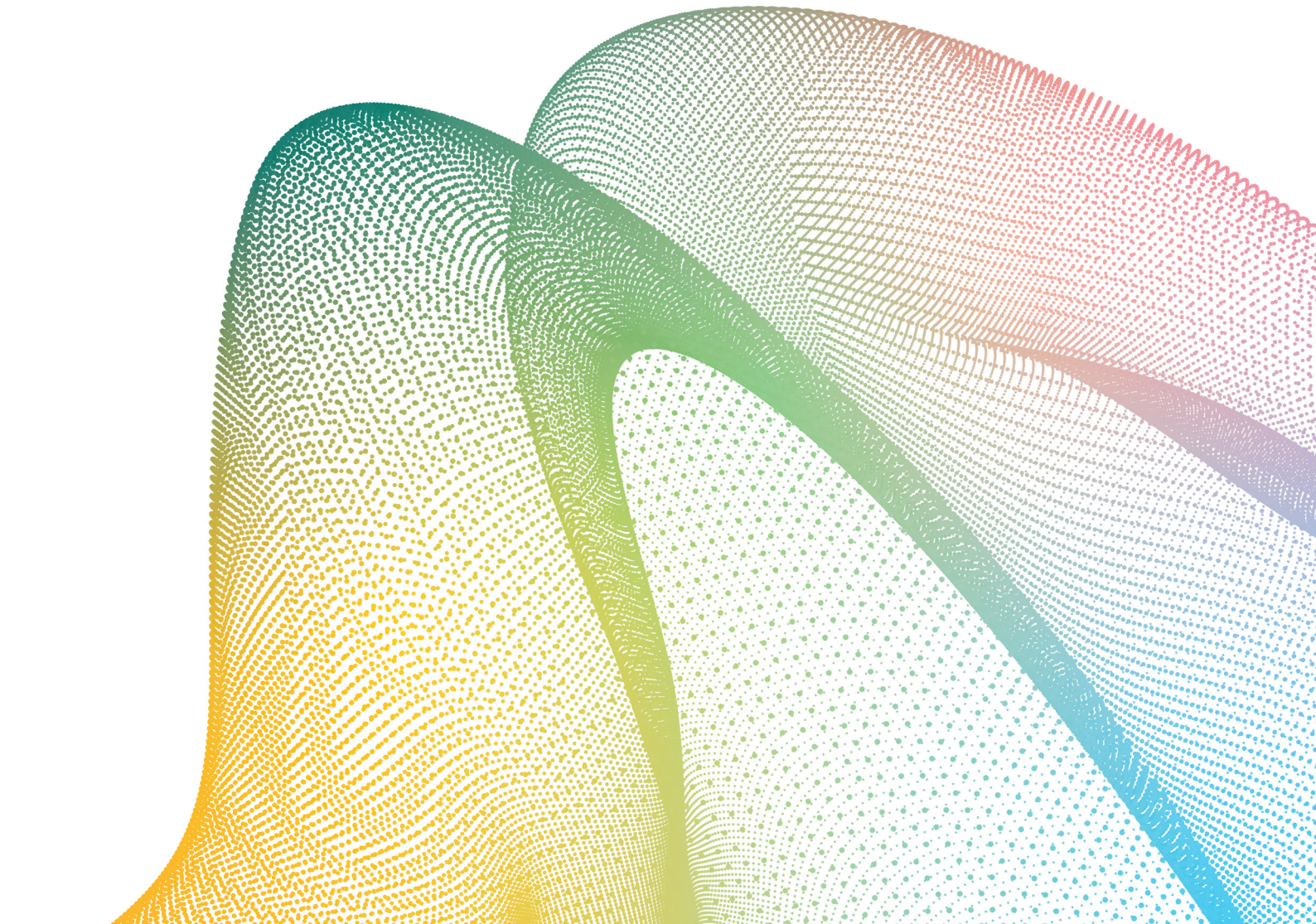
partners life

Protection Plan

Application



Apply

for Quote number

(Mandatory Field)
initial application

partners life

Partners Protection Plan

Version 23

Type of application

New application ☐

Replacement business* ☐

* Please complete the Advice on Replacement Business form attached.

Increase/addition Policy number

Special terms review Policy number

1.0 Lives to be assured

Life assured 1 (LA1)

Mr ☐ First Name

Mrs ☐ Middle Name(s)

Miss ☐ Surname

Ms ☐ Previous Name

Dr ☐ Male ☐ Female ☐ Date of Birth D D M M Y Y

Place of Birth NZ ☐ Other

Home Address

Number

Street Name

Rural Delivery No. Suburb

Town/City Postcode

Email Address

Business Phone

Home Phone

Mobile Phone

Postal Address (if different)

PO Box ☐ Private Bag ☐ Street Number ☐

Number

Street Name

Rural Delivery No. Suburb

Town/City Postcode

Email Address

Life assured 2 (LA2)

Mr ☐ First Name

Mrs ☐ Middle Name(s)

Miss ☐ Surname

Ms ☐ Previous Name

Dr ☐ Male ☐ Female ☐ Date of Birth D D M M Y Y

Place of Birth NZ ☐ Other

Home Address

Number

Street Name

Rural Delivery No. Suburb

Town/City Postcode

Email Address

Business Phone

Home Phone

Mobile Phone

Postal Address (if different)

PO Box ☐ Private Bag ☐ Street Number ☐

Number

Street Name

Rural Delivery No. Suburb

Town/City Postcode

Email Address

2.0 Policy owners

Life assured 1 only ☐ Life assured 2 only ☐ Lives assured 1 & 2 as joint tenants ☐ All lives assured as joint tenants ☐

Other *(details to be completed in Question 13.0 Ownership)* ☐

3.0 Policy details

a) Payment details

Payment method Direct debit ☐ Annual cheque ☐ Credit/debit card ☐ Use existing payment method ☐

Preferred payment date No preference ☐ Preferred day of week ☐ M ☐ T ☐ W ☐ Th ☐ F

Or preferred payment day of month *(eg between 1st and 28th)* ☐☐

b) Premium and benefit details

Please ensure the **'Quote number'** is clearly indicated at the top of page 1.

4.0 Personal statement

a) Partners Life may need to contact you to clarify details regarding your application. To enable us to do so please provide your preferred daytime contact number and your preferred day and time for us to contact you (between the hours of 8.30a.m. and 5.00p.m. Mon – Fri).

Contact details Life assured 1

Business ☐ Home ☐ Mobile ☐ Text ☐ Email ☐

Other ☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐

Preferred day of week M ☐ T ☐ W ☐ Th ☐ F ☐

Preferred time of day

8.30-10.00 ☐ 10.00-12.30 ☐ 12.30-2.00 ☐ 2.00-3.30 ☐ 3.30-5.00 ☐

Contact details Life assured 2

Business ☐ Home ☐ Mobile ☐ Text ☐ Email ☐

Other ☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐

Preferred day of week M ☐ T ☐ W ☐ Th ☐ F ☐

Preferred time of day

8.30-10.00 ☐ 10.00-12.30 ☐ 12.30-2.00 ☐ 2.00-3.30 ☐ 3.30-5.00 ☐

b) Please provide the name, address and telephone numbers of the health practice(s) that hold your medical records

Contact details Life assured 1

Doctor's name	Clinic name	Clinic address	Clinic phone number	Clinic fax number

Contact details Life assured 2

Doctor's name	Clinic name	Clinic address	Clinic phone number	Clinic fax number

c) Please answer the following questions:

Life assured 1

i. Have you smoked tobacco or any other substance within the last 12 months? If **yes** what type and what is the average quantity you smoke?

No ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Marijuana ☐ Other ☐

If other please provide details

Number ☐☐☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

ii. Do you drink alcohol? If **yes** what type and what is the average quantity you consumed over the last 12 months?

No ☐ Beer ☐ Wine ☐ Spirits ☐ Other ☐

If other please provide details

Number of average glasses ☐☐☐ Daily ☐ Weekly ☐ Monthly ☐

iii. What is your height?

Feet ☐ Inches ☐☐ Centimetres ☐☐☐

iv. What is your weight and when were you last weighed?

Kilograms ☐☐☐ Stone ☐☐ Pounds ☐☐☐ MM/YY ☐☐☐☐

Life assured 2

i. Have you smoked tobacco or any other substance within the last 12 months? If **yes** what type and what is the average quantity you smoke?

No ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Marijuana ☐ Other ☐

If other please provide details

Number ☐☐☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

ii. Do you drink alcohol? If **yes** what type and what is the average quantity you consumed over the last 12 months?

No ☐ Beer ☐ Wine ☐ Spirits ☐ Other ☐

If other please provide details

Number of average glasses ☐☐☐ Daily ☐ Weekly ☐ Monthly ☐

iii. What is your height?

Feet ☐ Inches ☐☐ Centimetres ☐☐☐

iv. What is your weight and when were you last weighed?

Kilograms ☐☐☐ Stone ☐☐ Pounds ☐☐☐ MM/YY ☐☐☐☐

v. Have you ever used any restricted drug which was not prescribed to you by a doctor or purchased from a pharmacist or have you ever received medical advice, counselling or treatment for the use of alcohol, drugs or participation in gambling? If **yes** please give full details.

Yes ☐ Details

No ☐

Yes ☐ Details

No ☐

d) Please indicate below by ticking the box if you are currently suffering from, experiencing symptoms of or being treated for, or if you have ever suffered from, had symptoms of or had treatment for any of the following. (If you tick a box, please also complete the indicated questionnaire(s) in **section 6.0).**

		LA1		LA2
1.	High blood pressure. **Questionnaire 1**	☐	1.	☐
2.	Abnormal or high cholesterol. **Questionnaire 2**	☐	2.	☐
3.	Respiratory or breathing disorder (e.g. asthma, lung disorder, bronchitis, emphysema, TB etc.). **Questionnaire 3**	☐	3.	☐
4.	Liver disease or disorder (e.g. hepatitis, fatty liver or abnormal liver function tests etc.). **Questionnaire 11**	☐	4.	☐
5.	Kidney disease or disorder (e.g. kidney stones, infections or abnormal renal function tests etc.). **Questionnaire 11**	☐	5.	☐
6.	Urinary tract or bladder disorder. **Questionnaire 11**	☐	6.	☐
7.	Prostate disorders including abnormal PSA tests, or gynaecological disorders. **Questionnaire 11**	☐	7.	☐
8.	Breast disorders including lumps, cysts, discharge or abnormal mammograms or ultrasound scans. **Questionnaire 11**	☐	8.	☐
9.	Gastrointestinal tract, stomach or bowel disorder (e.g. polyps, GORD, colitis, Crohn's disease, etc). **Questionnaire 4**	☐	9.	☐
10.	Skin disorders (e.g. dermatitis, psoriasis, eczema, cysts, suspicious moles, lesions etc.). **Questionnaire 8**	☐	10.	☐
11.	Cancer or tumour or abnormal PAP/cervical smears. **Questionnaire 9**	☐	11.	☐
12.	Diabetes, abnormal blood sugar test or impaired glucose tolerance. **Questionnaire 11**	☐	12.	☐
13.	Thyroid disorder, gout or any other glandular condition. **Questionnaire 10**	☐	13.	☐
14.	Disorders of the ears, eyes (excluding long or short sightedness), nose or throat. **Questionnaire 11**	☐	14.	☐
15.	Epilepsy or seizures. **Questionnaire 6**	☐	15.	☐
16.	Blood disorders. **Questionnaire 11**	☐	16.	☐
17.	Varicose veins or haemorrhoids. **Questionnaire 11**	☐	17.	☐
18.	Mental or nervous disorders (e.g. depression, anxiety, stress, phobias). **Questionnaire 7**	☐	18.	☐
19.	Chronic fatigue, fibromyalgia or chronic pain syndrome. **Questionnaire 7**	☐	19.	☐
20.	HIV, AIDS or antibodies to HIV, or potential exposure to HIV. **Questionnaire 11**	☐	20.	☐
21.	Sleep disorders (e.g. chronic insomnia or obstructive sleep apnoea etc.). **Questionnaire 7**	☐	21.	☐
22.	Recurrent(1) or recent(2) dizziness or vertigo. **Questionnaire 11**	☐	22.	☐
23.	Heart disorder (e.g. heart attack, heart failure, heart valve disorders, cardiomyopathy, angina, endocarditis, chest pain etc.). **Questionnaire 11**	☐	23.	☐
24.	Muscle, joint, spine, tendon or bone disorder or injury. **Questionnaire 5**	☐	24.	☐
25.	Arthritis or rheumatism. **Questionnaire 5**	☐	25.	☐
26.	Any neurological disorder (e.g. stroke, MS, paralysis, migraines or motor neurone disease). **Questionnaire 11**	☐	26.	☐
27.	Any other conditions not listed above for which you have received treatment or therapy from any health provider (including alternative practitioners), in the past 5 years including for weight reduction (excluding minor ailments such as colds, flu and contraception). **Questionnaire 11**	☐	27.	☐
28.	Any other conditions not listed above for which you currently take medications, drugs, sedatives or over the counter preparations (excluding medications for minor ailments such as colds, flu and contraception). **Questionnaire 11**	☐	28.	☐
29.	Any other conditions not listed above for which you have undergone or have been advised to undergo tests or investigations, including genetic testing, in the past five years. **Questionnaire 12**	☐	29.	☐
30.	Any other recent* or recurrent** symptoms or signs which you are currently experiencing or have experienced whether or not you have consulted a health professional regarding them. **Questionnaire 12**	☐	30.	☐

Please check that all relevant boxes have been ticked. Partners Life will only assess the answer to each question where the box has been ticked.

(1) Recurrent means more than once in any 12 month period.
(2) Recent means within the last 6 months.

*Recent means within the last 12 months.
** Recurrent means more than once in any 12 month period over the past 5 years.

Life assured 1

e) Are you currently pregnant? If **yes** please complete **Questionnaire 13**

Yes ☐ No ☐

Life assured 2

Yes ☐ No ☐

f) Provide details of any claims you have made or are in the process of making against any life, trauma, disability or medical insurance benefits.

Claims

Claims

g) Provide details of any applications you have made for any life, trauma, disability or medical insurance benefits which were declined, deferred or offered with special acceptance terms.

Applications

Applications

Life assured 1

Life assured 2

h) Provide details of life, trauma, disability or medical insurance benefits which you currently have or are currently applying for, excluding this application.

Company, type of cover, sum assured

Company, type of cover, sum assured

i) Provide details of any plans you have to travel, live or work overseas (excluding vacations of less than one month).

Plans

Plans

j) Please list your New Zealand residency status (e.g. citizen, permanent resident, work visa etc.).

Citizen ☐ Permanent resident ☐

Work permit(s) totalling 2 years or more with 11 months or more until expiry ☐

Other ☐ *Please provide details*

If you are a non-resident please see the * below for contract conditions.

Citizen ☐ Permanent resident ☐

Work permit(s) totalling 2 years or more with 11 months or more until expiry ☐

Other ☐ *Please provide details*

If you are a non-resident please see the * below for contract conditions.

k) Please provide details of any convictions you have ever had for offences involving fraud or dishonesty and/or details of any driving related convictions (not simply fines) you may have had over the past 2 years.

Convictions

Convictions

l) Please provide details of any circumstances you are aware of that could result in you receiving a custodial prison sentence.

Circumstances

Circumstances

m) Please indicate below by ticking the box if you participate in or intend to participate in any of the following pastimes or hazardous sports. (If you tick a box, please also complete the questionnaire in **section 7**).

	LA1	LA2
1. Abseiling	☐	☐
2. Aviation	☐	☐
3. Competitive boxing	☐	☐
4. Equestrian – competitive show jumping, cross country or racing	☐	☐
5. Hang gliding	☐	☐
6. Scuba diving – over 30m or solo	☐	☐
7. Motor racing	☐	☐
8. Parachuting	☐	☐
9. Skydiving	☐	☐
10. Powerboat racing	☐	☐
11. Mountaineering	☐	☐
12. Hunting – using aircraft	☐	☐
13. Competitive martial arts	☐	☐
14. Voluntary fire-fighting	☐	☐
15. Any other hazardous pursuit or sport	☐	☐

Please check that all relevant boxes have been ticked. Partners Life will only assess the answer to each question where the box has been ticked.

* If you are a non-resident and on a work visa you accept that the following exclusion will apply to Total and Permanent Disability and Trauma Cover.

- No benefit will be payable where the event, condition, illness, accident or injury causing or contributing to the insured event occurs at a time when the life assured is outside the territorial boundaries of New Zealand and has been so for a continuous period of more than ninety days. This exclusion automatically ceases to apply from the date that the life assured gains permanent residency or citizenship status in New Zealand.

If you are applying for Income Cover, Premium Cover or Mortgage Repayment Cover, your application will be assessed on an individual basis.

n) Please provide details of any first degree relative (e.g. mother [m], father [f] brothers [b] or sisters [s]) who have ever suffered from any of the following conditions:

LA	Cancer*	Stroke	Heart disease**	Diabetes Type I	Diabetes Type II	Cystic Fibrosis	Familial Polyposis	Multiple Sclerosis
1 ☐ 2 ☐	☐	☐	☐	☐	☐	☐	☐	☐

Mental health condition (including depression)	Huntington's Chorea	Muscular Dystrophy	Kidney Disease***	Inherited neurological disease***	Inherited blood disorder***	Any other inherited Familial disease or disorder***
☐	☐	☐	☐	☐	☐	☐

Relative M F B S	Age at diagnosis	Current age	Age at death	*For Cancer, put type & site **For heart disease, put type & lifestyle factors ***For these conditions describe disease or disorder	
☐ ☐ ☐ ☐				Type & disease or disorder	Sites, lifestyle factors, or description

LA	Cancer*	Stroke	Heart disease**	Diabetes Type I	Diabetes Type II	Cystic Fibrosis	Familial Polyposis	Multiple Sclerosis
1 ☐ 2 ☐	☐	☐	☐	☐	☐	☐	☐	☐

Mental health condition (including depression)	Huntington's Chorea	Muscular Dystrophy	Kidney Disease***	Inherited neurological disease***	Inherited blood disorder***	Any other inherited Familial disease or disorder***
☐	☐	☐	☐	☐	☐	☐

Relative M F B S	Age at diagnosis	Current age	Age at death	*For Cancer, put type & site **For heart disease, put type & lifestyle factors ***For these conditions describe disease or disorder	
☐ ☐ ☐ ☐				Type & disease or disorder	Sites, lifestyle factors, or description

LA	Cancer*	Stroke	Heart disease**	Diabetes Type I	Diabetes Type II	Cystic Fibrosis	Familial Polyposis	Multiple Sclerosis
1 ☐ 2 ☐	☐	☐	☐	☐	☐	☐	☐	☐

Mental health condition (including depression)	Huntington's Chorea	Muscular Dystrophy	Kidney Disease***	Inherited neurological disease***	Inherited blood disorder***	Any other inherited Familial disease or disorder***
☐	☐	☐	☐	☐	☐	☐

Relative M F B S	Age at diagnosis	Current age	Age at death	*For Cancer, put type & site **For heart disease, put type & lifestyle factors ***For these conditions describe disease or disorder	
☐ ☐ ☐ ☐				Type & disease or disorder	Sites, lifestyle factors, or description

LA	Cancer*	Stroke	Heart disease**	Diabetes Type I	Diabetes Type II	Cystic Fibrosis	Familial Polyposis	Multiple Sclerosis
1 ☐ 2 ☐	☐	☐	☐	☐	☐	☐	☐	☐

Mental health condition (including depression)	Huntington's Chorea	Muscular Dystrophy	Kidney Disease***	Inherited neurological disease***	Inherited blood disorder***	Any other inherited Familial disease or disorder***
☐	☐	☐	☐	☐	☐	☐

Relative M F B S	Age at diagnosis	Current age	Age at death	*For Cancer, put type & site **For heart disease, put type & lifestyle factors ***For these conditions describe disease or disorder	
☐ ☐ ☐ ☐				Type & disease or disorder	Sites, lifestyle factors, or description

LA	Cancer*	Stroke	Heart disease**	Diabetes Type I	Diabetes Type II	Cystic Fibrosis	Familial Polyposis	Multiple Sclerosis
1 ☐ 2 ☐	☐	☐	☐	☐	☐	☐	☐	☐

Mental health condition (including depression)	Huntington's Chorea	Muscular Dystrophy	Kidney Disease***	Inherited neurological disease***	Inherited blood disorder***	Any other inherited Familial disease or disorder***
☐	☐	☐	☐	☐	☐	☐

Relative M F B S	Age at diagnosis	Current age	Age at death	*For Cancer, put type & site **For heart disease, put type & lifestyle factors ***For these conditions describe disease or disorder	
☐ ☐ ☐ ☐				Type & disease or disorder	Sites, lifestyle factors, or description

LA	Cancer*	Stroke	Heart disease**	Diabetes Type I	Diabetes Type II	Cystic Fibrosis	Familial Polyposis	Multiple Sclerosis
1 ☐ 2 ☐	☐	☐	☐	☐	☐	☐	☐	☐

Mental health condition (including depression)	Huntington's Chorea	Muscular Dystrophy	Kidney Disease***	Inherited neurological disease***	Inherited blood disorder***	Any other inherited Familial disease or disorder***
☐	☐	☐	☐	☐	☐	☐

Relative M F B S	Age at diagnosis	Current age	Age at death	*For Cancer, put type & site **For heart disease, put type & lifestyle factors ***For these conditions describe disease or disorder	
☐ ☐ ☐ ☐				Type & disease or disorder	Sites, lifestyle factors, or description

5.0 Additional medical questions (only required if applying for Private Medical Cover and/or Hospital Cash Cover)

a) Please indicate below by ticking the box if you are currently being treated for, have ever had treatment for, are currently considering to (or have been advised to) seek treatment for any of the following: (If you tick a box, please also complete the indicated questionnaire(s) in **section 6.0**).

		LA1	LA2
1.	Recurrent* ear, nose, throat, adenoid or tonsil infections. **Questionnaire 11**	☐	☐
2.	Recent** ear, nose, throat, adenoid or tonsil infections (within the past 12 months). **Questionnaire 11**	☐	☐
3.	Grommet insertion (or been advised that this may be required). **Questionnaire 11**	☐	☐
4.	Oral surgery, impacted or unerupted teeth, gum infections or cysts within the past 12 months. **Questionnaire 11**	☐	☐
5.	Irregular, heavy or painful menstrual bleeding or hormonal problems. **Questionnaire 11**	☐	☐
6.	Blood in the urine, slow urinary stream, difficulties passing urine or sexual dysfunction. **Questionnaire 11**	☐	☐

Please check that all relevant boxes have been ticked. Partners Life will only assess the answer to each question where the box has been ticked.

* Recurrent means more than once in any 12 month period. ** Recent means within the past 12 months.

6.0 Medical questionnaires

Questionnaire 1 – blood pressure

Life assured 1

a) When was your first high blood pressure reading?

M M Y Y

Life assured 2

M M Y Y

b) What treatment or medication have you most recently been prescribed for blood pressure?

c) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

d) How often is your blood pressure checked and by whom?

e) When was your blood pressure last checked?

M M Y Y

M M Y Y

f) What are your three most recent blood pressure readings? If you don't know the actual reading please confirm whether your doctor told you they were in normal limits.

/ / Normal ☐
/ / or Abnormal ☐
/ / Unsure ☐

/ / Normal ☐
/ / or Abnormal ☐
/ / Unsure ☐

g) If you have ever been admitted to hospital or consulted a specialist regarding your blood pressure please give dates, names and outcomes.

M M Y Y

Specialist or Hospital name

Outcome

M M Y Y

Specialist or Hospital name

Outcome

h) If you have ever suffered complications as a result of your blood pressure please give details.

i) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 2 – cholesterol

Life assured 1

Life assured 2

a) When was your first abnormal cholesterol test?

M M Y Y

M M Y Y

b) What treatment or medication have you most recently been prescribed for abnormal cholesterol?

c) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

d) How often is your cholesterol checked?

e) When was your cholesterol last tested?

M M Y Y

M M Y Y

f) What were your most recent cholesterol test results? If you don't know the actual results please confirm whether your doctor told you they were within normal limits or not.

Total
HDL
LDL
Trigs

or

Normal ☐
Abnormal ☐
Unsure ☐

Total
HDL
LDL
Trigs

or

Normal ☐
Abnormal ☐
Unsure ☐

g) If you have ever been admitted to hospital or consulted a specialist regarding your cholesterol please give dates, names and outcomes.

M M Y Y
Specialist or Hospital name
Outcome

M M Y Y
Specialist or Hospital name
Outcome

h) If you have ever suffered complications as a result of your cholesterol please give details.

i) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 3 – respiratory or breathing

Life assured 1

Life assured 2

a) What is the disorder? (e.g. asthma etc.)

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) How frequently do you experience symptoms?

d) What treatment or medication have you most recently been prescribed for this disorder?

e) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

f) If applicable, how many inhalers do you use in a year?

g) If you have been prescribed steroids in the past two years please give date, type and reason.

M M Y Y

Type

Reason

M M Y Y

Type

Reason

h) If you have been nebulised in the past two years please give date and reason.

M M Y Y

Reason

M M Y Y

Reason

i) If you have had an attack requiring medical attention in the past two years please give date, name of medical facility, reason and outcome.

M M Y Y

Facility

Reason

Outcome

M M Y Y

Facility

Reason

Outcome

j) If your condition limits your activities such as your daily work, sport or home life in any way please give details.

k) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Life assured 1

Life assured 2

a) What is the disorder? (e.g. polyps, GORD, colitis, ulcers, Crohn's disease etc.)

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) Give details of your specialist where applicable.

d) What treatment or medication have you most recently been prescribed for this disorder?

e) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

f) What tests or investigations have you undergone for this condition and what were the results?

g) How frequently do you experience symptoms and what are those symptoms?

h) When did you last experience those symptoms?

M M Y Y

M M Y Y

i) If you have been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

j) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 5 – muscles, joints, tendons and bones

CONDITION 1

Life assured 1 Condition 1 | **Life assured 2** Condition 1

a) What is the condition? (e.g. arthritis, fracture, dislocation, soft tissue injury, bone injury, bone disorder etc)

b) Which part of the body and which side of the body is affected? (e.g. right arm, left knee etc)

c) When were you first diagnosed with this condition or when did the injury occur?

M M Y Y

M M Y Y

d) What tests or investigations have you undergone for this condition and what were the results?

e) Give details of your specialist where applicable.

f) What treatment or medication have you most recently been prescribed for this condition?

g) Do you currently have metalware in place? If **yes,** is this in place permanently?

Yes ☐ No ☐ Yes and permanent ☐

Yes ☐ No ☐ Yes and permanent ☐

h) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

i) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

j) Provide details of any time off work required as a result of this condition.

k) How frequently do you experience symptoms and what are those symptoms?

l) When did you last experience those symptoms?

M M Y Y

M M Y Y

m) Describe any long-term or permanent disability you suffer from as a result of this condition.

n) If you have been hospitalised for this condition please give date, reason and outcome.

M M Y Y

Reason

Outcome

M M Y Y

Reason

Outcome

o) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 5B – muscles, joints, tendons and bones

CONDITION 2

Life assured 1 Condition 2 | **Life assured 2** Condition 2

a) What is the condition? (e.g. arthritis, fracture, dislocation, soft tissue injury, bone injury, bone disorder etc)

b) Which part of the body and which side of the body is affected? (e.g. right arm, left knee etc)

c) When were you first diagnosed with this condition or when did the injury occur?

M M Y Y

M M Y Y

d) What tests or investigations have you undergone for this condition and what were the results?

e) Give details of your specialist where applicable.

f) What treatment or medication have you most recently been prescribed for this condition?

g) Do you currently have metalware in place? If **yes,** is this in place permanently?

Yes ☐ No ☐ Yes and permanent ☐

Yes No Yes and permanent

h) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

i) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

j) Provide details of any time off work required as a result of this condition.

k) How frequently do you experience symptoms and what are those symptoms?

l) When did you last experience those symptoms?

M M Y Y

M M Y Y

m) Describe any long-term or permanent disability you suffer from as a result of this condition.

n) If you have been hospitalised for this condition please give date, reason and outcome.

M M Y Y

Reason

Outcome

M M Y Y

Reason

Outcome

o) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 6 – epilepsy and seizures

Life assured 1

Life assured 2

a) What is the type of epilepsy or seizures?

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) Give details of your specialist where applicable.

d) What treatment or medication have you most recently been prescribed?

e) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

f) Provide details of any impact this condition has had on your work.

g) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

h) What tests or investigations have you undergone for this condition and what were the results?

i) How frequently do you experience seizures?

j) When did you last experience a seizure?

M M Y Y

M M Y Y

k) If you have been hospitalised for this condition please give date, name of hospital, reason and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

l) Describe any long-term or permanent disability you suffer from as a result of this condition.

m) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 7 – mental health, sleep and chronic conditions

Life assured 1

Life assured 2

a) What is the condition?

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) Give details of your specialist where applicable. (i.e. psychiatrist)

d) What treatment or medication have you most recently been prescribed?

e) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

f) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

g) Please provide details of any tests or investigations you have undergone for this condition including dates, the name of the medical facility and the outcome.

M M Y Y

Test or investigation

Facility

Outcome

M M Y Y

Test or investigation

Facility

Outcome

M M Y Y

M M Y Y

h) Provide details of any impact this condition has had on your work.

i) How frequently do you experience symptoms?

j) When did you last experience symptoms?

M M Y Y

M M Y Y

k) If you have been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

l) Describe any long-term or permanent disability you suffer from as a result of this condition.

m) Have you ever had suicidal thoughts or made a suicide attempt?

Yes ☐ No ☐

Yes No

Questionnaire 8 – skin

Life assured 1

Life assured 2

a) What is the condition?

b) What body parts are affected?

c) What tests or investigations have you undergone for this condition and what were the results including histology, if known?

d) If the histology is not known was the lesion definitely benign?

Yes ☐ No ☐

Yes ☐ No ☐

e) Give details of your specialist where applicable.

f) What treatment or medication have you most recently been prescribed?

g) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

h) When did you last experience symptoms?

M M Y Y

M M Y Y

i) If you have been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

j) How often do you require follow-up checks?

Questionnaire 9 – cancer or tumour

Life assured 1

Life assured 2

a) What is the condition?

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) Give details of your specialist where applicable.

d) What tests or investigations have you undergone for this condition and what were the results including histology/staging, if known?

Test

Result

Test

Result

e) Has the tumour(s) been surgically removed?

Yes No

Yes No

f) If the histology is not known was the tumour definitely benign?

Yes No

Yes No

g) What treatment or medication have you most recently been prescribed?

h) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

i) Provide details of any time off work required as a result of this condition.

j) If you have been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

k) If you have been advised by your specialist that you are in remission please provide date.

M M Y Y

M M Y Y

l) Describe any long-term or permanent disability you suffer from as a result of this condition.

m) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 10 – thyroid, gout, glandular condition

Life assured 1

Life assured 2

a) What was the diagnosis you were given?

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) What treatment or medication have you most recently been prescribed?

d) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

e) How often do you have blood tests or other investigations/monitoring for the condition identified above?

f) When were your last tests, investigations or monitoring completed?

M M Y Y

M M Y Y

g) What were your most recent tests, investigations or monitoring results? Please confirm whether your doctor informed you if they were within normal limits or not.

h) If you have consulted a specialist or been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Specialist/Hospital

Outcome

M M Y Y

Reason

Specialist/Hospital

Outcome

i) If you have ever suffered from any complications as a result of this condition please give details.

j) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 11 – other conditions

CONDITION 1

Life assured 1 Condition 1

Life assured 2 Condition 1

a) What is the condition?

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) Give details of your specialist where applicable.

d) What tests or investigations have you undergone for this condition and what were the results if known?

e) What treatment or medication have you most recently been prescribed?

f) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

g) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

h) Provide details of any time off work required as a result of this condition.

i) If you have been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

j) How frequently do you experience symptoms and what are those symptoms?

k) When did you last experience those symptoms?

M M Y Y

M M Y Y

l) Describe any long-term or permanent disability you suffer from as a result of this condition.

m) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 11B – other conditions

CONDITION 2

Life assured 1 Condition 2

Life assured 2 Condition 2

a) What is the condition?

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) Give details of your specialist where applicable.

d) What tests or investigations have you undergone for this condition and what were the results if known?

e) What treatment or medication have you most recently been prescribed?

f) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

g) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

h) Provide details of any time off work required as a result of this condition.

i) If you have been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

j) How frequently do you experience symptoms and what are those symptoms?

k) When did you last experience those symptoms?

M M Y Y

M M Y Y

l) Describe any long-term or permanent disability you suffer from as a result of this condition.

m) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 11C – other conditions

CONDITION 3

Life assured 1 Condition 3

Life assured 2 Condition 3

a) What is the condition?

b) When were you first diagnosed with this condition?

M M Y Y

M M Y Y

c) Give details of your specialist where applicable.

d) What tests or investigations have you undergone for this condition and what were the results if known?

e) What treatment or medication have you most recently been prescribed?

f) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

g) If you do not always follow the prescribed treatment or take the medication as prescribed please explain.

h) Provide details of any time off work required as a result of this condition.

i) If you have been hospitalised for this condition please give date, reason, name of hospital and outcome.

M M Y Y

Reason

Hospital

Outcome

M M Y Y

Reason

Hospital

Outcome

j) How frequently do you experience symptoms and what are those symptoms?

k) When did you last experience those symptoms?

M M Y Y

M M Y Y

l) Describe any long-term or permanent disability you suffer from as a result of this condition.

m) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 12 – tests, investigations, symptoms and signs

Life assured 1

Life assured 2

a) What are or were the signs or symptoms you have experienced and/or the reasons for the tests or investigations?

b) When did you first experience those signs or symptoms?

M M Y Y

M M Y Y

c) How frequently do you experience them?

d) When did you last experience them?

M M Y Y

M M Y Y

e) What are the tests or investigations you have undergone and what were the dates, names of the facilities and the results?

M M Y Y

Test or investigation

Facility(ies)

Result

M M Y Y

M M Y Y

Test or investigation

Facility(ies)

Result

M M Y Y

f) What treatment or medication have you been prescribed or recommended for these signs/symptoms?

g) If you no longer require treatment or medication for this condition when did you stop?

M M Y Y

M M Y Y

h) If you are considering or have been advised to undergo any further tests or investigations for this condition please give details.

Questionnaire 13 – pregnancy

Life assured 1

Life assured 2

a) Please provide details of any complications you have experienced or are currently experiencing with this pregnancy.

b) Please provide details of any complications you experienced with any previous pregnancies.

(The next two questions are only required if applying for Income, Premium, Mortgage Repayment, Household Expenses or TPD Covers).

c) Please provide the date you are expecting to leave work.

D D M M Y Y

D D M M Y Y

d) Do you have an expected return to work date? If yes please provide the date.

No

D D M M Y Y

No

D D M M Y Y

e) If you have given an expected return to work date please advise the average number of hours you expect to work each week.

7.0 Pastimes and sports questionnaire

PASTIME 1

Life assured 1 Pastime 1

Life assured 2 Pastime 1

a) What is the pursuit?

b) How long have you been involved in this pursuit?

c) How many times a year and how many hours a month, on average, do you participate in this pursuit?

Times a year | Hours a month

Times a year | Hours a month

d) Provide details of any qualifications, certificates or memberships you hold?

e) Do you participate alone or with a buddy or group?

f) What formal training have you had?

g) If you compete in this pursuit please give details.

h) If you get paid to participate in this pursuit please give details.

i) Give details of maximum depths, speeds or heights involved.

j) What locations and/or facilities are involved in this pursuit?

k) What safety precautions do you take?

l) Please provide details of any motor vehicle, boat or aircraft you use including engine size, type of fuel and modifications from standard.

PASTIME 2

Life assured 1 Pastime 2

Life assured 2 Pastime 2

a) What is the pursuit?

b) How long have you been involved in this pursuit?

c) How many times a year and how many hours a month, on average, do you participate in this pursuit?

Times a year | Hours a month

Times a year | Hours a month

d) Provide details of any qualifications, certificates or memberships you hold?

e) Do you participate alone or with a buddy or group?

f) What formal training have you had?

g) If you compete in this pursuit please give details.

h) If you get paid to participate in this pursuit please give details.

i) Give details of maximum depths, speeds or heights involved.

j) What locations and/or facilities are involved in this pursuit?

k) What safety precautions do you take?

l) Please provide details of any motor vehicle, boat or aircraft you use including engine size, type of fuel and modifications from standard.

Notes

8.0 Occupation details

Life assured 1

(Question a. is required for all applicants)

Life assured 2

a) Please indicate your work status.

Retired ☐ Student ☐ Unemployed ☐ In work ☐ Homemaker ☐

Retired ☐ Student ☐ Unemployed ☐ In work ☐ Homemaker ☐

(Questions from b. onwards are only required for all applicants who are in work)

b) What is your primary occupation?

c) What industry is that in?

d) What is your secondary occupation?

e) What industry is that in?

f) If any of your occupations involve any hazardous tasks or expose you to any hazardous environments please provide details.

(Questions from g. onwards are required for all covers except Life Cover, Terminal Illness Cover, Private Medical Cover and Hospital Cash Cover)

g) If your primary occupation involves manual labour please provide the percentage of overall tasks that are manual and details of the nature of those manual tasks.

Task ☐ %
Task ☐ %
Task ☐ %

Task ☐ %
Task ☐ %
Task ☐ %

h) How many days on average do you work each week in your occupations?

Primary ☐ Secondary ☐

Primary ☐ Secondary ☐

i) How many hours on average do you work each week in your occupations?

Primary ☐☐☐ Secondary ☐☐☐

Primary ☐☐☐ Secondary ☐☐☐

j) How many weeks on average do you work each year in your occupations?

Primary ☐☐ Secondary ☐☐

Primary ☐☐ Secondary ☐☐

k) What percentages of your occupations are done from home (please enter a value between 0 and 100)?

Primary ☐☐☐ % Secondary ☐☐☐ %

Primary ☐☐☐ % Secondary ☐☐☐ %

l) Please provide details of your current occupational duties for your primary occupation and the percentage of time spent on each.

Duty ☐ %
Duty ☐ %
Duty ☐ %

Duty ☐ %
Duty ☐ %
Duty ☐ %

m) Please provide details of any formal qualifications you hold for your primary occupation.

Life assured 1

Life assured 2

n) If you are currently working under a casual contract or a contract with a fixed end date please provide details, including end date where applicable.

o) If you are aware of any pending liquidation of your current employer or if you have been made aware of any potential for your current role to be made redundant please provide details including date where applicable.

p) If you have ever been involved in disciplinary action or any other employment dispute with your current employer please provide details.

q) Please provide the name and address of your current employer or, if self-employed, your company name.

r) If you have been in your current occupation for less than three years please provide details of your previous occupation including dates, duties, industry and employer.

s) If you are employed and you are intending to change your current occupation or become self-employed within the next 12 months please provide details of your plans.

(Questions from t. onwards are only required for self-employed applicants)

t) Please provide details of your business structure.

Sole trader ☐ Partnership ☐ Company ☐

Sole trader ☐ Partnership ☐ Company ☐

u) What percentage of the business do you own?

☐☐☐ %

☐☐☐ %

v) If you intend to change the structure of your business please give details.

w) How many employees do you have working for you?

☐☐☐☐

☐☐☐☐

x) If you have been adjudged bankrupt in the past seven years please give details.

9.0 Annual income details

(only required for Mortgage Repayment Cover and Household Expenses Cover based on income, Specific Condition Cover and Income Cover)

a) Please provide details of any of the following annual incomes that are applicable to you.

Income details	Life assured 1	Life assured 2
Annual salary (for employed)	$	$
Fringe benefits (e.g. company car)	$	$
Commission income	$	$
Bonuses	$	$
Profit share	$	$
Other annual remuneration amount	$	$
Other annual remuneration details		
Your share of annual business income less business expenses for past three years (for self employed)	Last year $	Last year $
	Previous year $	Previous year $
	2 years previous $	2 years previous $
Annual unearned income (not arising from personal exertion e.g. rental income, investment income, trust distributions etc.)	$	$

Life assured 1 **Life assured 2**

b) If you split any of the above incomes with your spouse/partner please provide details of the percentage they receive and details of any duties they undertake in your business.

% %

Duties Duties

c) If you became totally disabled what percentage of your current income would continue and for how long?

% Months % Months

10.0 Mortgage details (only required if applying for Mortgage Repayment Cover based on actual mortgage repayments)

a) What are the amounts of mortgage debts to be covered? $ $

b) Who are the lenders of these mortgages?

c) What are the terms of these mortgages?

d) What are/were the advance dates of these mortgages?

e) What are the types of these mortgages?
(e.g. table, revolving credit, interest only etc.)

f) What are the monthly repayments for these mortgages? $ $

g) What is/are the address(es) of the property(ies) used as security?

Address 1

Address 2

h) What will the property(ies) be used for?
(e.g. residential rental investment etc.)

i) Please provide details of the monthly rental or investment income you will receive from any of these properties. $ $

j) If you had any previous mortgage defaults please give date, lender and reason

D D M M Y Y

Lender

Reason

11.0 Household expense details (only required if applying for Household Expenses Cover based on actual household expenses)

a) Monthly Expenses: Please provide your share of the average total monthly bills over the past three months for the household expenses that are listed below. Please note the expenses must be solely for domestic purposes supplied to the primary place of residence of the life (lives) assured.

Allowable Monthly Expenses:
(where these are paid annually, please provide 1/12th of the annual cost)

Electricity, Gas, Phone, Water, Rent, Internet, Television, Hire Purchase, Bank or other Personal Loan, House/Contents/Motor Vehicle Insurance Premiums, Rates, Private School Fees, Body Corporate Fees.

Average total monthly expenses $ _____ . __

b) What is your share of the total expenses for your household (please enter a value between 0 and 100)?

Life assured 1 ___ %

Life assured 2 ___ %

c) How many contributing adults live in the household? __

12.0 Pre-assessment exclusion acceptance

Pastimes

I/we hereby acknowledge that should death, disability or the occurrence of a covered condition arise as a direct or indirect result of participation in or preparation for the listed pursuits then no benefit will be payable under the listed benefits which are included in this contract.

Life assured 1	
Pursuit	Benefits

Life assured 2	
Pursuit	Benefits

Disability

I/we hereby acknowledge that should disability arise as a direct or indirect result of any disease or disorder of the listed body parts or conditions (including complications thereof), then no benefit will be payable under the listed benefits which are included in this contract.

Life assured 1	
Body part or condition	Benefits

Life assured 2	
Body part or condition	Benefits

Trauma Cover

I/we hereby acknowledge that the listed covered conditions have been removed from the Trauma Cover which is included in this contract.

Life assured 1 – covered condition

Life assured 2 – covered condition

Private Medical Cover

I/we hereby acknowledge that any medical costs arising as a direct or indirect result of any disease or disorder or investigation of the listed body parts and conditions will not be covered under the Private Medical Cover which is included in this contract.

Life assured 1 – condition or body part

Life assured 2 – condition or body part

13.0 Ownership (only required if Other selected on page 1)

First owner

Mr ☐ First Name

Mrs ☐ Middle Name(s)

Miss ☐ Surname

Ms ☐ Previous Name

Dr ☐ Male ☐ Female ☐ Date of Birth D D M M Y Y

OR

Company Name

Second owner

Mr ☐ First Name

Mrs ☐ Middle Name(s)

Miss ☐ Surname

Ms ☐ Previous Name

Dr ☐ Male ☐ Female ☐ Date of Birth D D M M Y Y

OR

Company Name

Postal Address

PO Box ☐ Private Bag ☐ Street Number ☐

Number

Street Name

Rural Delivery No. Suburb

Town/City Postcode

Email Address

Contact Phone

Postal Address

PO Box ☐ Private Bag ☐ Street Number ☐

Number

Street Name

Rural Delivery No. Suburb

Town/City Postcode

Email Address

Contact Phone

14.0 Declaration and consent

Duty of disclosure

Before you enter this contract of insurance (including the Interim Cover detailed in the quote) you have a duty to disclose to Partners Life Limited every matter that you know (or could reasonably be expected to know) is relevant to Partners Life Limited's decision whether to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose those matters to Partners Life Limited when you apply to vary or reinstate the insurance.

If you fail to comply with your duty of disclosure to Partners Life Limited, Partners Life Limited will enact the remedies available to it under the terms and conditions contained within the policy document. (Also applies to the Interim Cover).

The below named lives to be assured and policy owner(s) declare and agree that:

1. The information provided in this application whether in my/our handwriting or not is true and complete and I/we have not withheld or misstated any material fact; and
2. Should the lives to be assured or any children to be assured undergo any alteration in mental or physical health or have a change of occupation or change in financial circumstances between the date of this application and the issue of the insurance, I/we agree to notify Partners Life Limited immediately, as I/we acknowledge this information is relevant to Partners Life Limited's decision to accept this application; and
3. I/we understand that statements made in this application, any statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf and any statements made to Partners Life Limited by phone or in writing form the basis of the insurance contract between me/us and Partners Life Limited; and
4. I/we acknowledge that any additional information on my/our behalf, including but not limited to copies of other companies' application forms, will form part of this application and will be used to form the basis of the insurance contract between me/us and Partners Life Limited; and
5. I/we understand that the insurance proposed in this application shall not commence until this application has been accepted by Partners Life Limited and the initial premium or a completed direct debit or credit card authority has been received by Partners Life Limited; and
6. I/we understand that Partners Life Limited will draw money from my/our chosen payment method where applicable (bank account, credit card or debit card) on the date specified by me/us in my/our application, or on the nearest corresponding date thereafter (and ongoing in accordance with my/our specified payment frequency). I/we understand that, and give consent to, the first billing may be within 10 days of you sending me/us confirmation that my/our chosen account will be debited.
7. I/we will be bound by the standard conditions applicable to the proposed insurance upon Partners Life Limited's acceptance of this application; and
8. I/we have been advised a specimen policy document is available to me/us on request from Partners Life Limited's head office; and
9. I/we agree you will hold my/our personal information and use it to provide the products and services I/we have requested, including for the assessment, management, and administration of this application and any subsequent insurance contract or claims that I/we make. I/we understand and agree that my/our personal information (including but not limited to full medical history):
   - Is made up of information I/we provide you, you collect from third parties that I/we authorise you to contact, or third parties authorised to disclose information to you;
   - May be used by you to tell us about other products and services that may be of interest to me/us, unless I/we tell you otherwise;
   - May be disclosed to third parties who assist you in providing the products and services I/we have requested or where you are required by law to disclose such information to regulatory or government agencies; and
   - May be transferred overseas for information storage or reinsurance purposes.
10. I/we consent and give authority to you to seek any information (including full medical history) you require for the purposes set out above from:
    - Health treatment and/or medical providers;
    - Other insurers who you have previously had dealings with;
    - Previous and/or current employers;
    - Regulatory or government agencies;
    - Financial advisers;
    - Banks and financial institutions; and
    - Credit reference and fraud prevention agencies.
11. I/we understand that your Privacy Policy is set out in full on the Partners Life website or that I/we can request a copy from you.
12. I/we acknowledge that the illustration related to the quote number as specified at the top of page 1 of this application (or any subsequently provided illustrations which are to amend the original illustration) forms part of the application and sets out the insured benefits I/we are applying for; and
13. I/we accept any pre-assessment exclusions listed in section 12 of this application form will be applied to the benefits included under this policy; and
14. I/we agree that a photocopy, facsimile digital reproduction or scan of this application form, declaration and consent will be as valid as the original.
15. I/we agree that the adviser who has submitted this application to Partners Life Limited on my/our behalf is to be my/our servicing adviser for all Partners Life policies I/we hold from this date onwards until instructed otherwise by me/us.
16. I hereby confirm that prior to completing this application for insurance I/we had either:
    - Invited the Adviser detailed in Section 15.0 of this application form to discuss and agree to this application for insurance with me/us; or
    - If the discussion was uninvited by me/us, I/we have been verbally notified by the Adviser detailed in Section 15.0 of this application form of my/our right to cancel the contract within 5 working days of receipt of the policy document.

Name of first life to be assured

Signature of first life to be assured

Date D D M M Y Y

Name of second life to be assured

Signature of second life to be assured

Date D D M M Y Y

First policy owner's name/company details (if different from life to be assured)

Signature/authorised signature of first policy owner

Date D D M M Y Y

Second policy owner's name/company details (if different from life to be assured)

Signature/authorised signature of second policy owner

Date D D M M Y Y

Parent or guardian if life to be assured is under the age of 16.

Name of parent or guardian

Signature of parent or guardian

Date D D M M Y Y

As of 15 December 2022, Partners Life has an A (Excellent) financial strength rating from A.M. Best, an approved RBNZ rating agency. For the latest rating or further details around the latest rating, please visit www.ambest.com.

Superior		Excellent		Good		Fair		Marginal		Weak		Poor
A++	A+	A	A-	B++	B+	B	B-	C++	C+	C	C-	D

15.0 Adviser details

a) Adviser name

b) Adviser code

partners life

Direct Debit Authority

Bank instructions

Name of Account Holder

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

Bank account from which payments to be made

Bank | Branch | Account | Suffix

Authorisation code

0 3 1 9 6 3 7

To: The Bank Manager

Bank

Branch

Town/city

I/we authorise you until further notice, to debit my/our account with all amounts which Partners Life Limited (hereinafter referred to as the initiator), the registered Initiator of the above authorisation code, may initiate by direct debit. I/we acknowledge and accept that the bank accepts this authority only upon the conditions listed on the reverse of this form.

Information to appear on my/our bank statement

P A R T N E R S L I F E

Your Policy Number

Name of signatory

Your signature

Date D D M M Y Y

Name of signatory

Your signature

Date D D M M Y Y

Approved

1963

03 | 11

For Bank use only original – retain at branch

Date received:	Checked by:	Recorded by:

Bank stamp

Conditions of this Authority

1.0 The initiator

a) 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). This notice will be provided either:

   i) in writing; or

   ii) by electronic mail where the customer has provided prior written consent to the Initiator.

   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. 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** changes come into effect. This notice must be provided either:

   i) in writing; or

   ii) by electronic mail where the customer has provided prior written consent to the initiator.

b) May, upon the relationship which gave rise to this authority being terminated, give notice to the bank that no further direct debits are to be initiated under the authority. Upon receipt of such notice the bank may terminate this authority as to future payments by notice in writing to me/us.

2.0 The customer may:

a) At any time, terminate this authority as to future payments by giving written notice of termination to the bank and to the initiator.

b) Stop payment of any direct debit to be initiated under this authority by the initiator by giving written notice to the bank **prior** to the direct debit being paid by the bank.

c) Where a variation to the amount agreed between the initiator and the customer from time to time to be direct debited has been made without notice being given in terms of clause 1(a) 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 a direct debit back to the initiator through the initiator's bank, **provided** such a request is made not more than 120 days from the date when the direct debit was debited to my/our account.

3.0 The customer acknowledges that:

a) This authority will remain in full force and effect in respect of all direct debits passed to my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the bank.

b) In any event this authority is subject to any arrangement now or hereafter existing between me/us and the bank in relation to my/our account.

c) Any dispute as to the correctness or validity of 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 authority. Any other disputes lies between me/us and the initiator.

d) Where the bank has used reasonable care and skill in acting in accordance with this authority, the bank accepts no responsibility or liability in respect of:

   - the accuracy of information about direct debits on bank statements
   - any variations between notices given by the initiator and the amounts of direct debits.

e) The bank is not responsible for, or under any liability in respect of the initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the initiator.

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

4.0 The bank may:

a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the bank.

b) At any time terminate this authority as to future payments by notice in writing to me/us.

c) Charge its current fees for this service in force from time to time.

Partners Life Limited
Private Bag 300995
Albany
Auckland 0752
New Zealand
0800 14 54 33

partnerslife.co.nz

Credit Card Payment

Visa or MasterCard only*

For your security, Partners Life does not accept written credit card details. If you would like to pay via credit card, please complete the information below.
Prior to issuing your policy you will receive an email with a secure link to enter your credit card details.

Name of policy owner

Policy number(s) for which this payment applies

Payment type Debit card ☐ Visa ☐ MasterCard ☐

* Please note that we only accept Visa or MasterCard. We do not accept American Express, Diner's Club etc

Policy Owner Identity Verification

a) The following information must be completed for each policy owner in order to comply with the Financial Transactions Reporting Act 1996.

b) Where the policy owner is a company, partnership, incorporated society or club, the individual who signs on behalf of the company, partnership, incorporated society or club must be identified below.

c) Details of only one of the following acceptable forms of identification is required:

- **Current and valid passport**
- **New Zealand drivers licence**
- **New Zealand firearms licence**
- **New Zealand bank issued pre-printed deposit slip.**

d) Identification

Policy owner 1

- Identification previously provided ☐
- Pre-printed deposit slip enclosed ☐
- Photographic identification (current passport, firearms licence or driver's licence) ☐

Type

Number (if applicable)

Expiry date (if applicable) D D M M Y Y

Policy owner 2

- Identification previously provided ☐
- Pre-printed deposit slip enclosed ☐
- Photographic identification (current passport, firearms licence or drivers licence) ☐

Type

Number (if applicable)

Expiry date (if applicable) D D M M Y Y

Adviser declaration

I confirm that I have sighted the above identification documents as proof of identity in respect of the policy owner(s).

Name of adviser (please print)

Adviser signature

Date D D M M Y Y

partners life

Advice on Replacement Business

A separate form is to be completed for each existing contract, plan or policy to be replaced. The original of this form should be kept by the policy owner, and a copy held by the company issuing the new contract, plan or policy.

Details of the new contract/plan/policy

Name of policy owner

Name of company

Type of contract/plan/policy

Annual premium or contribution $

Is initial commission being received in relation to the new contract? YES ☐ NO ☐

Is renewal commission being taken as an alternative form? YES ☐ NO ☐

Details of the contract/plan/policy being replaced

Name of policy owner

Name of company

Type of contract/plan/policy

Annual premium or contribution $

Details of the contract/plan/policy being replaced

Life assured	Benefit type	Sum assured	Commencement date	Cancellation date	Acceptance terms*
			D D M M Y Y	D D M M Y Y	

* Note: If the life assured's health has change since the commencement date of the benefit to be replaced, he/she may not be able to obtain acceptance terms as beneficial as they already have.

Is this application for replacement benefits dependant on the acceptance terms at least matching those already in place?

Details of replacement – statement by adviser/intermediary

a) The specific reasons for the replacement of this existing contract/plan/policy are:

b) The policy replaced cannot adequately fulfil the owner's objectives because:

c) The following risks are not covered by the new contract/plan/policy which were covered by the old contract/plan/policy:

Name of adviser/intermediary

Address of adviser/intermediary

Adviser code

Phone

Your signature(s)

Date D D M M Y Y

Advice to policy owner(s)

You might find this advice helpful in deciding whether to replace an existing contract/plan/policy.

This includes all situations where a new contract/plan/policy is being issued within a period of six months after an existing one has been discontinued, or six months before an existing contract/plan/policy is planned to be discontinued: and

1. The lives assured (or one of the lives assured) is the same; or
2. The policy owner (or one of the policy owners) is known to be the same; or
3. The premium payer (or one of the premium payers) is known to be the same.

Policy owner(s) acknowledgement

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

1. There are sometimes establishment costs in setting up a contract/plan/ policy. Replacing it with a new contract/ plan/policy may involve further establishment costs;
2. If the policy, which is being replaced, was purchased on the life to be assured at a younger age, the same or similar benefits in the new policy may now cost more;
3. A change in health, pastimes or occupation of the life to be assured may affect insurability and the new policy may contain restriction limitations, and/or be more costly;
4. In a new policy the Suicide Exclusion Clause may recommence;
5. Conditions or benefits may be more (or less) favourable under the contract/plan/policy which is being replaced. For example, the contract duration, wording and/or benefit definitions may differ.

I/we also acknowledge that this information was provided and explained before I/we signed this application for the new contract/plan/policy.

I am/we are aware I/we may cancel this application, in writing, within the 'free look' period of 30 days from the date the new contract/plan/policy is received. In this event Partners Life Limited will refund any premium, deposit or other payment made in respect of the new contract/plan/policy.

Name of policy owner(s)

Signature of policy owner(s)

Date

D D M M Y Y

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partners life

Scan and email to service@partnerslife.co.nz or post to:
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