AIA LIVING

APPLICATION FORM

HEALTHIER, LONGER, BETTER LIVES

Welcome to AIA New Zealand, and thanks for choosing us.

If you prefer, you can complete this form in private and post it directly to:

Private Bag 92499, Victoria Street West, Auckland 1142

Please return with a quote illustration setting out the benefits applied for.

If you need extra space to provide any response, please use the notes on pages 20 and 39 and write 'refer to notes' next to the original question.

DUTY OF DISCLOSURE: WHAT YOU NEED TO TELL US

The purpose of this application is to prompt you to provide information we may consider relevant to the assessment of your application for insurance.

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

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

This means you should:

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

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

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

Please indicate how you would like us to refer to this policy in future correspondence (eg John's Protection Plan):

Would you like this policy to be grouped with another AIA and/or related policy/policies* for correspondence purposes? ☐ YES ☐ NO

If YES, please list policy numbers

(NB: Not all policies can be grouped. Contact the Operations Team for details
* Where related policy/policies means eligible policy(s) issued for the Life to be Assured, where Sovereign Assurance Company Limited ("Sovereign"), or AIA International Limited, New Zealand Branch ("AIA International"), was the insurer.)

Is this application part of a joint policy? ☐ YES ☐ NO

If YES, please complete a separate application form for each Life to be Assured

AA
(Very Strong)

Financial Strength Rating

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

Ratings Scale

SECURE
AAA (Exceptionally Strong) | AA (Very Strong) | A (Strong) | BBB (Good)

VULNERABLE
BB (Moderately Weak) | B (Weak) | CCC (Very Weak) | CC (Extremely Weak) | C (Distressed)

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

1 Life to be Assured

Title

Last name | First names

Previous name (if changed)

Home address

Street

Suburb | Town/City | Postcode

Mailing address (if different)

Contact details

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

Email

Date of birth

Day / Month / Year | Place of birth | ☐ Male ☐ Female ☐ X

Preferred language

Optional, information collected to better understand customer needs.

Occupation | Industry

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

☐ YES ☐ NO

If Yes, please give details of each substance including date started (or stopped) and quantity per day

2 Policy Owner(s)

If the policy is owned by a business, a company director should complete this section and provide his/her authorisation in SECTION 10. **Please note:** If you are applying for Critical Conditions or Progressive Care for a child under the age of 16 these policies can only be owned by the child's parent(s) and/or legal guardian(s).

POLICY OWNER (1)

Title

☐ as above, **or**

Last name | First names

or Company name

Home address

Street

Suburb | Town/City | Postcode

Mailing address (if different)

Contact details

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

Date of birth

Day / Month / Year | Email

POLICY OWNER (2)

Title

☐ as above, **or**

Last name | First names

or Company name

Home address

Street

Suburb | Town/City | Postcode

Mailing address (if different)

Contact details

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

Date of birth

Day / Month / Year | Email

3 Your Insurance Details

DO YOU ALREADY HAVE COVER?

It is important that you provide details of any existing cover that you may have, whether you intend to retain or replace that cover, or any new cover that you are currently applying for outside of this application. This includes any cover you have cancelled in the last six months.

WHY IS THIS IMPORTANT?

- AIA will use this information to assess your eligibility for the level of cover and benefits you are applying for.
- This helps ensure that you are only accepted for any cover that you would be eligible to claim under.
- There are risks associated with replacing existing cover that you need to be aware of as outlined below.

REPLACING EXISTING COVER

If you are intending to replace any existing cover, you should understand there are associated risks (as well as benefits) of doing so. Examples of risks related to taking out a new policy are that the new policy may contain restrictions or exclusions that your old policy didn't have or there may be initial 'stand down periods' meaning you would temporarily lose cover once you've switched.

In some cases, your ability to claim under the new AIA policy may depend on you cancelling your existing cover listed below. You should only do this once the new AIA policy has been issued.

Further details and examples of the risks can be found on the Replacement Policy Advice form attached to the back of this Application form.

Please take the time to read and understand the potential risks involved in replacing existing cover and discuss with your Adviser if you have concerns.

(a) Do you have, or are you currently applying for, any other Life, Income Protection, Trauma (including Living Assurance / Critical Conditions, Progressive Care), Total Permanent Disablement or Health cover with AIA or any other company? ☐ YES ☐ NO

If YES, please give details below

COMPANY	TYPE OF INSURANCE	BENEFIT AMOUNT	APPLIED FOR	EXISTING / IN FORCE	TO BE REPLACED*
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

*ADVISER INSTRUCTION: If 'To be replaced' has been ticked YES, please complete the **Replacement Policy Advice** form at the back of this application to demonstrate that you have discussed the risks and benefits of the policy replacement. A customer's policy should only be replaced if it is in the best interests of the customer.

(b) Has any insurance you currently have, or have applied for (eg Life, Income Protection), ever been declined, deferred or modified including any loadings or Exclusions? ☐ YES ☐ NO

If YES, please give details below.

DATE	INSURANCE COMPANY	TYPE OF INSURANCE	DECLINED	DEFERRED	SPECIAL TERMS	REASON

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

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

CLAIM DATE	TYPE OF CLAIM	REASON/CONDITION

4 Personal Statement

(a) i. Please indicate your New Zealand residency status

☐ Citizen/ Permanent resident ☐ Work permit - Please enclose a copy ☐ Long-term business visa and permit ☐ Other

ii. How long have you resided in New Zealand?

/ Years/Months

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

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

Country	Start date	Duration

(c) Do you participate, intend to participate, or in the last three years have you participated, in any hazardous occupation or pursuit (eg motor racing, aviation, martial arts, parachuting, scuba diving, or motor boat racing)?

☐ YES ☐ NO

If YES, please complete the **Hazardous Occupation or Pursuit Questionnaire** in SECTION 6

(d) What is your height and weight?

cm/feet/inches	kg/stone/lb

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

☐ YES ☐ NO If YES, please give full details

(f) Do you drink alcohol?

☐ YES ☐ NO If YES, please give full details

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

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

☐ YES ☐ NO If YES, please give full details

(h) Are you currently, have you ever been, or are you on notice that you are likely to be adjudged bankrupt, or placed under receivership or administration?

☐ YES ☐ NO If YES, please give full details

(i) Have you ever been convicted of fraud or any offence involving dishonesty?

☐ YES ☐ NO If YES, please give full details

4 Personal Statement (continued)

(j) **Family history**

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

If yes please complete this table.
***For Cancer please specify type**

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

Doctors' details

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

Medical professional and clinic

Doctors name | Does this professional hold your records? ☐ YES ☐ NO

Clinic name | Business phone ( )

Clinic address | Business fax ( )

Years attended

Medical professional and clinic

Doctors name | Does this professional hold your records? ☐ YES ☐ NO

Clinic name | Business phone ( )

Clinic address | Business fax ( )

Years attended

HealthScreen

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

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

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

Telephone Underwriting

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

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

(l) If we require further information to process your application quickly, would you use our Telephone Underwriting and HealthScreen services? ☐ YES ☐ NO

4 Personal Statement (continued)

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

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

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

(n) In the last five years, have you had any medical examinations by a doctor or specialist, specialist tests, blood tests or X-rays? ☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 5

(o) Have you had surgery or been in hospital before? ☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 5

(p) Are you experiencing any health problems or are you receiving or considering seeking medical advice, counselling, specialist tests, blood tests, treatment or an operation from a health professional or awaiting any screening or tests results? ☐ YES ☐ NO If YES, please give details in the **General Health Questionnaire** in SECTION 5

5 General Health Questionnaire

Please complete this section if you answered YES to any of the selected questions in SECTIONS 4 or 9. If you need extra space to provide your response, please use the NOTES on pages 20 and 39 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name | First names

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

Life to be Assured / Child

Last name | First names

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

5 General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on pages 20 and 39 and write 'refer to notes' next to the original question.

Life to be Assured / Child

Last name	First names

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

Life to be Assured / Child

Last name	First names

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

5 General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on pages 20 and 39 and write 'refer to notes' next to the original question.

Life to be Assured / Child — Last name | First names

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

Life to be Assured / Child — Last name | First names

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

5 General Health Questionnaire (continued)

i. Mental health questionnaire

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

Life to be Assured / Child

Last name | First names

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

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

If OTHER, please give name of condition

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

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

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

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

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

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

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

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

ii. Respiratory questionnaire

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

Life to be Assured / Child

Last name | First names

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

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

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

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

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

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

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

5 General Health Questionnaire (continued)

iii. Gastrointestinal tract/bowel questionnaire

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

Life to be Assured / Child

Last name | First names

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

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

If OTHER, please give name of condition

(b) Have you ever consulted a specialist about symptoms of any of the above?

☐ YES ☐ NO

(c) Are you on continuous medication?

☐ YES ☐ NO If YES, is your medication prescribed by your GP/specialist? ☐ YES ☐ NO

(d) Have you ever had any investigations of the gastrointestinal tract?

☐ YES ☐ NO If YES, please give details below

Name of investigation	Result: Normal	Abnormal	Unknown
	☐	☐	☐

Name of investigation	Result: Normal	Abnormal	Unknown
	☐	☐	☐

(e) How often do you experience any symptoms?

times per year

(f) When were your last symptoms?

Day / Month / Year

iv. Tumour questionnaire

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

Life to be Assured / Child

Last name | First names

(a) What was the site of the tumour?

(b) Histology of the tumour if known

☐ Benign ☐ Malignant or pre-malignant ☐ Unknown

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

Years Months

(d) Have you received treatment within the last three years?

☐ YES ☐ NO If YES, please give details

(e) Has there been any recurrence?

☐ YES ☐ NO If YES, please give details

(f) Are you undergoing any ongoing follow-up or have you been advised that follow-up treatment is required?

☐ YES ☐ NO If YES, please give details

(g) Date of last cervical smear, mammogram or other routine screening?

Day / Month / Year

Result

5 General Health Questionnaire (continued)

v. Musculoskeletal questionnaire

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

Life to be Assured / Child

Last name | First names

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

6 Hazardous Occupation Or Pursuit

Please complete this section if you answered YES to question (c) in SECTION 4 or question (f) in SECTION 9.

	OCCUPATION / PURSUIT ONE	OCCUPATION / PURSUIT TWO
(a) Name of occupation or pursuit?		
(b) How long have you participated in this activity?	Years Months	Years Months
(c) Are you a certified instructor?	YES NO	YES NO
(d) In the last 12 months how many events / trips / climbs / jumps did you participate in?		
(e) Please advise the number of hours you engaged in this activity in the last 12 months	hours	hours
(f) Where do you participate in this activity (geographically)?		
(g) If your occupation or pursuit is scuba diving, do you ever dive alone?	YES NO	YES NO
(h) Do you have any plans to become a professional?	YES NO	YES NO
	If YES, please give details	If YES, please give details
(i) Please disclose maximum heights, speeds, depths		
(j) Please give full details including the engine size for boats or other equipment used		
(k) Are you involved in any record attempts?	YES NO	YES NO
	If YES, please give details	If YES, please give details

7 Occupation And Income Details

Application/ policy no.

If you are applying for **Income Protection (IP)** including **Loss of Earnings, Retirement Protection, Redundancy, Mortgage and Income Protection, Business Continuity,** and **Rural Continuity** please complete questions **(a)** to **(s)**.

If you are applying for **Total Permanent Disablement (TPD), Optional TPD under Critical Conditions or Progressive Care, Waiver of Premium, Start Up Income Protection,** please complete question **(a)** to **(m)**. (For TPD applications AIA may request additional financial information as necessary.)

If you are applying for **Accidental Injury Cover**, please complete question **(h)**.

(a) What is your current main occupation?

(b) Do you hold a professional or trade qualification? ☐ YES ☐ NO If YES, please give details

(c) Is your income derived from: (select all that apply)

i. Salaried employment

☐ Full-time ☐ Part-time ☐ Seasonal

ii. Self-employment

☐ Sole proprietor — Name of business

☐ Partnership — Name of business

☐ Company (in which you have a shareholding of 25% or more) — Name of business

☐ Other (eg director's fees, trusts) — Please give details (eg name of trusts)

(d) If self-employed, please state

Number of partners/shareholders | Year your business was established

Number of part-time employees | Number of full-time employees

Profit share entitlement %

(e) Are you applying for Rural Continuity benefit ☐ YES ☐ NO If YES, please give details

i. Do you own or lease your farm/herd

☐ Own ☐ Lease

ii. Farm type (tick all that apply)

☐ Beef ☐ Dairy ☐ Lamb ☐ Wool

iii. Are you a sharemilker?

☐ YES ☐ NO If yes, what type

☐ 50:50 ☐ Casual ☐ Variable order ☐ Contract Other percentage

iv. Gross turnover $

(f) Are you intending to change your occupation or duties or sell your business? ☐ YES ☐ NO If YES, please give details

(g) Are you aware of any pending redundancy or liquidation at your place of permanent employment or have you been advised that you may be made redundant? ☐ YES ☐ NO If YES, please give details

(h) Describe your exact duties (including details as applicable of heights, depths and locations at which you work and chemicals, gases or any toxic substances used) and provide the % of time spent on each duty and the % of time that each duty requires manual or physical work, including driving

Exact duties	% of time on each duty	% that requires manual or physical work, including driving

(i) Number of hours worked? per week

(j) Do you work from home? ☐ YES ☐ NO If YES, please give details of your home set up and % of time spent in this workplace

(k) Do you have any other occupation? ☐ YES ☐ NO If YES, please give details

7 Occupation And Income Details (continued)

(l) Give details of your current and previous occupations during the last five years?

From	To	Occupation	Employer

(m) Is the cover for a mortgage taken out in respect of an investment (eg a mortgage to purchase an investment property)? ☐ YES ☐ NO
(Mortgages where the funds are to be used for investment purposes are not eligible for Mortgage and Income Protection)

(n) Annual earned income details

Have you selected the Retirement Protection Benefit

☐ YES ☐ NO

Salary/wage	$
Fringe benefits (eg company car)	$
Commission income	$
Bonus	$
Share of profits	$
Other (please specify)	$
Total earned income	$ **0.00**
Less business expenses	$
Net earned income – before tax	$ **0.00**

(o) Do you have any unearned income? ☐ YES ☐ NO

(p) Annual unearned income details

Interest	$
Rental	$
Dividend	$
Annuity	$
Other (please specify)	$
Total unearned income	$ **0.00**
Less related expenses	$
Net unearned income – before tax	$ **0.00**
NET INCOME (earned and unearned)	**$ 0.00**

(q) How much of your income would continue if you were disabled? How long would it continue for? What would be the source of income?

Eg sick leave, outstanding accounts, retainers, superannuation benefits, ongoing profits or entitlements

(r) Have you attached evidence of income and/or evidence of mortgage? ☐ YES ☐ NO

Please speak to your adviser for requirements

8 AIA Living Business Continuity

Application/ policy no.

Only complete the following if you are applying for Business Continuity

(a) Name of the Business

(b) How long has the business been trading?

(c) Are you an income generating employee or Key Person in the business? ☐ YES ☐ NO

(d) How long have you been in your current position?

(e) What are the main duties of your role?

(f) What was the Gross Profit for the last financial year?

(g) What percentage of the Gross Profit is attributed to your position and duties and how has this percentage been calculated?

(h) What measures would the business need to take in order to continue to trade if you became disabled?

(i) How many employees work within the business?

(j) Are you aware or have you been advised that the business will cease to trade or that there are potential future redundancies or mergers? ☐ Yes ☐ No If Yes, please explain:

(k) Do you have any personal or business cover? For example - Income Protection, Locum Cover, Business Overheads, Key Person, Business Revenue Cover. ☐ Yes ☐ No If Yes, please complete below:

	Policy One	Policy Two	Policy Three
Owner			
Policy Type			
Amount of Cover			
Reason for Cover			

(l) Can we contact your Accountant direct for financial evidence? ☐ Yes ☐ No

Name of Accountant | Name of Firm

Address

Street

Suburb | Town/City | Postcode

Phone number | E-mail Address

9 Children To Be Assured

Application/ policy no.

Please complete this section if you are applying for **Life, Private Health, Critical Conditions or Progressive Care (including Optional Children's & Maternity Benefit)**. Answers to all questions should be given by the parent or legal guardian on the basis that they relate to the child to be assured. **Children 16 and over need to complete these questions themselves.**

You do not need to complete the Children's personal statement if you are **only** applying for **Optional Children's & Maternity Benefit** for **Critical Conditions** or **Progressive Care.**

Child one

Last name | First names

Date of birth Day / Month / Year | Place of birth | Male | Female | X

Child two

Last name | First names

Date of birth Day / Month / Year | Place of birth | Male | Female | X

Child three

Last name | First names

Date of birth Day / Month / Year | Place of birth | Male | Female | X

Child four

Last name | First names

Date of birth Day / Month / Year | Place of birth | Male | Female | X

Child's insurance details

IMPORTANT NOTICE: If you are intending to replace any existing cover, you should be aware that there are associated risks and benefits. Please see section 3 for more information of these risks.

(a) Do you have or are you currently applying for any other Life, Income Protection, Trauma, Total Permanent Disablement or Health insurance with AIA or any other company for this child? If Yes, please give details below: ☐ Yes ☐ No

Name of child	Name of company	Type of cover	Sum insured	Date commenced	To be replaced?*
				/ /	☐ Yes ☐ No
				/ /	☐ Yes ☐ No

* ADVISER INSTRUCTION: If 'To be replaced' has been ticked, please complete the **Replacement Policy Advice form** at the back of this application to demonstrate that you have discussed the risks and benefits of the policy replacement. A customer's policy should only be replaced if it is in the best interests of the customer.

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

(c) Have any benefits ever been claimed or are currently being claimed from ACC, WINZ or an insurer for this child due to sickness, injury or treatment for injury (eg physiotherapy)?

Child one		Child two		Child three		Child four	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

If YES, please give details

Children's personal statement

(d) **Doctors' details**

i. Please give the name and mailing address of any doctors the child has consulted in the last five years and indicate with an asterix the GP who holds medical records.

Child one	Child two	Child three	Child four

(e) Does the child have permanent residency status in New Zealand?

Child one		Child two		Child three		Child four	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

If NO, please give details

(f) Does the child participate, intend to participate or in the last three years has the child participated in any hazardous occupation or pursuit (eg motor racing, aviation, martial arts, parachuting, scuba diving, or motor boat racing)?

Child one		Child two		Child three		Child four	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

If YES, please complete the **Hazardous Occupation OR Pursuit Questionnaire** in SECTION 6

9 Children To Be Assured (continued)

Application/ policy no.

(g) What is the child's height and weight? (only required for children from age 11 or older)

Height (cm/feet inches)	Weight (kg/stone/lb)	Height (cm/feet inches)	Weight (kg/stone/lb)	Height (cm/feet inches)	Weight (kg/stone/lb)	Height (cm/feet inches)	Weight (kg/stone/lb)

(h) In the last 12 months has the child smoked tobacco or any other substance and/or used smoking alternatives (e.g. e-cigarettes, vaping, nicotine gum or patches)? (only needs to be answered if the child is 14 or older)

Child one	Child two	Child three	Child four
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If YES, please give details of each substance including date started (or stopped) and quantity per day			

(i) Does the child drink alcohol? (only needs to be answered if the child is 14 or older)

If YES, please state the type and quantity (eg beer, wine, spirits)

Child one	Child two	Child three	Child four
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Type and Average per day	Type and Average per day	Type and Average per day	Type and Average per day

(j) Has the child ever used any drug, not prescribed by a doctor, or received medical advice, counselling or treatment for the use of alcohol, drugs or gambling? (only needs to be answered if the child is 14 or older)

Child one	Child two	Child three	Child four
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If YES, please give details.			

(k) Has the child ever had any signs or symptoms of, or been tested for, monitored, treated for, or diagnosed with any of following:

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

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

NOTES

10 Declaration and Consent

Application/ policy no.

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

IMPORTANT NOTICE: Your Duty of Disclosure and Personal Information

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

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

THE BELOW NAMED LIFE TO BE ASSURED AND POLICY OWNER(S) DECLARE AND AGREE THAT:

Disclosure:

1. I/We have read the notice explaining my/our duty of disclosure and all the statements contained in this application for insurance ('Application') are true and complete to the best of my/our knowledge.
2. Should the Life to be Assured undergo any alteration in mental or physical health or have a change of occupation between the date of this Application and the issue of the insurance, I/we agree to notify AIA immediately as this information is relevant to any decision AIA may make to accept this Application.
3. I/We understand that statements made in this Application, including statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf, forms the entire basis of the insurance contract between me/us and AIA.
4. I/We acknowledge that my/our adviser receives commission from AIA.
5. I/We acknowledge that I/we are signing on behalf of any children and declare that I/we have disclosed all health information, including any pre-existing conditions, for such children and ourselves.
6. I/We understand that irrespective of whether I/we have been insured with AIA before, that AIA will rely on the accuracy and completeness of my/our answers given in this Application and I/we must not assume AIA has any prior knowledge of my/our history.
7. I/We understand that if I/we apply or have applied to become AIA Vitality members any information I/we subsequently provide through participation in the AIA Vitality Programme will not be available to AIA for the purposes of administering or assessing any AIA policy (current or future). I/We understand that the segregation of information between the AIA Vitality Programme and AIA insurance policies requires that any information that may affect an insurance policy needs to be provided to AIA as part of any insurance application or variation to an existing insurance policy, even if it has also been provided as part of my/our participation in the AIA Vitality Programme. I/We understand that AIA does not have any prior knowledge of my/our history as a consequence of my/our AIA Vitality membership.

Underwriting:

8. I/We will be bound by the standard conditions applicable to the proposed insurance upon AIA's acceptance of this Application. I/We understand that if my/our Application requires underwriting, then special terms (including special conditions, premium loadings, exclusions or maximums) may be applied to my/our policy. I/We understand that any special terms will apply from the risk commencement date of my/our insurance. I/We understand that the special terms will be set out in the schedule to my/our policy document and will form part of my/our insurance contract. I/We will accept the special terms if I/we either make a premium payment after the policy free look period or agree to the special terms in writing.
9. I/We understand if additional information is required to process my/our Application, I/we may be telephoned by an Underwriter. The information that I/we provide to the Underwriter will form part of my/our Application.
10. I/We understand that if I/we do not consent to AIA collecting personal information on this Application and from the sources listed in clause (26) AIA may not be able to undertake a full underwriting assessment which may result in AIA declining to offer cover or offering cover on less favourable terms than I/we may otherwise be offered.
11. I/We understand that financial information may be required as part of the Illustration (quoting) process, and that any such information, if requested, will form part of my/our Application.

Replacement Policy:

12. I/We acknowledge that I/we are responsible for cancelling any existing cover listed in this Application as 'to be replaced' and that if I/we do not cancel this existing cover then AIA may terminate my/our new policy from inception and decline any claim under it.

Premiums:

13. I/We understand the insurance proposed in this Application shall not commence until this Application has been accepted by AIA and the initial premium or a completed Direct Debit Authority or premium payment direction (such as a Credit Card) has been received by AIA.
14. I/We authorise AIA to debit the nominated credit card account with the premiums payable for the insurance. AIA may debit the credit card account with an Insurance premium even where there may be insufficient clear funds in the credit card account, but AIA shall not be obliged to do so. If there are insufficient funds but AIA debits the credit card AIA may also debit the credit card account with any applicable fees and charges. If the insurance premium cannot be recovered from me/us, then AIA may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and AIA may be entitled to cancel the insurance in accordance with the insurance terms relating to non-payment of premiums.
15. I/we understand that the premium relating to my/our policy may be discounted in some circumstances based on the Life to be Assured's participation in the AIA Vitality Programme. I/We understand that further information can be found in the AIA Vitality Premium Adjustment Rules available on www.aia.co.nz/vitality
16. I/we understand that the premium relating to my/our policy may be discounted in some circumstances based on the Life to be Assured holding multiple benefits across this and other policies with AIA or related companies, and any cancellation or alteration of benefits for the Life to be Assured may result in that discount being changed or removed. I understand that further information can be found in the Multi-Benefit Discount Terms and Conditions available on www.aia.co.nz/mbd

My Personal Information

17. I/We understand that any personal information that I/we provide in this Application will be collected, used, stored and disclosed in accordance with AIA's privacy statement, available on www.aia.co.nz/privacy
18. I/We acknowledge and consent that except in relation to "health information" (as that term is defined in the Health Information Privacy Code 2020) personal information provided in this Application to AIA, or obtained by AIA from the sources listed in clause (26) may be used, held, stored and/or disclosed by AIA and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers:
    - to assess and process this Application and any other application for insurance I/we make to AIA;
    - for the purposes of assessing any claim(s), including assessing if I/we have met my/our duty of disclosure under this Application;
    - to design new, or enhance existing, products and services provided by AIA, including research/direct marketing firms engaged by AIA or its related companies to seek my/our views on products or services offered by AIA or its related companies (whether or not I/we choose to proceed with this Application);
    - to communicate with me/us, including to send me/us administrative communications about any policy I/we may have with AIA;
    - to third parties for the purposes of such parties providing AIA with technology services;
    - for statistical or actuarial research undertaken by AIA;
    - unless I/we tell AIA otherwise or opt out, to tell me/us about other products and services that are offered by AIA, or by reputable organisations with whom AIA contracts, or to send me/us other information or promotional material that we think may be of interest to you;
    - to assist AIA to work with other reputable organisations with whom AIA contracts, whether in New Zealand or overseas, that offer products or services (including loyalty programmes) connected with any of the services that AIA provides. Such assistance may include undertaking data matching exercises both internally within AIA and with such organisations in order to identify products and services that I/we might be interested in;
    - for internal business and administrative purposes;
    - where disclosure is required by law;
    - as otherwise specified in this declaration.
19. I/We acknowledge and consent that health information provided in this Application to AIA, or obtained by AIA from the sources listed in

clause (26) may be used, held, stored and/or disclosed by AIA and/ or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers:

- to assess and process this Application and any other application for insurance I/we make to AIA;
- for the purposes of assessing any claim(s), including assessing if I/we have met my/our duty of disclosure under this Application;
- where disclosure is required by law;
- in accordance with clauses (20), (21) and (22) below.

20. All personal information (including health information) may be collected, held and/or stored by AIA and may be made available to AIA related companies, local and overseas (and in this regard I/we consent to the transfer of my/our information outside New Zealand) and to any agent, contractor or third party who provides technology, administrative or other services to AIA or any member of the AIA Group.
21. I/we understand that AIA is a member of the Health Funds Association of New Zealand (HFANZ). I/we agree that AIA is authorised to collect, use, store and disclose personal information and health information about me/us for the purposes of the HFANZ Integrity Registry. I/we authorise disclosure of personal and health information to HFANZ or its agents, and HFANZ Members, for that purpose.
22. I/we authorise AIA to obtain my/our full medical history where the application form contains:
    - ongoing medical conditions
    - partial or incomplete medical history
    - multiple medical conditions
    - a referral to a medical provider
23. I/We understand that all of my/our personal information (including health information) will be stored by AIA at, 74 Taharoto Road, Takapuna, New Zealand, and may also be held by AIA's data storage providers, including cloud-based data storage providers (in New Zealand or elsewhere). I/We understand that AIA will take reasonable steps to keep such information secure.
24. I/We understand access to and correction of my/our personal information (including health information) may be requested by me/ us.
25. I/We authorise AIA to disclose all personal information (including health information) relating to this Application to my financial adviser for the purposes of providing me with advice regarding the underwriting of this Application by AIA. This authority is limited to this Application, and is only valid for the period of the assessment and until an outcome is reached. I/We acknowledge that the personal information which may be disclosed includes, but is not limited to, health information, vocational, occupational and financial information relevant to the assessment of this Application.
26. I/We consent and give authority to AIA and/or any of its related companies to seek from, and for all and any of the following, their officers and employees, to disclose to AIA and/or any of its related companies, their advisers, reinsurers, and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me/us:
    - any doctor or other registered medical practitioner or specialist, counsellor, psychologist, therapist, dentist, clinic, hospital or medical laboratory;
    - the Accident Compensation Corporation;
    - any bank, financial institution, accountant or financial adviser;
    - any of my/our current or former employers;
    - insurers or reinsurers (whether public or private); and
    - any government department, agency, organisation or enterprise.
27. I/We understand that the supply of the information gathered from the above sources is voluntary and that AIA and/or any of its related companies may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my/our insurance.
28. I/We understand that in collecting information that is relevant to this Application AIA may also receive/collect information that is not relevant to the assessment of this Application or the assessment and administration of my claim and AIA will not use this non-relevant information for any purpose other than as permitted under the Privacy Act.
29. I/We understand that if I/we are the life assured/s for existing cover with AIA or related companies, that cover may be used by AIA to calculate and apply a Multi-Benefit Discount to any policy issued pursuant to this Application. Any subsequent cancellation or alteration of cover for me/us as the life assured/s may result in that discount being changed or removed. Accordingly, if there is any change in my/our cover which results in a change to, or removal of, a Multi-Benefit Discount, I/we consent to AIA notifying the policy owner(s) of any impacted policy.
30. I/We consent to the release of my/our name/s and basic contact details to Business Mentors under my/our Business Continuity Benefit, if applicable.

Correspondence by Email:

31. Where I/we have provided my/our email address(es) in this Application, I/we consent to AIA corresponding with me/us by email for the purposes set out in clause (18) above.
32. Such correspondence can be sent to the email address(es) detailed in this Application or subsequent email addresses I/we provide to AIA.
33. I am/we are responsible for advising AIA if my/our email address(es) change.
34. I am/we are responsible for the security of the information sent to and held in my/our email account(s) and the access that others have to this account/these accounts e.g. the access other family members/colleagues may have to my/our emails.

Insurance Policy:

35. I/We have checked the information that my/our Insurance adviser has entered onto this Application form.
36. At the date of this Application, no statement affecting this Application has been made to any representative of AIA that has not been recorded in this Application.
37. I/We acknowledge that the illustration attached to this Application forms part of the Application and sets out the insurance benefits I/ we are applying for.
38. I/We have been advised that a Specimen Policy Document and the financial statements of AIA are available to me/us on request from AIA's Head Office.

PLEASE COMPLETE THE FOLLOWING DISCLOSURE CHECK BOXES BEFORE SIGNING BELOW

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

I/We understand the importance of full disclosure of all information required in this application for Insurance and have read the "Disclosure"section above..... ☐ YES

I/We understand that AIA may require access to my/our medical records, other sensitive financial information or other personal information from my/our medical providers and other agencies. I/We give consent to AIA to do so pursuant to clause (26) under the "My personal information" section above..... ☐ YES

I/We authorise AIA to disclose **all** personal information relating to this application for insurance to my/our financial adviser pursuant to clause (25) under the "My personal information" section above..... ☐ YES

Please print full names of Life to be Assured

Signature of Life to be Assured X

Date Day / Month / Year

Please print full names of Child / Children to be Assured.

Any children aged 16 and over need to sign as a Life Assured.

CHILD ONE — Date Day / Month / Year

CHILD TWO — Date Day / Month / Year

CHILD THREE — Date Day / Month / Year

CHILD FOUR — Date Day / Month / Year

10 Declaration and Consent (continued)

Application/ policy no.

PLEASE COMPLETE THIS SECTION IF THE LIFE/CHILD TO BE ASSURED IS LESS THAN 16 YEARS OF AGE

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

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

Relationship (please tick) ☐ Parent ☐ Guardian

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

X

Date Day / Month / Year

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

Where deceased minor is under the age of 10 years
Payment is limited to a return of premiums paid plus interest thereon (compounded annually) at the rate prescribed for the purposes of Section 87 of the Judicature Act 1908 at the date of death of the minor plus the amount that, when added to any other sum permitted to be paid by any other company or friendly society, equals $2,000 (or such larger sum as may be specified by Order in Council).

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

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

Signature of Individual policy owner(s)
(if other than Life to be Assured and as named in SECTION 2 of this application form)

Name (please print)

Signature X Date Day / Month / Year

Name (please print)

Signature X Date Day / Month / Year

Name (please print)

Signature X Date Day / Month / Year

Name (please print)

Signature X Date Day / Month / Year

Signature of company policy owner(s)
I/We acknowledge that we are signing on behalf of the company as named in SECTION 2 of this application form and that I/we have the authority to do so.

Name (please print)

Job title

Signature X Date Day / Month / Year

Name (please print)

Job title

Signature X Date Day / Month / Year

Payment Details

Application/ policy no.

Payment Method (please ✓ one option) ☐ Direct Debit ☐ Credit Card ☐ Cheque (annual)

If paying by credit card/debit card or direct debit, please complete the attached Authority Form (page 25 or 27).

Payment Frequency*:

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Annually

deduction to be on every ____ day

starting on the ☐☐ ☐☐

Please specify date of first payment (between 1st and 28th) ☐☐ ☐☐ ☐☐☐☐

*Paying premiums by instalments may increase the total annual premiums payable. Should you require further information please contact us.

Adviser Details

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

Group Voluntary Code

Percentage split Initial | Renewal

Adviser's company | Adviser name

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

Second Adviser (if applicable)

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

Group Voluntary Code

Percentage split Initial | Renewal

Adviser's company | Adviser name

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

Checklist

Type of application

☐ New application ☐ Single Life ☐ Joint Life (please complete a separate application)

☐ Increase Policy no. ____ ☐ Use existing DD/CC ☐ Use new DD/CC

☐ Amendment Policy no. ____

Application details

☐ All relevant sections completed and signature(s) obtained on the declaration

☐ The illustration is attached to this application

☐ A Business Cover Financial Report is completed (for AIA Living Business Continuity applications)

Credit Card/Debit Card Payment Authority

Application/ policy no.

Please ensure Section 10 is completed in conjunction with the following:

1 Policy owner details

Policy numbers you want this authority applied to

First name and surname

Telephone

Day

Evening

Mobile

Email address

Payment start date (between 1st and 28th of the month) DD / MM / YYYY

2 Credit or debit card details

Card type (Tick one) ☐ MasterCard ☐ Visa ☐ Debit Card

Frequency (Tick one) ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Annually

Name on card

Card number

Expiry date /

I/We declare and agree that I/We authorise AIA New Zealand Limited ("AIA") to debit the nominated credit card/debit card account with the premiums payable (and any increases to those premiums), for the insurance cover provided under the policies listed above. AIA may debit the credit card/debit card account with an insurance premium even when there may be insufficient clear funds in the credit card/debit card account, but AIA shall not be obliged to do so. If there are insufficient funds but AIA debits the credit card/debit card, AIA may also debit the credit card/debit card account with any applicable fees and charges. If the insurance premium cannot be recovered from me/us, then AIA may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and AIA may be entitled to cancel the Insurance in accordance with the insurance terms relating to non-payment of premiums.

Card holder 1 signature X

Date DD / MM / YYYY

Card holder 2 signature X

Date DD / MM / YYYY

AIA House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag 92499,
Victoria Street West,
Auckland 1142

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

Authority To Accept Direct Debits

1 Personal Details

Policy number

Or, apply to all policies ☐

Mr/Mrs/Miss/Ms/Other

Name of policy owner

Telephone — Home | Work | Mobile

Email address (optional)

No Change to Payment Date/Frequency ☐

Date of first payment (between 1st and 28th of the month) DD / MM / YYYY

You do not need to complete this date field if you want the payment date relating to this new authority to remain the same as your existing direct debit.

Frequency (please tick one) ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half yearly ☐ Annually

2 Authority to accept direct debits

Authority to accept direct debits
(Not to operate as an assignment or agreement)

Name of Account

Customer (Debtor) to complete Bank/Branch number and Account Number and Suffix of Account to be debited.

Bank | Branch number | Account number | Suffix

To: The Manager
(Insert name of Bank and Branch)

Start date DD / MM / YYYY

(Hereinafter referred to as the Bank)

Address (PO Box)

Town/City

I/We authorise you until further notice in writing to debit my/our account with all amounts which AIA New Zealand Limited (hereinafter referred to as the Initiator) the registered Initiator of the above Authorisation Code, may initiate by Direct Debit.

Authorisation code

1	2	0	0	3	6	5

I/We acknowledge and accept that the bank accepts this authority only upon the conditions listed on the reverse of this form.

Information to appear in my/our Bank Statement

Payer particulars

A	I	A		N	Z						

Payer code

Payer reference

Your signature must appear here – Name of Account – Customer (Debtor) to complete

Authorised signature(s) X

Date DD / MM / YYYY

Authorised signature(s) X

Date DD / MM / YYYY

Conditions of authority to accept direct debits

1 The Initiator:

1.1. Will provide notice either:
  1.1.1. in writing; or
  1.1.2. by electronic means, including SMS and email, where the Customer has provided prior written consent to the Initiator.
1.2. Has agreed to give advance notice of the net amount of each Direct Debit and the due date of the debiting at least 2 calendar days (but not more than 2 calendar months) before the date when the Direct Debit will be initiated.
  1.2.1. The advance notice will include the following message:
  Unless advice to the contrary is received from you by (date*), the amount of $..... will be directly debited to your Bank account on (initiating date*).
  *This date will be at least two (2) days prior to the initiating date to allow for amendment of Direct Debits.
1.3. Alternatively, the Initiator undertakes to give notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the first Direct Debit is drawn (but no more than 2 calendar months).
  1.3.1. 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 the Acceptor with a schedule detailing each payment amount and each payment date.
  1.3.2. In the event of any subsequent change to the frequency or amount of the Direct Debits, the Initiator has agreed to give advance notice of at least 30 days before the changes comes into effect. This notice must be provided either:
  (a) in writing; or
  (b) by electronic mail where the Customer has provided prior written consent to the Initiator.
1.4. May initiate a Direct Debit on my/our account when authorisation is received from me/us in accordance with the terms and conditions agreed between me/us and the Initiator of each amount to be debited from my/our account.
  1.4.1. Notice will be sent of the net amount of each Direct Debit and the due date of debiting after receiving authorisation from me/us under clause 1.4 but no later than the date the Direct Debit will be initiated. This notice must be provided either:
  (a) in writing; or
  (b) by any other means which provides a verifiable record of the initiated transaction and where the Customer has provided prior written consent to the Initiator.
  1.4.2. Where the notice is in writing it must include the following message: "The amount $..... was directly debited to your Bank account on (initiating date)."
  1.4.3. Where the notice is provided by other means:
  (a) the Initiator should hold prior written consent of those means of providing notice; and
  (b) the notice should provide a verifiable record of the initiated transaction and include the amount and initiating date of that transaction.
1.5. May, upon the relationship which gave rise to this Instruction being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Instruction. Upon receipt of such notice the Bank may terminate this Instruction as to future payments by notice in writing to me/us.
1.6. May rely on this authority to debit a different bank account upon receipt of instructions from the customer via a bank to which their account has been transferred.

2 The Customer may:

2.1. At any time, terminate this Instruction as to future payments by giving written (or by the means previously agreed in writing) notice oftermination to the Bank and to the Initiator.
2.2. Stop payment of any Direct Debit to be initiated under this Instruction by the Initiator by giving written notice to the Bank prior to the Direct Debit being paid by the Bank.
2.3. Where no advance notice is provided under clause 1.4 a variation to the amount agreed between the Initiator and the Customer from time to time to be Direct Debited had been made without notice being given in terms of clause 1.4 above, 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 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:

3.1. This Instruction 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 Instruction until actual notice of such event is received by the Bank.
3.2. In any event this Instruction is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.
3.3. Any dispute as to the correctness or validity of an 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 Instruction. Any other disputes lie between me/us and the Initiator.
3.4. Where the Bank has used reasonable care and skill in acting in accordance with this Instruction, the Bank accepts no responsibility or liability in respect of:
  3.4.1. the accuracy of information about Direct Debits on Bank statements; and
  3.4.2. any variations between notices given by the Initiator and the amounts of Direct Debits.
3.5. The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give notice in accordance with clauses 1.1 to 1.4. 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.
3.6. Where notice given by the Initiator in terms of clause 1.4 to the debtor responsible for the payment shall be effective. Any communication necessary be cause 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:

4.1. In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other Instruction, cheque or draft properly signed by me/us and given to or drawn on the Bank.
4.2. At any time terminate this Instruction as to future payments by notice in writing to me/us.
4.3. Charge its current fees for this service in force from time to time.
4.4. Upon receipt of an "authority to transfer form" signed by me/us from a bank to which my/our account has been transferred, transfer to that bank this Authority to Accept Direct Debits.

Bank use only

Approved
0036
---
02 I 02

Date received
DD / MM / YYYY

Recorded by

Checked by

Bank Stamp

AIA House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag 92499,
Victoria Street West,
Auckland 1142

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

Replacement Policy Advice

Application/ policy no.

This form must be completed whenever an existing or recently discontinued (within 6-months) Risk / Health Policy or Benefit is to be fully or partially replaced. It is important that you provide all requested information. This form is intended to meet AIA's internal operational requirements for replacement business only and should be completed in addition to an Advisers' record-keeping requirements, such as a Statement of Advice.

In all instances, please return this form with a quote illustration setting out the details of the new policy or benefit(s) being applied for.

ADVISER: Please complete sections 1-4 below, then complete and sign the Declaration of Advice on last page.

1 Replacement Type

☐ AIA Internal Policy Replacement — Includes any policy or benefit issued or underwritten by AIA New Zealand Limited ("AIA"), Sovereign Assurance Company Limited ("Sovereign") or AIA International Limited, New Zealand Branch ("AIA International")

☐ External Policy Replacement — Current Insurer

2 Details of Policy and/or Benefit(s) being Replaced or Cancelled

Complete one (1) line per Life Assured for each Policy / Benefit that is to be replaced or cancelled.

Policy number	Life assured	Benefit / Policy Type (i.e. Life/TPD/Health)	Existing Sum Assured	To be replaced	Sum Assured to remain on existing policy after replacement	To be cancelled
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes
			$	☐ Yes	$	☐ Yes

3 Policy Ownership of New Policy / Benefit

Please indicate whether the policy ownership will change as a result of the replacement:

☐ Policy Ownership to remain unchanged on new policy

☐ Policy Ownership to change on new policy
(attach a completed change of ownership form or new ownership page & signature page from the main application form)

4 Reason for Replacement

A customer's policy should only be replaced if it is in the best interests of the customer.
Please indicate the primary reason for the replacement:

☐ Change in premium structure (Rate for Age to Level or, Level to Rate for Age)

☐ Policy Owner's needs have changed and their existing policy/benefit do not match their current needs.

☐ Policy Owner's needs have not changed, but new policy/benefit is advantageous.

☐ Other

NOTE: Policy Owner is intended as a broad term in this section, including the life assured, the premium payer and any nominated beneficiary.

Application/
policy no.

POLICY OWNER(S): Please read, then complete and sign the Acknowledgements and Declaration over page.

Important information before you proceed

There can be risks and benefits in replacing an existing policy/benefit(s). Before you make a decision to replace your existing policies/ benefit(s) your financial adviser can help you to understand the advantages and disadvantages of switching and/or the types adverse circumstances which might occur as a result of changing policies/benefit(s).

Your financial adviser can help you consider key aspects such as:

- **Your personal situation** – changes in health, leisure activities or occupation may mean your new policy contains new or different restrictions/exclusions than your old policy/benefit(s).
- **Differences in cover** – particularly reduction or loss of benefits, any unusual features, different expiry ages/dates, waiting periods, or changes in limits/cover amounts.
- **"Stand down" periods** – a new policy/benefit can have initial "stand down periods" in which you may temporarily lose some of your cover.
- **Definitions and exclusions** – while policies may seem similar, there can be differences in the definitions and exclusions used between policies (e.g. medical conditions, employment, occupation, income, etc) which could affect your ability to claim on your policy.
- **Cost** – this should consider all costs related to the policy/benefit(s), short and long-term.
- **Financial strength ratings** – There may be differences in financial strength ratings between the old and new insurers. This is an assessment of an insurer's ability to meet obligations to policyholders.

Policy Owner(s) Acknowledgements and Declaration

1. I/We acknowledge that, prior to signing the application form for the new policy(cies)/benefit(s) my/our financial adviser:
   - has provided me/us with a comparison between my/our existing and proposed policy(cies)/benefit(s) that covers the key aspects outlined above, and that I/we understand the consequences of my/our financial adviser's recommendation; or
   - has not provided me/us with advice in respect of this replacement, but I/we have been informed of the types of adverse circumstances which might occur as a result of changing products and I/we understand the risks.
2. I/We acknowledge that in issuing my/our replacement policy, AIA is relying on the information provided in this form, together with the information provided in the original proposal(s).
3. I/We acknowledge that any loading(s) and/or exclusion(s) (Special Terms) applied my/our current policy(cies) will also apply to my/our replacement policy(cies), unless the replacement policy(cies) is subject to full underwriting by AIA and as a consequence Special Terms are removed or changed. My/our financial adviser has explained Special Terms to me/us.
4. I/We acknowledge that where my/our existing policy(cies) are replaced, the cover that I/we had in place has changed and therefore I/ we may no longer be covered for any event that was previously covered by my/our policy(cies) and/or the conditions of my/our cover may have changed. If my/our replacement policy(cies) is subject to full underwriting by AIA, my/our financial adviser has explained that underwriting might result in Special Terms being applied to my/our replacement policy(cies).
5. I/We request that where I/we are replacing an AIA Internal Policy/Benefit(s), our current AIA policy(cies) or benefit(s) identified in Sections 1 and 2 above as "to be replaced or cancelled", be cancelled/altered immediately.
6. I/We acknowledge that where I/we are replacing an AIA External Policy/Benefit(s), I/we must contact the old insurer directly to cancel my/our existing policy/benefit. I/We acknowledge that I/we should NOT cancel my/our existing policy/benefit(s) until I/we have disclosed everything necessary to AIA, the new policy/benefit(s) has been issued and I/we are happy that I/we are appropriately insured.

Application/
policy no.

POLICY OWNER(S): Acknowledgements and Declaration.

Please sign below to confirm you understand and accept the terms set out in acknowledgements 1-6 above

IMPORTANT NOTICE: Signatures are required from ALL Policy Owners on joint policy(ies). Written confirmation will be sent to the Policy Owners named below if an AIA policy or benefit is being cancelled or altered due to replacement

Policy owner 1

Full name:

Signature:

Date / /

Policy owner 2

Full name:

Signature:

Date / /

ADVISER: Please complete and sign the Declaration of Advice below.

5 Declaration of Advice

Select the check box that correctly reflects the level of advice you have provided the Policy Owner(s) regarding this replacement.

☐ **Declaration of Advice**
I confirm that I have taken all reasonable steps to advise the Policy Owner(s) of the risks and benefits of replacing the policy/ benefit(s) listed on this form. To the best of my knowledge the information contained in this form is true and correct.

OR

☐ **Declaration of No Advice**
I confirm that I have not given any advice to the Policy Owner in respect of this replacement.
Although I have not made any comparison between the new policy/benefit(s) and the existing policy/benefit(s) I have informed the Policy Owner(s) of the types of adverse circumstances which might occur as a result of changing products.

Adviser Name

Adviser code

Signature

Date / /

AIA Vitality Application Form

AIA Vitality

Important Information

This Application Form is to be used where the life assured is insured under one or more eligible AIA New Zealand Limited (AIA) insurance policies and wishes to apply for AIA Vitality. This form is intended to supplement information already collected from the policy owner(s) and the life assured on any previous Application Form.

This Application Form will need to be completed by the life assured.

Please send the completed form to: **enquireNZ@aia.com**

Note: Ongoing AIA Vitality membership fee must be paid by Direct Debit or Credit/Debit Card.

1 AIA Vitality member details (Life Assured to complete this section in full)

AIA Vitality is a health and wellness programme, encouraging you to get healthier and earn great rewards. Premiums relating to the eligible policy(s) that covers you may be discounted in certain circumstances based on your participation in the AIA Vitality Programme, the terms of which were provided to you with your application and are available on the AIA Vitality member website www.aiavitality.co.nz

Title	
Surname	
Given Name	
Gender	
Date of Birth (dd/mm/yyyy)	/ /

Note: To be eligible for AIA Vitality you must be 16 years and over.

Email	

A unique email address is mandatory. You cannot have the same email address as another AIA Vitality member.

	Mobile	Phone (home)	Phone (work)
Contact Details			

Do you have existing insurance policy(s) with AIA, ASB or Sovereign? ☐ Yes ☐ No

If yes, do you know your policy number(s)?			

Your AIA Vitality membership will be associated with your eligible insurance policy(s)

Information for completion of Payment Authority forms

In order to have the AIA Vitality membership fee deducted please complete the AIA Vitality Payment Form, either **Credit or debit card details** or **Authority to accept direct debits** (page 35-36).

Declaration and Consent: AIA Vitality

There is some important information you need to know about AIA Vitality. You need to be over 18, or if you're 16 or 17, have the permission of a parent/guardian, to confirm your understanding of the following:

- **I understand that any personal information I provide in this AIA Vitality application, or during my membership, will be used and disclosed in accordance with the AIA Vitality terms and conditions and AIA's privacy statement, both available on AIA's website aia.co.nz**
- **I understand that AIA operates AIA Vitality separately from its business of providing insurance policies. My personal information provided through AIA Vitality will not be available to AIA for the purposes of any AIA insurance policy.**
- **I understand that I am still obliged to disclose any information that might be relevant to any insurance policy with AIA (current or future), even if I provide information to AIA as part of my participation in AIA Vitality.**
- **I understand that I need an eligible insurance policy to get AIA Vitality and that any discounts or benefits provided as part of my AIA Vitality membership are not guaranteed and may be varied or withdrawn by AIA at any time.**

I, the named Life to be Assured who is applying to become an AIA Vitality Programme ('AIA Vitality') member, declare and agree that I:

- Am either over 18 years of age, or if you're 16 or 17 years of age, and have the permission of my parent/guardian to make this declaration;
- Understand that any personal information that I provide in this application to become a member of AIA Vitality will be used and disclosed in accordance with the terms and conditions of AIA Vitality (available on the AIA Vitality website at www.aiavitality.co.nz) and will be collected, used, stored and disclosed in accordance with AIA's privacy statement (available on www.aia.co.nz/privacy);

Declaration and Consent: AIA Vitality continued...

- Understand that AIA Services New Zealand Limited ('AIA') operates AIA Vitality separately from its business of providing insurance policies. The only information that is received out of AIA Vitality that will be passed through to AIA in relation to insurance policies is information that might relate to AIA Vitality status (for example to provide me with a discount on my insurance policy). Accordingly, I understand that:
  - once I am a member of AIA Vitality, any personal information (including "Health Information" as defined in the Health Information Privacy Code 2020) that I subsequently provide through participation in AIA Vitality will not be available to AIA for the purposes of renewing, amending or assessing any AIA insurance policy (current or future); and
  - in accordance with my duty of disclosure, I am still obliged to disclose any information to the extent it may be relevant to any future application for insurance cover (including increased or varied cover) or changes to existing insurance cover or claims under an insurance policy with AIA, even if I provide information to AIA as part of my participation in AIA Vitality; and
  - AIA does not have any prior knowledge of my history as a consequence of my membership of AIA Vitality.
- Understand any discounts or benefits provided in respect of membership in AIA Vitality are not guaranteed and AIA reserves the right to vary or withdraw the discounts or benefits or AIA Vitality.

Use and Disclosure of Personal Information

Please note that if you **do not consent** to the use and disclosure of your personal information (including Health Information) as set out below you will not be able to participate in AIA Vitality. For further information or if you have any questions, please feel free to contact us on 0800 242 888.

I agree to my personal information being shared with AIA Australia and AIA Vitality Partners to administer the programme

To administer AIA Vitality, I provide authority and consent for AIA to disclose my personal information to:

a. AIA's third party service providers;
b. AIA Australia Limited and its third party service providers; and
c. AIA Vitality Partners for verification purposes only.

I agree that anonymised information will be shared with members of the AIA Group (based in Hong Kong) and Discovery Holdings Limited (based in South Africa) the company who owns the Vitality programme and licenses it to AIA.

To administer AIA Vitality, I provide authority and consent for AIA to disclose my non-personally identifiable information (including anonymised Health Information) to other members of the AIA Group (Hong Kong) and to Discovery Holdings Limited (South Africa) (who owns the Vitality programme and licenses it to AIA), and their third party service providers. Anonymised Health Information will be disclosed in such a way that it is not reasonably capable of being de-anonymised by these entities.

Note: The Privacy statement of each of the entities above is available on their websites. For Discovery Holdings Limited's privacy statement see: https://www.discovery.co.za/portal/ individual/terms-and-conditions. These documents may be updated from time to time.

I agree to receive marketing communications for non-financial products/services that are outside of AIA Vitality, but relate to our AIA Vitality Partners. You can unsubscribe at any time.

I provide authority and consent for AIA to use and disclose my personal information (other than Health Information) to AIA Australia, to promote or market AIA Vitality Partner offers.

If subsequently I do not wish to receive marketing communications, I will follow unsubscribe instructions in the communications themselves where prompted, or contact AIA on 0800 242 888.

I agree to AIA sharing information relating to my AIA Vitality membership to Policy Owner(s) and/or my Financial Adviser.

I provide authority and consent for AIA to disclose information (other than Health Information) that relates to my membership of AIA Vitality to my financial adviser, ASB Insurance Manager and/or to the policy owner of any AIA insurance policy to which my membership of AIA Vitality attaches for the purposes of administering AIA Vitality and for me to receive the benefits and services of AIA Vitality. Such information may include AIA Vitality membership information such as my AIA Vitality status, membership number, whether I have purchased or used certain devices and/or accessories or whether I have visited or used certain AIA Vitality Partners, to earn AIA Vitality points.

I understand that there are terms and conditions that relate to the AIA Vitality Programme and I agree to read, understand and accept these before activating my AIA Vitality membership.

The terms and conditions of AIA Vitality are available on the AIA Vitality website at www.aiavitality.co.nz. A link to the terms and conditions will be sent to you in your activation email. By agreeing to the terms and conditions, you do so in your capacity as a life assured named in this application.

Please note that if you do not agree to the terms and conditions of AIA Vitality, your membership application will not be able to be accepted by AIA.

By completing the check box you the Life Assured confirm you have read and accepted the 'Use and Disclosure of Personal Information' section.

Please tick ☐

Please note that if you do not consent to the use and disclosure of your personal information as set out above you will not be able to participate in AIA Vitality.

Name of Life Assured			
Signature of Life Assured	X	Date (dd/mm/yyyy)	/ /

Parent or guardian consent is only required where the Life Assured is 16 or 17 years of age.

Parent or guardian Signature	X	Date (dd/mm/yyyy)	/ /
Financial Adviser or Insurance Manager name **(If applicable)**		Date (dd/mm/yyyy)	/ /

AIA Vitality Payment Form

AIA Vitality

1 Personal details

Mr/Mrs/Miss/Ms/Other

Contact number

Name of AIA Vitality member

Email address

Payment frequency and AIA Vitality membership fee including GST (please tick one)

☐ Monthly $11.50 ☐ Half yearly $69 ☐ Annually $138

AIA Vitality membership fee could be subject to change.

2 Payment method

Please tick the appropriate box for your AIA Vitality membership payment only.

☐ **Credit Card or Debit Card** (please complete Section 3)

☐ **Direct Debit** (please complete Section 4)

3 Credit or debit card details

Card type (Tick one) ☐ MasterCard ☐ Visa ☐ Debit Card

Expiry date (mm/yy) /

Name on card

Card number

I/We declare and agree that I/We authorise AIA Services New Zealand Limited ("AIA") to debit the nominated credit card/debit card account with the AIA Vitality membership fees payable (and any increases to those fees), AIA may debit the credit card/debit card account with AIA Vitality membership fees even when there may be insufficient clear funds in the credit card/debit card account, but AIA shall not be obliged to do so. If there are insufficient funds but AIA debits the credit card/debit card, AIA may also debit the credit card/debit card account with any applicable fees and charges. If the AIA Vitality membership fees cannot be recovered from me, then AIA may reverse the AIA Vitality membership fees payment resulting in the fees being treated as not having been paid and AIA may be entitled to cancel the AIA Vitality membership in accordance with the AIA Vitality terms and conditions.

4 Authority to accept direct debits

Authority to accept direct debits
(Not to operate as an assignment or agreement)

Name of my Account to be debited (Acceptor)

Customer (Debtor) to complete Bank/Branch number and Account Number and Suffix of Account to be debited.

Bank | Branch number | Account number | Suffix

To: The Manager (Insert name of Bank and Branch)

I authorise you, until further notice in writing, to debit my account with all amounts which GoCardless, the registered initiator of authorisation code 1226237, may initiate by direct debit on behalf of AIA Services New Zealand Limited ("AIA"). 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.

I provide authorisation to GoCardless, the initiator acting on behalf of AIA Services New Zealand Limited ("AIA") to send the confirmation of this authority to me via email.

Authorisation code: 1 2 2 6 2 3 7

Information to appear on my/our Bank Statement

Payer particulars: A I A V I T A L I T Y

Payer code: F E E

Payer reference

5 AIA Vitality payment authorised signature(s)

Signature 1 X

Date (dd/mm/yyyy) / /

Signature 2 X

Date (dd/mm/yyyy) / /

Bank Terms and Conditions

Specific conditions relating to notices and disputes

- 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 notice of the amount and date of each direct debit from the initiator, 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.
  - I may ask my bank to reverse a direct debit up to 9 months after the date the initiator sent the first direct debit under the authority if I am not reasonably satisfied that the authority authorised my bank to debit my account with the amount of the direct debit.
- The initiator is required to give a written notice of the amount and date of each direct debit, including the first direct debit in a series, of no less than 2 working days. The notice is to include: the dates of the debits, and the amount of each direct debit.
- If the initiator proposes to change an amount or date of a direct debit specified in the notice, the initiator is required to give you notice no less than 10 days before the change.
- If the bank dishonours a direct debit but the initiator sends the direct debit a second time within 5 business days of the original direct debit, the initiator is not required to notify you a second time of the amount and date of the direct debit.

Banks and building societies may not accept Direct Debit Instructions for some types of accounts

GoCardless Terms and Conditions

GoCardless process Direct Debit payments on behalf of other businesses and organisations, such as the merchant that you wish to make payments to. These businesses and organisations create payments for their customers using our system and we then process these according to the parameters and instructions they have set. These terms and conditions explain how GoCardless will operate, when it collects payments from your bank account.

1 Definitions

- Unless otherwise defined in these terms and conditions (the "**GoCardless Terms**"), capitalised terms have the meaning given to them in the "Conditions of Instruction to Accept Direct Debits" ("**Bank Terms**").
- **Customer** means the person or entity identified as such on the Application, who intends to make payments to the Merchant by way of direct debit (also referred to as "you" and "your" in these Terms and Conditions).
- **Direct Debit Instruction** means the application form containing the GoCardless Terms and the Bank Terms and completed by you for the purposes of authorising payments to be made from your bank account to the Merchant by way of direct debit.
- **GoCardless** means GoCardless Limited, the payment service provider authorised by the Merchant to process direct debit payments made by you to it, on its behalf. The "Initiator" in the "Conditions of Instruction to Accept Direct Debits" above is GoCardless.
- **Merchant** means the person or entity that the Customer intends to make payments to by way of direct debit, and identified as such on the Application.

2 Direct Debit Instruction

2.1 By completing the Direct Debit Instruction, you agree to be bound by the Bank Terms in addition to the GoCardless Terms.

2.2 You acknowledge that by completing the Direct Debit Instruction, you are authorising the Merchant to debit your nominated bank account (as it appears on the Direct Debit Instruction) for the amounts and at the frequency set out in the Direct Debit Instruction. You acknowledge that GoCardless provides direct debit payment processing activities to the Merchant and as such, where GoCardless is instructed by the Merchant, GoCardless will debit your nominated bank in accordance with the instruction.

2.3 Any changes to the information provided by you on the Direct Debit Instruction must be communicated by you directly to the Merchant. You acknowledge that GoCardless will not accept any instruction directly from you to vary the Direct Debit Instruction.

3 Liability of GoCardless

3.1 GoCardless may cease providing the Merchant with direct debit payment processing services upon written notice to the Merchant in accordance with the agreement entered into by GoCardless and the Merchant for the supply of those services. In such circumstances, GoCardless will cease accepting the Merchant's instruction to debit your nominated bank account in connection with the Direct Debit Instruction. If you continue to receive goods or services from the Merchant, you must contact the Merchant directly to set up an alternative payment method.

3.2 GoCardless will not be responsible for any delay that may occur in processing a direct debit payment on the Merchant's behalf if:

3.2.1 there is a public holiday on the day or on the day after a payment is due to be made;

3.2.2 a payment is received either on a day that is not a business day or after the normal close of business on a business day;

3.2.3 GoCardless does not receive the Direct Debit Instruction in sufficient time to process the payment; or

3.2.4 the Direct Debit Instruction is not duly completed.

3.3 You acknowledge that GoCardless is not involved in the supply of any goods and/or services to you, and any disputes regarding the supply of any goods and/or services for which you have made payment for in connection with the Direct Debit Instruction are to be dealt with directly by you and the Merchant. GoCardless has no involvement in or express or implied liability in relation to any goods or services provided by the Merchant.

3.4 Nothing in the GoCardless Terms or the Bank Terms creates any relationship or liability between GoCardless and you for any purpose and any disputes regarding any payments debited from your nominated bank account should be directed to the Merchant.

4 General

4.1 If there is any inconsistency or conflict between the GoCardless Terms and the Bank Terms, the GoCardless Terms will prevail.

4.2 The GoCardless Terms are governed by the laws of New Zealand.

Bank use only

Approved
2623
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03 I 19

Date received (dd/mm/yyyy) / /

Recorded by

Checked by

Bank Stamp

AIA House,
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag 92499,
Victoria Street West,
Auckland 1142

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

Airpoints Dollars™ Application Form

Earn Airpoints Dollars™ with AIA*

For every $100 premium paid on eligible products and benefits, you will earn 1 Airpoints Dollar™.

To start earning Airpoints Dollars on your eligible insurance policy, please provide your Airpoints™ number.

Note that we can accept only one Airpoints number for each application/policy. All Policy Owners must sign this form to confirm the Airpoints number which will earn Airpoints Dollars for the AIA policy detailed below.

*Terms and conditions apply.

1 Policy Owner details

Please complete all fields below.

Application/policy no.	
First name (as held by Air New Zealand)	
Last name (as held by Air New Zealand)	
Airpoints™ number	
Telephone number	
Email address	

If you are not an Airpoints member, you can join for free at **www.airnz.co.nz/airpoints**

You can request to change the Airpoints number registered to your AIA policy at any time by contacting our call centre on 0800 500 108 or talk to your adviser.

It is your responsibility to provide us with accurate details of your Airpoints account, and to let us know of any changes to your Airpoints account name or number.

2 Policy Owners to complete

By signing this form you:

- Agree that the nominated Airpoints number will earn Airpoints Dollars on the AIA policy referred to above; and
- Confirm that you are authorised, by the individual(s) to which the Airpoints number relates, to provide to AIA New Zealand the information set out in the Airpoints Details section above.

Full name of Policy Owner (1)			
Signature of Policy Owner (1)	X	Date	DD / MM / YYYY
Full name of Policy Owner (2)			
Signature of Policy Owner (2)	X	Date	DD / MM / YYYY
Full name of Policy Owner (3)			
Signature of Policy Owner (3)	X	Date	DD / MM / YYYY

3 AIA Airpoints™ terms and conditions

These Airpoints™ terms and conditions set out the terms under which a customer of ours ("**you**" or "**your**") may earn Airpoints Dollars™ through AIA Services New Zealand Limited ("**us**", "**we**" or "**our**") in accordance with the Airpoints loyalty programme that is offered by Air New Zealand Limited (**Air NZ**). You acknowledge that your ability to earn Airpoints Dollars is subject to Air NZ's Airpoints terms and conditions.

Eligibility

1. To be eligible to earn Airpoints Dollars™ (an Eligible Customer) you must:
   a. be a policy owner of one or more of the "Eligible Products and Benefits" (as defined in Section 2 below);
   b. be a member of Air NZ's Airpoints programme (which will be subject to Air NZ's Airpoints terms and conditions); and
   c. register your Airpoints membership number with us.
2. Eligible Customers will be eligible to earn Airpoints Dollars™ in respect of the following products and benefits issued on any policy or policies where AIA New Zealand Limited ("AIA") is the insurer, including any related policy(s) issued by either Sovereign Assurance Company Limited ("Sovereign") or AIA International Limited, New Zealand Branch ("AIA International"):

   (Policies issued from 5 August 2019, where AIA is the insurer)

   a. AIA Living Personal and Business: Life, Critical Conditions, Progressive Care, Total Permanent Disablement, Income Protection, Loss of Earnings, Family Protection, Accidental Death, Mortgage and Income Protection, Redundancy, Retirement Protection, Rural Continuity, Waiver of Premium, Business Continuity, Accidental Injury Cover.

   (Policies issued from 1 June 2001 to 4 August 2019, where AIA International was the insurer)

   b. REAL Life Cover, REAL Level Life Cover, REAL Accidental Death, REAL Business Continuation Cover, REAL Income Protection, REAL Farmers Revenue Protection Cover, REAL Health, REAL Easy Life Cover, REAL Easy Funeral Cover, REAL Level Trauma Cover, REAL Total Permanent Disability, REAL Level Total Permanent Disability, REAL Business Life Cover, REAL Business Trauma Cover, REAL Business Total and Permanent Disability, REAL Vital Income Protection, REAL Mortgage Income and Rent Cover, REAL New to Business Cover, REAL Trauma Cover, Business Overheads, Cancer Benefit Rider, Cancer Treatment Benefit, Family Protect Cancer Treatment Benefit, Family Protect Critical Illness Cover, Family Protect Life Cover, Family Protect Terminal Illness Cover, Income Protection Redundancy LOE Premier, Income Protection Redundancy - Agreed), Income Protection Redundancy - Indemnity, Key Person Benefit, Level Cancer Benefit Rider, Monthly Life Cover, Mortgage Redundancy Cover, Mortgage Repayment Cover, Personal Accident Benefit, Spouse or Partner Funeral Benefit, Superior Health Cover, Superior - 3 Health Cover, Trauma - Child Top Up.

   (Policies issued from 1 February 2001 to 4 August 2019, where Sovereign was the insurer)

   c. TotalCare and TotalCareMax Personal and Business (policies issued from 1 February 2001 with Guaranteed Enhancement Benefit): Life, Living Assurance Comprehensive and Essential, Progressive Care, Total Permanent Disablement, Disability Income Protection, Loss of Earnings, Essential Disability Income Protection, Family Protection, Accidental Death, Mortgage and Income Protection, Redundancy, Locum Cover, Retirement Protection, Business Overheads, Rural Continuity, Waiver of Premium, Business Continuity, Specialist and Diagnostic Testing, Accidental Injury Cover.
   d. Start-Up Income Protection
   e. Private Health
   f. Private Health Plus
   g. Absolute Health
   h. MajorCare Health
   i. Key Health
   j. Surehealth

Products underwritten by AIA and distributed by ASB Bank, IAG New Zealand or any other distribution partner, are not included.

Registering your Airpoints number

3. Eligible Customers can register an Airpoints number with us by:
   a. including it on the application form when you apply for one or more of our Eligible Products and Benefits;
   b. calling our call centre on 0800 500 108;
   c. providing it to your insurance adviser to register with us on your behalf; or
   d. via any other means we make available for this purpose.
4. The Airpoints number that is provided to us under Section 3 will be registered to the policy number applicable to either:
   a. the Eligible Product and Benefit which you are applying under Section 3(a), once we have accepted your application; or
   b. the Eligible Product and Benefit or Eligible Products and Benefits that you have informed us of via the means set out in Sections 3(b) to 3(d).
5. We will only accept one Airpoints number for each policy number relating to an Eligible Product and Benefit. If there is more than one policy owner in relation to an Eligible Product and Benefit the policy owners must nominate one Airpoints number to earn Airpoints Dollars through that Eligible Product and Benefit.
6. You can request to change the Airpoints number registered to an applicable policy number at any time.
7. It is your responsibility to provide us with accurate details of the Airpoints account and to let us know of any changes to the Airpoints account name or number.
8. We will not be liable for any loss, including any loss of benefits, resulting from the Airpoints account details being out of date, inaccurate or otherwise.

Earning Airpoints Dollars

9. All new applications by Eligible Customers for Eligible Products and Benefits that are accepted by us will qualify to earn Airpoints Dollars subject to these terms and conditions.
10. If you are an Eligible Customer and you already have one of our Eligible Products and Benefits then, subject to these terms and conditions, you will be able to accrue Airpoints Dollars for each Eligible Product and Benefit from the date that you pay your next premium for that Eligible Product and Benefit.
11. Subject to these terms and conditions, Eligible Customers will earn 1 Airpoints Dollar for every $100 of premium actually paid to us in respect of an Eligible Product and Benefit, which will accrue to the Airpoints account registered with us in accordance with Section 3.
12. We may change the earn rate for Airpoints Dollars at any time.
13. This offer is not transferable or redeemable for cash.
14. Eligible Customers may also be eligible to earn additional Airpoints Dollars through special offers or promotions that we notify you of from time to time, subject to both these terms and conditions and any additional offer or promotion terms.
15. Airpoints Dollars will not accrue for premium payments received prior to the launch date (as determined by us), or in relation to premium payments received prior to Eligible Customers registering an Airpoints number with us.
16. Air NZ will use reasonable endeavours to credit Airpoints Dollars to the relevant Airpoints account notified to us in accordance with these terms and conditions within 30 days of the premium being paid on an Eligible Product and Benefit.

Deduction of Airpoints Dollars

17. If for any reason, the payment that earned you Airpoints Dollars is refunded or dishonoured, or you cancel the Eligible Product and Benefit that you took out with us, we reserve the right to deduct those Airpoints Dollars from the Airpoints account linked to the policy number for that Eligible Product and Benefit.

Privacy

18. Personal information disclosed to AIA in relation to the Airpoints programme will be collected, used, stored and disclosed in accordance with AIA's Privacy Statement: see www.aia.co.nz/privacy
19. In addition, by registering an Airpoints number with us, you acknowledge and agree that personal information about you, together with other data relating to transactions that earn you Airpoints Dollars, may be collected, used, stored and disclosed by us, our contractors, Air NZ and/or its Airpoints partners for the following purposes:
   a. to administer the Airpoints programme, including:
      - communicating with you about the Airpoints programme;
      - undertaking data matching activities;
      - providing such information and data to Air NZ and its Airpoints partners (including for the redemption of rewards);
   b. to enable marketing activities, including the planning, research, promotion and marketing of goods, services and products, to you by us, Air NZ or its Airpoints partners;
   c. to conduct analyses relating to the Airpoints programme; and
   d. to assist in law enforcement purposes, investigations by police or other government or regulatory authorities and to meet requirements imposed by applicable laws and regulations; and
   e. or other obligations committed to government or regulatory authorities.
20. You have the right to access and request correction of information held by us about you. To contact us for this purpose, please refer to our Privacy Statement.

Cancellation

21. We may stop awarding Airpoints Dollars to you at any time at our absolute discretion, including if:
   a. we cease to be a partner in Air NZ's Airpoints programme; or
   b. you are no longer eligible to earn Airpoints Dollars through us.

Liability

22. We are not responsible, and accept no liability, for any act or omission of Air NZ or its Airpoints partners in respect of the Airpoints programme.

Changes

23. We may change these terms and conditions at any time without prior notice by publishing an amendment to these terms and conditions on our website, with such amendment to be effective from the date of publication.

NOTES

AIA Vitality

AIA Vitality is our personalised, science-backed health and wellbeing programme that supports you every day to make healthier lifestyle choices. It helps you understand your current state of health, provides tools to improve it and offers great incentives to keep you motivated on your journey. The life assured under any eligible AIA policy can take out an AIA Vitality membership.

aiavitality.co.nz

AIA airpoints™

As an AIA customer, you can earn Airpoints Dollars™ for premiums paid on your eligible insurance policy.

aia.co.nz/airpoints

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

aia.co.nz

enquireNZ@aia.com

aia.co.nz/live-chat
Monday - Friday, 8am - 6pm

AIA House
74 Taharoto Road,
Takapuna,
Auckland 0622

Private Bag 92499,
Victoria Street West,
Auckland 1142

Disclaimer

Other things you should know: the availability of insurance cover is subject to your application being approved. All applications are subject to individual consideration. Special conditions, exclusions and premium loadings may apply. This insurance is underwritten by AIA New Zealand Limited ('AIA'). For full details of the products and benefits offered by AIA, please refer to the policy document(s) which are available from AIA. The information contained in this publication is general in nature and is not intended as advice. It may not be relevant to individual circumstances and before making any insurance decision, you should consult a professional Adviser. Copies of our disclosure statements are available on request, free of charge.

HEALTHIER, LONGER, BETTER LIVES