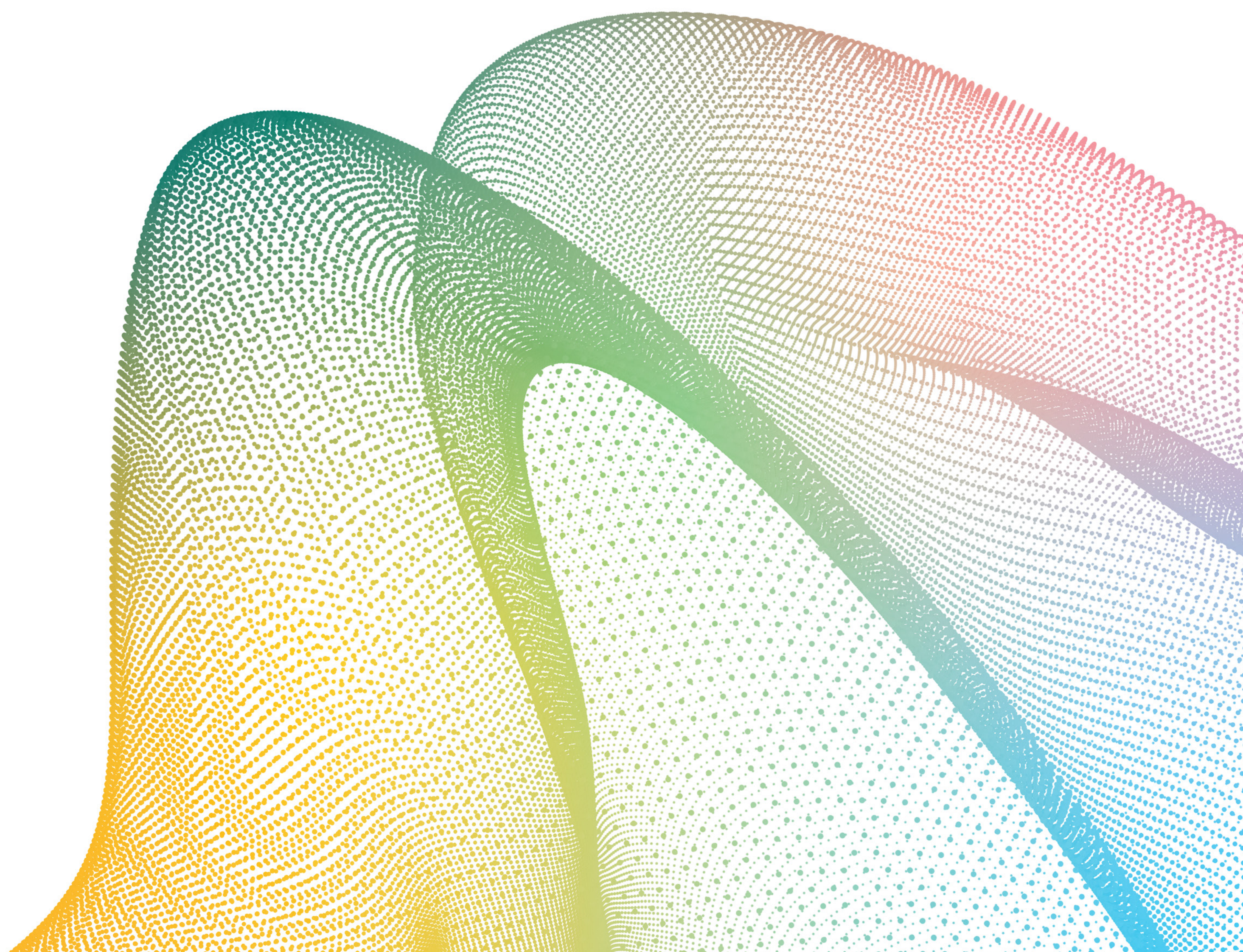
Partners Group Holdings Limited Consolidated Group

partners life

# Protection Plan

## Children's Application



# Apply

for Quote number

(Mandatory Field)
initial application

partners life

# Protection Plan Children's Application

Version 2

(for use of children aged 18 years and under for Private Medical Cover and/or Hospital Cash Cover and of children aged 15 years and under for all other cover types)

## 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

Additional to adult application for:

First Name(s)

Surname

First Name(s)

Surname

## 1.0 Children to be assured

**Child 1**

First Name

Middle Name(s)

Surname

Male Female Date of Birth D D M M Y Y

Place of Birth NZ Other

**Child 2**

First Name

Middle Name(s)

Surname

Male Female Date of Birth D D M M Y Y

Place of Birth NZ Other

**Child 3**

First Name

Middle Name(s)

Surname

Male Female Date of Birth D D M M Y Y

Place of Birth NZ Other

**Child 4**

First Name

Middle Name(s)

Surname

Male Female Date of Birth D D M M Y Y

Place of Birth NZ Other

## 2.0 Personal Statement

**a) Please provide the name, address and telephone numbers of the health practice(s) that hold the child's medical records.**

| | Clinic name | Clinic address | Clinic phone no. |
|---|---|---|---|
| Child 1 | | | |
| Child 2 | | | |
| Child 3 | | | |
| Child 4 | | | |

**b) Please answer the following questions for children over the age of 10.**

**Child 1**

Height

Feet Inches Centimetres

Weight

Kilograms Stone Pounds Date last weighed M M Y Y

**Child 2**

Height

Feet Inches Centimetres

Weight

Kilograms Stone Pounds Date last weighed M M Y Y

**Child 3**

Height

Feet Inches Centimetres

Weight

Kilograms Stone Pounds Date last weighed M M Y Y

**Child 4**

Height

Feet Inches Centimetres

Weight

Kilograms Stone Pounds Date last weighed M M Y Y

**c) Please indicate below by ticking the box if the child is currently suffering from, experiencing symptoms of or being treated for or if they have ever suffered from, had symptoms of or had treatment for any of the following.** (If you tick a box, please also complete the questionnaire in **section 3.0**).

| | C1 | C2 | C3 | C4 |
|---|---|---|---|---|
| 1. Respiratory or breathing disorder (e.g. asthma, lung disorder, bronchitis etc.). | ☐ | ☐ | ☐ | ☐ |
| 2. Liver disease or disorder (e.g. hepatitis or abnormal liver function tests etc.). | ☐ | ☐ | ☐ | ☐ |
| 3. Kidney disease or disorder (e.g. kidney stones, infections or abnormal renal function tests etc.). | ☐ | ☐ | ☐ | ☐ |
| 4. Urinary tract or bladder disorder. | ☐ | ☐ | ☐ | ☐ |
| 5. Gynaecological disorder. | ☐ | ☐ | ☐ | ☐ |
| 6. Breast disorders including lumps, cysts, discharge or abnormal mammograms or ultrasound scans. | ☐ | ☐ | ☐ | ☐ |
| 7. Gastrointestinal tract, stomach or bowel disorder (e.g. ulcers, colitis, Crohn's disease etc.). | ☐ | ☐ | ☐ | ☐ |
| 8. Skin disorders (e.g. dermatitis, psoriasis, eczema, cysts, suspicious moles, lesions etc.). | ☐ | ☐ | ☐ | ☐ |
| 9. Cancer or tumour. | ☐ | ☐ | ☐ | ☐ |
| 10. Diabetes, abnormal blood sugar test or impaired glucose tolerance. | ☐ | ☐ | ☐ | ☐ |
| 11. Thyroid disorder, gout or any other glandular condition. | ☐ | ☐ | ☐ | ☐ |
| 12. Disorders of the ears, eyes (excluding long or short sightedness), nose or throat. | ☐ | ☐ | ☐ | ☐ |
| 13. Epilepsy or seizures. | ☐ | ☐ | ☐ | ☐ |
| 14. Blood disorders. | ☐ | ☐ | ☐ | ☐ |
| 15. Mental or nervous disorders (e.g. depression, anxiety, stress, phobias) or chronic fatigue, fibromyalgia or chronic pain syndrome. | ☐ | ☐ | ☐ | ☐ |
| 16. Sleep disorders (e.g. chronic insomnia or obstructive sleep apnoea etc.). | ☐ | ☐ | ☐ | ☐ |
| 17. Recurrent(1) or recent(2) dizziness or vertigo. | ☐ | ☐ | ☐ | ☐ |
| 18. Heart disorder (e.g. heart failure, heart valve disorders, etc.). | ☐ | ☐ | ☐ | ☐ |
| 19. Muscle, joint, spine, tendon or bone disorder or injury. | ☐ | ☐ | ☐ | ☐ |
| 20. Arthritis or rheumatism. | ☐ | ☐ | ☐ | ☐ |
| 21. Any neurological disorder (e.g. stroke, MS, paralysis, migraines or motor neurone disease). | ☐ | ☐ | ☐ | ☐ |
| 22. Recurrent[1] ear, nose, throat, adenoid or tonsil infections. | ☐ | ☐ | ☐ | ☐ |
| 23. Recent[2] ear, nose, throat, adenoid or tonsil infections. | ☐ | ☐ | ☐ | ☐ |
| 24. Grommet insertion (or been advised that this may be required). | ☐ | ☐ | ☐ | ☐ |
| 25. Oral surgery, impacted or unerupted teeth, gum infections or cysts. | ☐ | ☐ | ☐ | ☐ |
| 26. Irregular, heavy or painful menstrual bleeding or hormonal problems. | ☐ | ☐ | ☐ | ☐ |
| 27. Any other conditions not listed above for which the child has received treatment or therapy from any health provider, (including alternative practitioners), in the past five years (excluding minor ailments such as colds, flu and contraception). | ☐ | ☐ | ☐ | ☐ |
| 28. Any other conditions not listed above for which the child currently takes medications, drugs, sedatives or over the counter preparations (excluding medications for minor ailments such as colds, flu and contraception). | ☐ | ☐ | ☐ | ☐ |
| 29. Any other conditions not listed above for which the child has undergone or has been advised to undergo tests or investigations, including genetic testing, in the past five years. | ☐ | ☐ | ☐ | ☐ |
| 30. Any other symptoms or signs which the child is currently experiencing or has experienced at any time in the past 12 months whether or not you have consulted a health professional regarding them. | ☐ | ☐ | ☐ | ☐ |

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

Please initial the following boxes to confirm that you have read and understood this question. ☐ ☐ ☐ ☐

**d) Please give details of any claims that have been made or are in the process of being made against any insurance benefits.**

| | Claim |
|---|---|
| Child 1 | |
| Child 2 | |
| Child 3 | |
| Child 4 | |

**e) Please give details of any applications you have made for any insurance benefits which were declined, deferred or offered with special acceptance terms.**

| | Application |
|---|---|
| Child 1 | |
| Child 2 | |
| Child 3 | |
| Child 4 | |

f) **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:**

| Child 1 ☐ 2 ☐ 3 ☐ 4 ☐ | Cancer* | Stroke | Heart disease** | Diabetes Type I | Diabetes Type II | Cystic Fibrosis | Familial Polyposis | Multiple Sclerosis |
|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| 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 |

| Child 1 ☐ 2 ☐ 3 ☐ 4 ☐ | Cancer* | Stroke | Heart disease** | Diabetes Type I | Diabetes Type II | Cystic Fibrosis | Familial Polyposis | Multiple Sclerosis |
|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| 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 |

| Child 1 ☐ 2 ☐ 3 ☐ 4 ☐ | Cancer* | Stroke | Heart disease** | Diabetes Type I | Diabetes Type II | Cystic Fibrosis | Familial Polyposis | Multiple Sclerosis |
|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| 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 |

| Child 1 ☐ 2 ☐ 3 ☐ 4 ☐ | Cancer* | Stroke | Heart disease** | Diabetes Type I | Diabetes Type II | Cystic Fibrosis | Familial Polyposis | Multiple Sclerosis |
|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| 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 |

## 3.0 Medical questionnaire

a) **What is the condition and when was the condition first diagnosed?**

**Child 1**

| | D | D | M | M | Y | Y |
|---|---|---|---|---|---|---|
| Condition 1 | | | | | | |
| Condition 2 | | | | | | |
| Condition 3 | | | | | | |

**Child 2**

| | D | D | M | M | Y | Y |
|---|---|---|---|---|---|---|
| Condition 1 | | | | | | |
| Condition 2 | | | | | | |
| Condition 3 | | | | | | |

**Child 3**

| | D | D | M | M | Y | Y |
|---|---|---|---|---|---|---|
| Condition 1 | | | | | | |
| Condition 2 | | | | | | |
| Condition 3 | | | | | | |

**Child 4**

| | D | D | M | M | Y | Y |
|---|---|---|---|---|---|---|
| Condition 1 | | | | | | |
| Condition 2 | | | | | | |
| Condition 3 | | | | | | |

**b) Give details of the specialist where applicable.**

**Child 1**

Condition 1

Condition 2

Condition 3

**Child 2**

Condition 1

Condition 2

Condition 3

**Child 3**

Condition 1

Condition 2

Condition 3

**Child 4**

Condition 1

Condition 2

Condition 3

**c) What treatment or medication has most recently been prescribed and does the child still require treatment or medication for this condition?**

**Child 1**

Condition 1

Yes ☐ No ☐

Condition 2

Yes ☐ No ☐

Condition 3

Yes ☐ No ☐

**Child 2**

Condition 1

Yes ☐ No ☐

Condition 2

Yes ☐ No ☐

Condition 3

Yes ☐ No ☐

**Child 3**

Condition 1

Yes ☐ No ☐

Condition 2

Yes ☐ No ☐

Condition 3

Yes ☐ No ☐

**Child 4**

Condition 1

Yes ☐ No ☐

Condition 2

Yes ☐ No ☐

Condition 3

Yes ☐ No ☐

**d) Provide details of any time off school required as a result of this condition.**

**Child 1**

Condition 1

Condition 2

Condition 3

**Child 2**

Condition 1

Condition 2

Condition 3

**Child 3**

Condition 1

Condition 2

Condition 3

**Child 4**

Condition 1

Condition 2

Condition 3

**e) What tests or investigations have been undertaken for this condition and what were the results?**

**Child 1**

Condition 1

Condition 2

Condition 3

**Child 2**

Condition 1

Condition 2

Condition 3

**Child 3**

Condition 1

Condition 2

Condition 3

**Child 4**

Condition 1

Condition 2

Condition 3

**f) How frequently does the child experience symptoms, what are those symptoms and when did the child last experience those symptoms?**

**Child 1**

Condition 1 M M Y Y

Condition 2 M M Y Y

Condition 3 M M Y Y

**Child 2**

Condition 1 M M Y Y

Condition 2 M M Y Y

Condition 3 M M Y Y

**Child 3**

Condition 1 M M Y Y

Condition 2 M M Y Y

Condition 3 M M Y Y

**Child 4**

Condition 1 M M Y Y

Condition 2 M M Y Y

Condition 3 M M Y Y

**g) If the child has been hospitalised for this condition please give date, reason and outcome.**

**Child 1**

Condition 1

M M Y Y Reason

Outcome

Condition 2

M M Y Y Reason

Outcome

Condition 3

M M Y Y Reason

Outcome

**Child 2**

Condition 1

M M Y Y Reason

Outcome

Condition 2

M M Y Y Reason

Outcome

Condition 3

M M Y Y Reason

Outcome

**Child 3**

Condition 1

M M Y Y Reason

Outcome

Condition 2

M M Y Y Reason

Outcome

Condition 3

M M Y Y Reason

Outcome

**Child 4**

Condition 1

M M Y Y Reason

Outcome

Condition 2

M M Y Y Reason

Outcome

Condition 3

M M Y Y Reason

Outcome

**h) Describe any long-term or permanent disability suffered as a result of this condition.**

**Child 1**

| Condition 1 |
|---|
| |

| Condition 2 |
|---|
| |

| Condition 3 |
|---|
| |

**Child 2**

| Condition 1 |
|---|
| |

| Condition 2 |
|---|
| |

| Condition 3 |
|---|
| |

**Child 3**

| Condition 1 |
|---|
| |

| Condition 2 |
|---|
| |

| Condition 3 |
|---|
| |

**Child 4**

| Condition 1 |
|---|
| |

| Condition 2 |
|---|
| |

| Condition 3 |
|---|
| |

**i) Are you considering or have you been advised to have the child undergo any further tests or investigations for this condition?** If **yes** please give details.

**Child 1**

| Condition 1 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 2 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 3 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

**Child 2**

| Condition 1 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 2 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 3 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

**Child 3**

| Condition 1 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 2 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 3 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

**Child 4**

| Condition 1 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 2 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

| Condition 3 | Yes ☐ | No ☐ |
|---|---|---|
| | | |

## 4.0 Pre-assessment exclusion acceptance

### 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.

| **Child 1** - Body part or condition |
|---|
| |
| |
| |
| |

| **Child 2** - Body part or condition |
|---|
| |
| |
| |
| |

| **Child 3** - Body part or condition |
|---|
| |
| |
| |
| |

| **Child 4** - Body part or condition |
|---|
| |
| |
| |
| |

## Duty of disclosure

Before you enter this contract of insurance 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.

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;
   - Will be held at the registered office of Partners Life and/or by Partners Life's data storage providers, which includes cloud-based data storage providers (both in New Zealand and overseas); and
   - May be transferred overseas for storage purposes (including to cloud-based data storage providers) or for 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 signed illustrations which are to amend the original illustration) forms part of the application and sets out the assured benefits I/we are applying for; and
13. I/we accept any pre-assessment exclusions listed in section 4 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 Limited policies I/we hold from this date onwards until instructed otherwise by me/us.

**Parent or guardian to sign if child to be assured is aged 15 years and under. If 16 or over child to be assured must sign.**

Name of first child to be assured

Signature of first child to be assured

Date D D M M Y Y

Name of second child to be assured

Signature of second child to be assured

Date D D M M Y Y

Name of third child to be assured

Signature of third child to be assured

Date D D M M Y Y

Name of fourth child to be assured

Signature of fourth child 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

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 |

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