes ☐ No ☐
   If 'yes', please provide details.
   _____

14. Your Habits (Must be completed)

1. Within the last 12 months have you used e-cigarettes/vaporisers (with or without nicotine), used or smoked any product containing tobacco, or used nicotine replacement therapy? Yes ☐ No ☐
   If 'yes', please provide details.
   Cigarette ☐ Daily quantity _____ Cigar ☐ Daily quantity _____
   Pipe ☐ Daily quantity _____
   E-cigarette ☐ What strength nicotine is being used? (12mg/1.2%) _____ How long does 10mls last? _____ days
   Nicotine replacement (patches, tablets, inhalers, etc.) ☐ Date commenced _____ Date ceased _____
   Other ☐ Daily quantity _____ What substance _____
2. How many standard drinks of alcohol do you consume on average per day? _____
   Standard drink = 1 nip spirits, 1 glass of wine, 1 glass of liqueur or port/sherry, 10oz/285ml of beer.
3. Have you ever used or injected yourself with any illegal or illicit drugs, or received any medical advice, counselling, or treatment for the use of alcohol, drugs or gambling? Yes ☐ No ☐

If you answered 'yes' please complete the following table.

Name of Drug	Date first used	Frequency	Date last used

Alcohol, Drug or Gambling	Type of Treatment	Frequency of Treatment	Period of Treatment (From — To)

15. Residence and travel (Must be completed)

1. Are you a New Zealand citizen or have you held a New Zealand permanent resident visa for more than 12 months? Yes ☐ No ☐
   If 'no', please provide details below.
   How long have you lived in New Zealand? _____ years Country of birth _____
   Visa type _____
2. a. In the next 12 months, do you have definite plans to travel, work or reside overseas? Yes ☐ No ☐
   If 'yes', please provide details below.

Countries to be visited	Purpose of the trip	Length of visit	Frequency

b. Will you adhere to the published advice of the New Zealand Government at the time of your travel? This includes not travelling to any locations the New Zealand Government advises avoiding non-essential travel to or not travelling to at all. Yes ☐ No ☐

If 'no', please provide details.

16. Pursuits and activities questionnaire (Must be completed)

1. Do you currently participate in, or plan to take part in, any organised **sport?** (for example, rugby, football, boxing, wrestling, professional sports, ocean racing, martial arts, etc)? Yes ☐ No ☐
   If 'yes', please provide details, in the Sport section, below.
2. Do you currently, or do you plan to participate in any **hazardous activity**, such as parachuting, hang gliding, rock climbing, caving, mountaineering, bungy jumping, aviation other than as a fare-paying passenger (e.g. Air NZ)? Yes ☐ No ☐
   If 'yes' please provide details below, in the Occupation/ Pursuit questionnaire.

Sport	Frequency	Professional/amateur	Location

Please complete this section if you answered YES to question 16.2, above.
(For multiple pursuits please attach separate questionnaire.)

a. Type of pursuit?

b. How long have you participated in this activity? Years ☐ Months ☐

c. Are you a certified instructor? Yes ☐ No ☐

d. In the last 12 months how many events / trips / climbs / dives / jumps did you participate in?

e. Please advise the number of hours you engaged in this activity in the last 12 months?

f. Where do you participate in this activity (geographically)?

g. Do you hold a current and relevant qualification/licence? (e.g. PADi, C grade licence, CPL or PPL) Yes ☐ No ☐

h. Do you ever participate in this activity alone? Yes ☐ No ☐

i. Please disclose maximum heights, speeds, depths.

j. Please give full details including the engine size for boats / cars /planes or other equipment used.

k. Do you take part in competition or intend to compete in the future? Yes ☐ No ☐
   If 'yes', please provide details.

l. Have you ever suffered from any sickness or injury due to this pursuit? Yes ☐ No ☐
   If 'yes', please provide details.

m. Do you have plans to become a professional or are you involved in any record attempts? Yes ☐ No ☐
   If 'yes', please provide details.

n. If the Pursuit is Diving – Have you ever dived, or do you intend to dive in caves, wrecks or do night dives? Yes ☐ No ☐
   If 'yes', please provide details.

17. Medical conditions: common conditions (Must be completed)

Have you ever had any symptoms, investigations, treatment or received a diagnosis for any of the following:

Asthma, bronchitis Yes ☐ No ☐

If 'yes', please complete the following:

1. What is the name of your condition?
2. Date condition first diagnosed
   How often do you experience symptoms?
   e.g. wheezing, breathlessness, chest tightness
3. When did you last experience symptoms?
4. Are you woken during the night with symptoms? Yes ☐ No ☐
   If 'yes', how often and date of last occurrence?
   Frequency
5. Have you ever been off work due to your asthma/bronchitis? Yes ☐ No ☐
   If 'yes', please advise when and for how long.
6. What is your current treatment?
   (Include type of medication and dosage)
   Medication
   Dosage and frequency
7. Have you ever required use of oral steroids or a nebuliser? Yes ☐ No ☐
   If 'yes', please advise when and for how long.
8. Please advise how many inhalers you use in a year.
9. Have you ever been in hospital or received emergency treatment for asthma/bronchitis? Yes ☐ No ☐
   If 'yes', please advise when and for how long and where.
10. Do you ever measure your peak flow or FEV (Forced Expiratory Volume)? Yes ☐ No ☐
    If 'yes', please advise your highest and lowest readings in the past six months.
    Lowest Highest
11. Have you ever consulted a specialist for this condition? Yes ☐ No ☐
    If 'yes', please advise name and address of doctor and date of last consultation.
    Specialist's name
    Address / Phone
    Date of last consultation
12. Please advise details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.
    Doctor's name
    Address / Phone
    Date of last consultation

Hypertension (high blood pressure) Yes ☐ No ☐

If 'yes', please complete the following:

1. Please state the date and reading when it was first noted.
   Reading
2. Please state the date when treatment commenced.
   Date treatment commenced
3. Has your treatment changed recently? Yes ☐ No ☐
   If 'yes', please provide details.
4. Please note the most current reading and the date it was recorded.
   Reading
5. Have you been referred to a specialist for treatment or investigation? Yes ☐ No ☐
   If 'yes', please provide dates, treatments and results (if known) and name and full address of specialist.

High Cholesterol Yes ☐ No ☐

If 'yes', please complete the following:

1. Please state the date and reading when it was first noted.
   Reading
2. Please state the date when treatment commenced.
   Date treatment commenced
3. Has your treatment changed recently? Yes ☐ No ☐
   If 'yes', please provide details.
4. Please note the most current reading and the date it was recorded.
   Reading
5. Have you been referred to a specialist for treatment or investigation? Yes ☐ No ☐
   If 'yes', please provide dates, treatments and results (if known) and name and full address of specialist.

Psychological

Depression, anxiety, panic attacks, or stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental or nervous disorder? Yes ☐ No ☐

If 'yes', please complete the following:

1. Nature of condition and underlying cause

2. Describe your symptoms

3. Date symptoms commenced

   a. Are you still experiencing symptoms? Yes ☐ No ☐

   b. If 'no', when did you last experience symptoms?

4. Have you taken regular or occasional medication for this condition. Yes ☐ No ☐
   If 'yes', please provide details.

   Medication

   Dosage and frequency

5. Are you still taking this medication? Yes ☐ No ☐
   If 'no', please advise date you last used the medication.

6. Have you had any other treatment (e.g. counselling, hospitalisation, ECT)? Yes ☐ No ☐
   If 'yes', please advise type, dates, hospital and name and address of treating doctor.

   Treatment

   Doctor's name

   Address / Phone

   Date

7. Have you ever been off work or your normal daily activities restricted in any way due to this condition? Yes ☐ No ☐
   If 'yes', please advise when and for how long.

8. Have you any ongoing effects or restriction in your activities of any kind? Yes ☐ No ☐
   If 'yes', please provide details.

9. Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist? Yes ☐ No ☐
   If 'yes', please advise dates, name and address of all persons consulted.

   Doctor's name

   Address / Phone

   Date

10. Have you ever had any suicidal thoughts or attempts of suicide or self-harm? Yes ☐ No ☐
    If 'yes', please provide details.

11. Does your usual doctor have details of this condition? Yes ☐ No ☐
    If 'no', please provide name and address of doctor who has full details.

    Doctor's name

    Address / Phone

Musculoskeletal

Any disorder or disease or injury to muscles, bones or joints including hips, shoulders, back, knees, including arthritis, gout, fibromyalgia, tendonitis, any rheumatic condition, tenosynovitis, OOS, RSI or any regional pain syndrome or chronic fatigue? Yes ☐ No ☐

If 'yes', please complete the following:

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

   a. cervical spine (neck) ☐

   b. knee joint R ☐ L ☐

   c. lumbar spine (low back) ☐

   d. hip joint R ☐ L ☐

   e. thoracic spine (mid back) ☐

   f. other (specify below)

2. When did you first suffer from any of the above problems?

Area	Date of first symptoms

3. Please state the cause

Area	Cause

4. Describe the symptoms/exact nature of the problems/diagnosis (if available).

Area	Symptoms

5. What was the severity of the pain?

Area	Mild	Moderate	Severe

6. Have you had any recurrences of any of these areas? Yes ☐ No ☐

Area	Number of occurrences	Date of last symptoms

7. Are you free of all symptoms? (e.g. no pain or stiffness) Yes ☐ No ☐

a. If 'yes', for how long?

b. If 'no', what is the current severity of pain?

Area	Mild	Moderate	Severe

8. How much time have you lost from work as a result of one or more of the above areas?

9. Please describe the treatment(s) received.

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

Area	Details

11. If treatment has ceased, please give date of last treatment.

Area	Date of last treatment

12. Please give the dates, names and address of doctors or other health providers or advisers consulted for these problems.

18. Medical conditions: other conditions (Must be completed)

Have you ever had any symptoms, investigations, treatment or received a diagnosis for any of the following:

A. Heart and blood disorders

Heart attack, heart murmur, angina, chest pain, cardiac investigations or any other heart or blood vessel disorder? Yes ☐ No ☐

B. Respiratory

Emphysema, tuberculosis? Yes ☐ No ☐

Sleep apnoea or any other lung or respiratory disorder? Yes ☐ No ☐

C. Gastro-intestinal and kidney

Recurrent indigestion, hernia, ulcer, passing of blood from the bowel, vomiting of blood? Yes ☐ No ☐

Any disorders related to the gall bladder, intestines, stomach or pancreas? Yes ☐ No ☐

Hepatitis (A, B, C or D), or any other disorder of the liver? Yes ☐ No ☐

D. Nervous system

Stroke? Yes ☐ No ☐

Epilepsy or seizures, fainting attacks, or fits of any kind? Yes ☐ No ☐

Paralysis, Multiple Sclerosis, recurrent headaches or any other disorder of the nervous system? Yes ☐ No ☐

E. Sight and hearing

Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (This does not include long or short sightedness corrected by glasses or contact lenses) Yes ☐ No ☐

F. Endocrine

Diabetes or abnormal blood sugar or thyroid disorder or any other glandular disorder? Yes ☐ No ☐

G. Blood

Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? Yes ☐ No ☐

H. Genito urinary

Prostate disorder, sexually transmitted infection, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? Yes ☐ No ☐

I. Cancer and skin

Psoriasis, eczema or any other disorder of the skin or any allergic or chemical sensitivity reaction? Yes ☐ No ☐

Cancer, tumour, cyst, lump or growth of any kind (even if you have not seen a doctor)? Yes ☐ No ☐

J. Medications and other tests

Any other sickness, injury, physical impairment, procedure or syndrome not previously mentioned? Yes ☐ No ☐

Do you take any medication or undergo treatment on a regular basis (other than contraceptive pill)? Yes ☐ No ☐

Have you ever had, been advised to have, or are you considering having a genetic test? Yes ☐ No ☐

Other than already stated, in the last 3 years have you consulted any other doctor or health professional (e.g. chiropractor, physiotherapist, osteopath, clinic) for any reason other than a common cold/flu? Yes ☐ No ☐

Have you been advised to consult a doctor or health professional, to seek any medical examination, advice, treatment, tests or an operation? Yes ☐ No ☐

Other than for a condition already stated, in the last 3 years have you been hospitalised? Yes ☐ No ☐

If you answered 'yes' to any of the above questions, please provide details on page 18.

Question Number	Name of condition	Date first diagnosed / /	Date of last symptoms / /	Treatment/investigation (tests, surgery, medication, etc)	Degree of recovery %	How much time off work?	Full name of doctor

19. Females (Must be completed by females only)

1. Have you ever had an abnormal breast ultrasound or mammogram? Yes ☐ No ☐
2. Have you ever had an abnormal pap smear? Yes ☐ No ☐

If 'yes' to either of the above questions, please provide details in the table below.

Test	Results	Date

3. Are you currently pregnant? Yes ☐ No ☐
   a. *If 'yes', please provide your due date.*
   b. Have there been or are there expected to be any complications with this or any previous pregnancy? Yes ☐ No ☐
   If 'yes, please provide details.

20. HIV and AIDS (Must be completed)

1. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS), diagnosed with the Human Immunodeficiency Virus (HIV) or carrying antibodies to HIV? Yes ☐ No ☐
2. Have you sought or do you intend to seek medical consultation treatment or investigation for any Aids or HIV related conditions? Yes ☐ No ☐

21. Family history (Must be completed)

Have any or your parents and/or siblings ever been diagnosed with any of the following conditions:

a. Angina, heart attack, and/or heart disease? Yes ☐ No ☐
b. Stroke? Yes ☐ No ☐
c. Diabetes? Yes ☐ No ☐
d. Bowel and/or colon cancer, familial adenomatous polyposis or any other hereditary bowel disorder? Yes ☐ No ☐
e. Breast cancer and/or ovarian cancer? Yes ☐ No ☐
f. Endometrial cancer or cancer of the Uterus (Uterine cancer)? Yes ☐ No ☐
g. Prostate cancer? Yes ☐ No ☐
h. Melanoma, or any other cancer not already mentioned? Yes ☐ No ☐
i. Muscular dystrophy, Parkinson's Disease, Alzheimer's Disease or Dementia? Yes ☐ No ☐
j. Haemochromatosis, Multiple Sclerosis (MS) and/or Huntington's Disease (Huntington's Chorea)? Yes ☐ No ☐
k. Polycystic Kidney Disease, Motor Neurone Disease and/or any other hereditary disorder? Yes ☐ No ☐

If yes to any of the above please provide details below.

Family member (relationship to you)	Condition/Sickness (please specify cancer or Heart disease and specify type of diabetes)	Age at onset (approx)

22. Insurance history (Must be completed)

1. Do you have with us or any other company, and/or are you currently applying for, any type of life, sickness, accident, trauma, lump sum disablement or disability insurance (including mortgage and redundancy cover)? Yes ☐ No ☐
If 'yes', please provide details below.

Name of company	Type of insurance	Insured benefit	Date commenced	Is this policy to be kept or discontinued/ replaced
		$		
		$		

2. Has any application for insurance been refused, deferred or accepted with modified terms? Yes ☐ No ☐
(For example, with an increased premium or exclusion). If 'yes', please provide details below.

3. Have you ever been paid a benefit, or are you expecting a benefit to be paid for an illness or injury? (e.g. insurance policy, ACC, social security (including unemployment benefits), sickness benefits, third party, etc) Yes ☐ No ☐
If 'yes', please provide details below.

Date from	Date to	Type of payment	Condition or cause	Amount
		$		$
		$		$
		$		$

23. Declarations (Must be completed)

Consent

I/we, the person to be insured, authorise Asteron Life to obtain at any time from any employer, doctor, hospital, health agency, insurance office, Government department or agency, or any other person or entity, any and all information Asteron Life may require. I/we understand that Asteron Life can only obtain information about me or any child to be insured for the purpose of assessing or re-assessing an application for cover; an application to alter or reinstate cover; a claim; reviewing observance of obligations including disclosure; or administering the policy. A photocopy of this authorisation shall be read as the original and any relevant person or entity is directed by me to release to Asteron Life any personal information they hold concerning me or any child to be insured. I/we understand that a third party may also be used to process this information for Asteron Life.

Acknowledgement, Authorisations and Declaration

Please read carefully before signing.

Parts 2 and 3 apply to the Person to be Insured only.

1. I/we the proposed **policy owner(s)**:
    a. have read and understood the Asteron Life Privacy Statement on page 2, "Your duty of disclosure" on page 3, as well as this Acknowledgement, Authorisations and Declaration, and Consent sections.
    b. agree that this application, declaration and any personal statements will form part of the proposed insurance contract between me/us and Asteron Life.
    c. understand that if I/we do not provide any information that is material to this application, or if any information provided by me/us is substantially incorrect and material, then Asteron Life may not be able to accept this application; and any policy issued may be avoided from inception. Any claims already paid may have to be paid back.
    d. confirm that the information provided by me/us in this application is either in my/our own handwriting or has been checked and approved by me/us as being accurate and complete.
    e. confirm that where any person(s) to be insured is less than sixteen (16) years of age, confirm that I/we are authorised, to act on their behalf.
    f. have agreed that a photocopy of this authority shall be treated as an original.
2. I/we, **the person(s) to be insured**, understand that:
    a. this application will form part of the basis of the proposed contract for insurance.
    b. I/we am required to advise Asteron Life of any change that is material to this application up until the contract of insurance is formed. The duty of disclosure also applies if in future there is a request to extend or alter the policy, or application to reinstate the policy after it has lapsed.
    c. If I/we do not provide any information that is material to this application, or if any information provided by me/us is substantially incorrect and material, then Asteron Life may not be able to accept this application; and any policy issued may be avoided from inception. Any claims already paid may have to be paid back.
    d. I/we will only be insured for pre-existing conditions if I/we have told Asteron Life about them in writing and insurance for those pre-existing conditions has been accepted by Asteron Life in writing.
    e. the information provided in this application is either in my/our own handwriting or has been checked and approved by me as being accurate and complete.
3. I/we, **the person(s) to be insured**, declare that:
    a. All the answers provided in this application are complete and correct.
    b. In addition, I/we confirm that I have advised Asteron Life of all additional information that may affect its decision to provide insurance cover on the terms and conditions applied for.
    c. I/we acknowledge it is my responsibility to ensure I/we have provided all information that may affect Asteron Life's decision to provide insurance cover, whether the information is specifically requested in the application or not.

	Full name	Signature	Date	
Person to be Insured				Sign here
Child to be Insured 1 (age 16 years or over)				Sign here
Child to be Insured 2 (age 16 years or over)				Sign here
Policy Owner(s) 1				Sign here
Policy Owner(s) 2				Sign here
Policy Owner(s) 3				Sign here

The person to be insured MUST SIGN on the 'Person to be Insured' line. If the Person to be Insured is also a Policy Owner, that person need only sign once in the box marked 'Person to be Insured'.

End of Part 1

PART 2: Adviser details

This section needs to be completed by the Adviser.

Advisers: If you have any questions, phone the Adviser Support team on 0800 808 106 or email them at contactus@asteronlife.co.nz.

1. Servicing adviser's report

Adviser no. _____ Adviser's name _____

Adviser's daytime phone no. _____ Email _____

Who completed this application form (i.e. whose handwriting)? _____

I confirm that the illustration(s) attached to this application accurately reflects the Person(s) to be Insured and the details and requirements of the Policy Owner(s) and has been verified by the Policy Owner(s) Yes ☐ No ☐

Signature of Adviser _____ Sign here

Date _____

1. Please enter your preferred FlexiRate. If Nil commission is selected then Commission by Cover is not available. The FlexiRate applies to all covers within the policy.

	FlexiRate *If left blank Standard commission applies*			
	FlexiRate	**Initial commission**	**Service commission**	**Nil comm**
Personal Insurance	%	%	%	☐
Business Insurance	%	%	%	☐

2. Please tick the appropriate box below to select the policy level commission type. Policy level commission will apply to *Needlestick, Kids Cover and We Pay Your Premium benefits*. It will also apply to any cover/s not listed at step 3 below.

	Policy Level Commission type		
	Upfront	**Spread 20**	**Level 30**
Personal Insurance	☐	☐	☐
Business Insurance	☐	☐	☐

3. Please fill out the table below if you want to select the commission type by specific covers within the policy (if different from the main commission type).

Policy Level Commission type					
Cover	**Sum insured**	**Stepped/Level**	**Upfront**	**Spread 20**	**Level 30**
			☐	☐	☐
			☐	☐	☐

Please note: Accelerated covers will be the same commission type as the main cover

4. **Commission split** *If left blank your default commission split will apply.*

	Adviser name	**Adviser number**	**Initial commission**	**Service commission**
			%	%
			%	%
			100%	100%

TEMPORARY COVER CERTIFICATE

Thank you for choosing Asteron Life

Name of Person to be Insured

The person named above will have temporary cover from Asteron Life Limited as set out in the terms and conditions shown on the next page of this certificate.

This certificate is valid for sixty days from the date on which the application was signed on page 21.

Please keep your Temporary Cover Certificate in a safe place until your policy document arrives.

Signature of adviser

Grant Willis
Head of Life
Asteron Life Limited

Terms and conditions for temporary cover

1. When Temporary Cover applies

Temporary Cover provides protection for those cover type(s) applied for in the application while being assessed by Asteron Life Limited. In addition to those in this certificate, the standard terms, conditions, definitions and exclusions for the cover(s) applied for in the application will apply to this temporary cover.

We will pay the Temporary Cover benefit if the person to be insured dies, or becomes disabled from any of the following conditions: coma, paralysis, blindness, deafness, loss of speech, loss of limbs, major head trauma or burns.

The maximum we will pay under this temporary cover, and any other temporary cover that you hold with us, in respect of any one event is the lesser of the sum applied for in the application or the following cover type limits:

Cover type	Maximum payable
Life	$500,000
Trauma	$500,000
Total and Permanent Disablement (TPD)	$500,000
Income Protection, Workability, and Mortgage and Living	$2,500 per month
Business Disability, Business Expenses, Farmers Disability	$2,500 per month
We Pay Your Premiums	$100 per month

Where you suffer injury or illness giving rise to a claim under this temporary cover, this may be taken into account in our assessment of your application and whether to provide you with cover and on what terms.

If you make a claim, you will need to provide us with any documents that we may ask for, at your own expense.

2. When we will not pay a Temporary Cover benefit

There is no cover if any of the following apply:

- for life cover, the Person to be Insured is under 16 years old or over 65 years old;
- for all other cover types, the Person to be Insured is under 16 years old or over 60 years old;
- you do not comply with your duty of disclosure when you complete your application;
- any information on either the application or personal statement (including telephone interview) is incorrect or incomplete;
- the application is not accompanied by the first premium or an authorised direct debit authority or credit card authority;
- the Person to be Insured has in the past:
  a. had an insurance application refused or deferred by any life insurance company;
  b. been offered cover with additional terms and/or reduced benefit(s) by any life insurance company;
  c. had an insurance policy avoided due to non-disclosure, or cancelled.
- an application for similar benefit(s) has been accepted and a policy issued by another company since this application was completed;
- death, disablement or other claim event occurs as a direct or indirect result of any of the following:
  a. an intentional self-inflicted act of the Person to be Insured, whether sane or insane;
  b. participation in a criminal activity by the Person to be Insured;
  c. as a result of any condition for which symptoms exist or existed that would cause a reasonable and prudent person to seek diagnosis, care or treatment from a registered doctor or other healthcare professional in the 30 days following the date of application;
  d. as a result of any condition for which medical advice or treatment was recommended by, or received from, a registered doctor or other healthcare professional before the application date;
  e. the Person to be Insured driving a motor vehicle with a blood alcohol level in excess of the legal limit;
  f. the Person to be Insured participating in racing (except on foot) or any sport or pastime for which he or she has received any type of reward in the previous two years;
  g. the Person to be Insured engaging in a work or a lifestyle activity that involves explosives, weapons, heights above 20metres, depths below 30metres or speeds above 130km per hour other than as a fare-paying passenger on a commercial airline;
  h. the Person to be Insured being incapable of normal personal care as a result of taking drugs, alcohol or any intoxicating substance;
  i. the Person to be Insured taking part in any of the pursuits, activities or occupations which would be excluded from the cover applied for; or
  j. the Person to be Insured working, residing in (including temporarily), travelling to or travelling from destinations which are deemed to be high or extreme risk. This can be determined by visiting www.safetravel.govt.nz.

3. When Temporary Cover ends

Temporary Cover ends on the earliest of:

- the policy commencement date;
- the date we receive a request to cancel the application;
- the date we advise you, or the Person to be Insured, that the application has been refused; or
- 60 days have passed since this temporary cover started.

Asteron Life PO Box 894, Wellington 6140, Freepost 795
Ph: **0800 737 101** (Contact Centre hours: Mon–Fri 8am–6pm)
Email: **claims@asteronlife.co.nz** Web: **asteronlife.co.nz**

RP350 (05/22)