CHUBB®

Application Form

Please read these instructions before completing this application form

Your duty of disclosure

So that we can assess your application accurately, we need you to tell us all material information about you. Material information is information which may affect our decision to insure you, and upon what terms and conditions that we offer you a contract of insurance.

You must answer all of the questions in this application honestly. It also means telling us anything else about your present or past circumstances which may alter our assessment in any way.

You must also tell us if any of the information you provide in this application form changes, or if there is any other material change to your personal, medical or financial circumstances, between the date you complete this application and the date we issue your policy.

Your duty of disclosure also applies if you make any alterations to your cover, or if your policy lapses, and you apply to have it reinstated.

Consequences of non-disclosure

If you leave out material information or provide information that is untrue, incorrect or incomplete, we can avoid your policy from the outset (which means we treat your policy as though it never existed), decline your claim and/or alter the terms and conditions of your policy, including the benefits covered.

If someone else is completing your application form on your behalf, make sure you check the information is correct and that nothing's been left out. If you're not sure, ask us or your adviser before submitting this application to us.

Any reference to "we", "our" and "us" is to Chubb Life Insurance New Zealand Limited.

Financial advice

If you've received financial advice in respect of this application, your financial adviser is responsible for providing you with personalised financial adviser services. In doing so, your financial adviser would have taken into account your personal circumstances when recommending the appropriate insurance cover(s) for you.

If you're replacing an existing insurance cover, any benefits and costs involved in doing so would be covered within the financial advice provided by your financial adviser. This could include any additional limitations or restrictions in or established costs in setting up a new policy. If you have any questions in relation to the financial advice provided to you, please discuss these with your financial adviser.

Please ensure the following sections are completed

Adviser to complete

- ☐ **Section A** – Application details

Applicant must complete

- ☐ **Section B** – Applicant's details
- ☐ **Section C** – Doctor's details
- ☐ **Section D** – Medical details
- ☐ Declaration and consent

Applicant to complete if applicable

- ☐ **Section E** – Occupation details
- ☐ **Section F** – Employed (by an independent employer)
- ☐ **Section G** – Self-Employed
- ☐ **Section H** – Mortgage details
- ☐ **Section I** – Questionnaires

Assurance Extra Business

If you are applying for Assurance Extra Business cover you should obtain a copy of the supplementary application forms and include the relevant sections with this application. These supplementary forms must be sent to us with this application form and will form part of your application.

Do you need help?

Talk to your adviser or call us on 0508 464 999.

Cover details

A copy of the Chubb Life Illustration (Quote) for personal and business covers you are applying for must be attached to this application form.

Section A - Application details

Adviser to complete

A1 – Please note: a separate application form must be completed for each life assured

Purpose of Cover

Please tick the boxes relating to the policy(ies) being applied for and/or amended:

New Policy ☐ Review of Terms ☐ Addition of Cover/Alteration of existing cover ☐

Is this application linked to any other applications? Yes ☐ No ☐

Name of applicants in any linked application(s)

A2 – Adviser details

Name

Company Email

Contact Number Adviser Code FSP #

A3 – Payment details

Payer Name Payer Email

Payment frequency Weekly ☐ Fortnightly ☐ Monthly ☐ Half-yearly ☐ Annually ☐

Payment method Direct debit (page 12) ☐ Credit/Debit card ☐ Use existing payment method ☐

Payment date (e.g Monday, or 5th of every month)

Total premium amount (including policy fee) $

Section B - Applicant's details

Applicant must complete

B1 – A separate application form must be completed for each life assured (with the exception of children's trauma cover)

Details of life to be assured

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other ☐

First name Middle name

Family name Previous name (if applicable)

Date of birth DD / MM / YYYY Gender

Email address

Home address

Postal address (if different)

Phone HOME WORK MOBILE

Height Feet Inches or Centimetres

Weight Stone Pounds or Kilograms

Current Occupation Industry

May one of our staff contact you by phone or via email if we require further information?

Yes – Phone or Email ☐ Yes – Phone only ☐ Yes – Email only ☐ No ☐

Please complete the table below if you are applying for the Optional Children's Trauma Cover

Children to be assured

First Name	Family Name	Gender	Date of Birth
1.			DD / MM / YYYY
2.			DD / MM / YYYY
3.			DD / MM / YYYY
4.			DD / MM / YYYY

B2 – Details of policy owner (if different from life assured)

Please note: If there is more than one policy owner, we will regard them as joint tenants. Where the policy is owned by a business, the authorised signatory must complete this section and provide his/her authorisation in the Declaration and consent.

Policy owner 1 Please tick if the life assured is also policy owner ☐

Company name

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other ☐

First name | Middle name

Family name | Previous name (if applicable)

Date of birth DD / MM / YYYY

No. and street

Suburb/town | Postcode

Phone HOME | WORK | MOBILE

Email address

Relationship to life assured

Policy owner 2 Please tick if the life assured is also policy owner ☐

Company name

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other ☐

First name | Middle name

Family name | Previous name (if applicable)

Date of birth DD / MM / YYYY

No. and street

Suburb/town | Postcode

Phone HOME | WORK | MOBILE

Email address

Relationship to life assured

Policy owner 3 Please tick if the life assured is also policy owner ☐

Company name

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other ☐

First name | Middle name

Family name | Previous name (if applicable)

Date of birth DD / MM / YYYY

No. and street

Suburb/town | Postcode

Phone HOME | WORK | MOBILE

Email address

Relationship to life assured

Your mailing address (if different to those listed above). Please specify the preferred mailing address for policy ownership. All correspondence for this policy will be sent to this address. This address should not be the address of your financial adviser.

No. and street | PO Box

Suburb/town | Postcode

B3 – Insurance Details

1. A. Do you currently have any other life insurance with any company, including Chubb Life? Yes ☐ No ☐
   B. Are you applying for any other life insurance with any company, including Chubb Life? Yes ☐ No ☐
   C. Within the last 6 months have you cancelled any other life insurance with any company, including Chubb Life? Yes ☐ No ☐

   This includes life, total permanent disablement, trauma (critical illness), disability income cover and insurance benefits provided by your employer.

   If you have answered **yes** to any of these questions, please provide details in the table below

Name of Insurer	Type of cover	Amount of cover	Date of inception	Is this policy being replaced or discontinued?
		$	DD / MM / YYYY	Yes ☐ No ☐
		$	DD / MM / YYYY	Yes ☐ No ☐
		$	DD / MM / YYYY	Yes ☐ No ☐
		$	DD / MM / YYYY	Yes ☐ No ☐

   If **yes**, provide reason for replacement or cancellation

2. Have you ever had an application for insurance on your life declined, deferred, or accepted with a higher than normal premium or with restrictions or exclusions? Yes ☐ No ☐
   If **yes**, please provide further details

3. Have you ever had a policy avoided, cancelled (other than for non-payment) or terms amended after it has been issued? Yes ☐ No ☐
   If **yes**, please provide further details

4. Have you ever made a claim for, or received sickness, accident or disability benefits, redundancy benefits, ACC benefits, unemployment benefits or similar form of compensation? Yes ☐ No ☐
   If **yes**, please provide further details including, dates, amount paid, time period paid and type of claim suffered

B4 – Lifestyle Details

1. Are you a permanent resident of New Zealand? Yes ☐ No ☐
   If **yes** skip to question 2, if **no**, please provide details

   A. How long have you been living in New Zealand?
   Less than 12 months ☐ 12 months to 2 years ☐ 2 to 5 years ☐
   Over 5 years ☐ I do not live in New Zealand ☐

   B. What is your country of birth?

   C. What countries have you lived in for the past 10 years?

   D. Do you have a work permit or visa which allows you a continuous stay of at least 2 years? Yes ☐ No ☐

2. Do you have any intention of travelling (other than for holidays less than 1 month), or living outside New Zealand within the next 12 months? Yes ☐ No ☐
   If **yes**, please provide details

Destination	Purpose (business, holiday)	Departure Date	Duration
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	
		DD / MM / YYYY	

3. Have any of your biological parents or brothers or sisters ever experienced any health problems from, or been diagnosed with any of the following conditions?
Diabetes, heart disease, high blood pressure, cancer, stroke, kidney disease or polycystic kidney disease, Huntington's disease, multiple sclerosis, familial adenomatous polyposis of the bowel, muscular dystrophy, motor neurone disease, cardiomyopathy, Alzheimer's disease or dementia or other hereditary neurological, blood or familial disease or disorder?
If **yes**, please provide further details Yes ☐ No ☐

Relation (e.g. Mother/Sister)	Condition	Age at Diagnosis

4. During the last 12 months have you used any product containing tobacco or nicotine or used e-cigarettes or vaporisers? Yes ☐ No ☐
If **yes**, then please advise what substance and quantity per day, and for how many years you have smoked

Type/Substance	Quantity per day	Years Smoked

5. How many standard alcoholic drinks do you usually consume per day (one standard drink= 330mls beer, 100mls wine, 30mls spirits)?
I do not drink at all ☐ 0-3 per day ☐ 4-5 per day ☐
6-8 per day ☐ 9-12 per day ☐ 12 per day or more ☐

6. Have you ever used any recreational and/or non-prescription drugs (except for over the counter medications)? If **yes**, please provide further details Yes ☐ No ☐

7. Have you ever received, or are you considering seeking, advice, counselling or treatment for the use of alcohol or drugs or gambling? If **yes**, please provide further details Yes ☐ No ☐

8. Do you engage in, or do you have any intention of engaging in, any hazardous or potentially hazardous activities, sports or pastimes (for example: Aviation, other than as a fare-paying passenger, Boxing/Martial Arts, Caving/Canyoning, Equestrian, Scuba Diving, Free Diving, Gliding/Hang Gliding, Hunting, Motocross, Motorcycle Racing, Motor Racing, Mountaineering, Parachuting/Skydiving, Powerboat Racing, Surf Lifesaving)? Yes ☐ No ☐
If **yes**, then please complete the Pastimes Questionnaire on page 23

Section C - Doctor's Details

1. Please provide the full name and address of your usual doctor/medical centre?

Name of Doctor
Practice name Phone number
Address
Email

2. How many years have you been attending this medical centre?

3. When was your last visit to this doctor/medical centre?
More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ Never ☐

4. Reasons for consultation

5. Outcome (including medication/treatment)

6 Degree of recovery 0-100% %

7. Have you visited any other doctor or medical centres in the past 5 years? Yes ☐ No ☐
If **yes**, then please provide the name and address of the other doctors seen, and reason for consultation

Section D - Medical Details

1. Have you ever had any signs or symptoms of, or been tested or treated for, or diagnosed with any of the following?

A. Asthma, bronchitis, sleep apnoea, persistent cough, tuberculosis or any other chest or lung condition or breathing problem? If **yes**, please complete Questionnaire A on page 14 — Yes ☐ No ☐

B. Hypertension (high blood pressure) or high cholesterol? If **yes**, please complete Questionnaire B on page 15 — Yes ☐ No ☐

C. Heart complaint, heart murmur, chest pain, rheumatic fever, irregular heart beat or pulse, stroke or vascular condition? If **yes**, please complete Questionnaire C on page 16 — Yes ☐ No ☐

D. Diabetes, impaired glucose intolerance or blood sugar above the normal reference range? If **yes**, please complete Questionnaire D on page 17 — Yes ☐ No ☐

E. Stress, anxiety, fatigue, phobia, depression, chronic fatigue syndrome, or any other mental health condition or impairment? If **yes**, please complete Questionnaire E on page 18 — Yes ☐ No ☐

F. Back or neck pain, sciatica or any disorder of the spine or neck? If **yes**, please complete Questionnaire F on page 19 — Yes ☐ No ☐

G. Any disease, disorder, injury, or pain of your muscles, joints or bones for example arthritis, lupus (SLE), gout, OOS, RSI, osteoporosis, fibromyalgia, hernia? If **yes**, please complete questionnaire F on page 19 — Yes ☐ No ☐

H. Cancer (including carcinoma in situ), tumour, cyst, growth, breast lump, suspicious or abnormal moles, skin lesions or skin disorders such as eczema, psoriasis (even if you have not seen a doctor)? — Yes ☐ No ☐

I. Thyroid disease or disorder or any other glandular condition such as hypothyroidism or Graves' disease? — Yes ☐ No ☐

J. Disease or disorder of the gastrointestinal tract (including mouth, throat, oesophagus, stomach, intestine, bowel), for example irritable bowel syndrome, Crohn's disease, hiatus hernia, bowel polyps, colitis, coeliac disease, ulcers, reflux, or recurrent indigestion, passing of blood from the bowel or coughing up blood? — Yes ☐ No ☐

K. Epilepsy, fits, seizures, dizziness, head injury, concussion(s) or persistent headaches or migraines, or any other neurological disease or disorder? — Yes ☐ No ☐

L. Any abnormality affecting physical mobility or muscular power such as multiple sclerosis, Parkinson's disease or paralysis? — Yes ☐ No ☐

M. Alzheimer's disease or dementia, or any diagnosed intellectual disability or cognitive impairment? — Yes ☐ No ☐

N. Kidney, prostate, bladder, urinary tract or urinary conditions, such as kidney stones or colic, kidney, bladder or urinary tract infections, elevated PSA, blood in the urine or urinary incontinence? — Yes ☐ No ☐

O. Anaemia, haemophilia, scleroderma, systemic sclerosis, varicose veins, blood clots, deep vein thrombosis or any other blood, bleeding or connective tissue disorder? — Yes ☐ No ☐

P. Liver, pancreas, gallbladder disease or disorder, for example fatty liver, gall stones, hepatitis, abnormal liver function tests or pancreatitis? — Yes ☐ No ☐

Q. Any condition or impairment affecting the eyes, ears, sight, hearing or speech? — Yes ☐ No ☐

R. AIDS or HIV Antibodies? — Yes ☐ No ☐

S. Have you ever had, or are you currently experiencing any health problems or any abnormal test result(s) not already disclosed above, 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 you have answered yes to any of the questions (H-T) please complete the General Questionnaire H that follows on page 23

Females Only

2. Have you ever had any complications with pregnancy or childbirth (e.g. gestational diabetes)? (Please do not include an elective caesarean section or miscarriage within the first 15 weeks of pregnancy as complications). If **yes**, please provide details — Yes ☐ No ☐

3. Are you now pregnant? If **yes**, please provide due date — Yes ☐ No ☐

DD / MM / YYYY

4. Are you currently on maternity leave? If **yes**, please provide details about your return to work and hours — Yes ☐ No ☐

5. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram or have you ever had any symptoms or sought advice or had treatment for any condition of the cervix, ovary, uterus, breast or endometrium? If **yes**, please complete Questionnaire G on page 21 — Yes ☐ No ☐

Section E - Occupation Details

1. Which of the following best describes your employment situation?

   a. Employed by independent employer ☐
   b. Self-Employed ☐
   c. Homemaker/Student/Retired/Unemployed (you do not need to complete any further questions in this section) ☐

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

   If less than 2 years, please advise your previous occupation

3. How many hours per week do you work, including any from home?

   0-24 ☐ 25-40 ☐ 40-50 ☐ 50-60 ☐ 60-80 ☐ 80+ ☐

4. How many days per week do you work?

5. Do you work from home? Yes ☐ No ☐

   If **yes**, please provide average hours worked from home per week & duties

6. Please tell us about the type of work you do (tick all that apply)

Category		Please describe your duties	% of time spent per week
Sedentary/Desk Bound	Yes ☐ No ☐		%
Site Visits	Yes ☐ No ☐		%
Supervising Manual work	Yes ☐ No ☐		%
Manual work Light	Yes ☐ No ☐		%
Manual work Heavy	Yes ☐ No ☐		%

Must add up to 100%

Are any of your occupational duties performed at home? Yes ☐ No ☐

7. Are any of your duties hazardous (working from heights, underground, handling dangerous substances, explosives / chemicals, handling needles, sharps or biohazardous material)? Yes ☐ No ☐

   If **yes**, please provide further details (hours and duties)

8. Are you considering a change in your current occupation(s), duties, working hours, employment situation(s) or financial situation (including income)? Yes ☐ No ☐

   If **yes**, please provide further details

9. Do you possess any trade or tertiary qualifications relevant to your occupation? Yes ☐ No ☐

   If **yes**, please advise qualifications

10. Do you have a second occupation? Yes ☐ No ☐

    If **yes**, please advise

    Occupation

    Duties

    Hours per week

    Current annual income after expenses and before tax from this occupation $

Please complete Section F if you are employed by an independent employer

Please complete Section G if you are Self-Employed

Section F - Employed (by an independent employer)

A. What is the name of the company that you work for?

B. What is your current annual salary?

C. Is any of your income likely to continue if you become disabled, e.g. sick pay, investment income etc.? If **yes**, please advise Yes ☐ No ☐

What is the source of this income?

How long will it continue if you become totally disabled?

How much income will be received (annual figure)?

D. 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 provide further details

Section G - Self Employed

A. What is the name of your company?

B. Year business established?

C. Number of shareholders in your business?

D. Profit share entitlement (%) You % Spouse %

E. How many people do you employ? (other than yourself and your spouse)

Full-time Part-time

F. Annual income for the two previous years?

	Year Ending 31 March 20_____	Year Ending 31 March 20_____
Gross Income	$	$
Expenses	$	$
Net Income before tax	$	$
Your Share of net income %	%	%

G. Is your business currently trading profitably? If **no**, please provide further details Yes ☐ No ☐

H. In the event of your total disability, will the business income continue for more than three months? Yes ☐ No ☐

If **yes**, then please advise what level of income (after expenses, but before tax) would you expect it to generate in the event of your total disablement?

1-20% ☐ 21-75% ☐ 76-100% ☐

How long do you estimate this income will continue for?

I. Have you or any entities owned or controlled by you ever been declared bankrupt or insolvent, or are you or any entities owned or controlled by you currently being declared bankrupt or insolvent? Yes ☐ No ☐

If **yes**, please advise

Date declared bankrupt DD / MM / YYYY

Date discharged DD / MM / YYYY

J. Does your spouse receive an income from the business? If **yes**, please advise Yes ☐ No ☐

Would they need to be replaced in the business if they were disabled? Yes ☐ No ☐

How many hours do they work each week in the business?

What are their duties?

Section H - Mortgage or Rent Details

Please advise what basis you are applying for Mortgage Repayment Cover

Based on your owner occupied mortgage repayments (please complete Section H1) ☐
Based on your residential rental repayments (please complete Section H2) ☐
Based on 45% of your income (you do not need to complete any question in this section) ☐

Please ensure that Occupation Section E is completed in full

Section H1

You will usually only need to supply evidence of mortgage for all sums assured over $6000 per month, Construction Loans, Holiday homes or Residential Investment/Rental properties.

1. Please advise the residence type — Owner Occupied ☐ — Construction Loan for Owner Occupied Home ☐ (please attach evidence of all mortgages)
2. Do you currently live at this property? — Yes ☐ — No ☐
   If no, please confirm the date you will take possession of the property and will move in — DD / MM / YYYY
3. How many home loans (mortgages) do you have for this property?
4. What is the total monthly repayment amount (the sum of all mortgage repayments) on this property? $
5. What is the total loan amount (sum of all mortgages) on this property? $
6. Please provide details of the home loan(s) (mortgages) for the **owner occupied** property you are insuring

	Remaining Loan Amount	Interest Rate	Remaining term on loan (how many years until repaid)
Loan 1			
Loan 2			
Loan 3			
Loan 4			
Loan 5			
Loan 6			
Loan 7			
Loan 8			
Loan 9			
Loan 10			

7. Have you failed to make one or more mortgage repayments (regardless of the reason for the default) in the last 12 months on any mortgages you hold (owner occupied, holiday home, investment/rental property)? — Yes ☐ — No ☐
   If yes, please provide further details
8. Are you applying for mortgage repayment cover on any property(ies) in addition to your owner occupied home?
   Yes (please complete questions 9 - 16 and attach evidence of mortgage) ☐ — No (please proceed to the declaration and consent) ☐
9. Type of residence
   Holiday Home ☐ — Residential Investment/Residential Rental Property ☐ — Other (please specify) ☐
10. If the property is a holiday home, what percentage of each year is the home rented out?
    (if more than 25% - what is the approximate annual gross income from rents received?)
11. How may home loan(s) (mortgages) do you have for this property?
12. What is the total monthly repayment amount (the sum of all mortgage repayments) on this property? $
13. What is the total loan amount (sum of all mortgages) on this property? $
14. If the property is a Residential Investment/Residential Rental Property what is the approximate annual gross income from rents received? $
15. What is the total monthly repayment amount (the sum of all mortgage repayments) on this property? $
16. What is the total loan amount (sum of all mortgages) on this property? $

Section H2

Complete this section if you are applying for Mortgage Cover based on your rental payments. You will need to provide a signed copy of your tenancy agreement or a letter from the letting agent or private landlord stating your rental obligations.

1. What is the total amount of rent payable on your property? Amount $ Frequency
2. What amount are you responsible for? Amount $ Frequency

Declaration and consent

Please read the summary of your duty of disclosure and the consequences of non-disclosure at the front of this application form carefully.

If we need more information, by signing this declaration and consent you give us your consent to request your personal information from other people. This enables us to get any other information that is necessary. Sometimes we might not get this information until you make a claim.

By signing on the next page, you agree to be bound by the policy wordings that govern the insurance you're applying for. You can get a copy of the policy wordings from us at any time. You also agree and confirm that:

1. You have read and understood the duty of disclosure summary on this application form and you have checked all the information in this application (including any supplementary application forms and information completed by someone else) and it is true, correct and complete and no material information has been left out.
2. You will tell us immediately if, between the date of this application and the date we issue your policy or cover, any of the following changes for a life assured (or any children to be covered under this application):
   - **a.** mental or physical health
   - **b.** occupation
   - **c.** financial circumstances.
3. Your application (and basis of your contract with us) is made up of:
   - **a.** all statements made in this application (including any supplementary application forms and the illustration(s) submitted with your application)
   - **b.** any additional information forwarded to us on your behalf, including:
     - **i.** application forms for insurance with other companies
     - **ii.** any statement made to any medical practitioner
     - **iii.** any statement made by any medical practitioner on your behalf.

Acceptance and Commencement of Cover

4. You acknowledge that:
   - **a.** your insurance won't start until we have accepted your application and received either payment of the initial premium, your completed direct debit authority form, or submission of your credit/debit card details via our secure payment portal
   - **b.** we may offer cover on non-standard terms (such as specific exclusions, additional premium or conditions) after assessing your application and, if so, you authorise your adviser to accept such terms on your behalf.

Your personal information

5. You authorise us, our related companies, reinsurers and your adviser to use your personal information, whether provided by you or someone else and including your full medical history, for any of the following purposes:
   - **a.** managing, administering and/or processing the proposed offer of insurance including any alteration to your cover
   - **b.** maintaining, managing, administering and enforcing any resulting insurance including any alteration to your cover
   - **c.** letting you know about other products and services
   - **d.** undertaking market research and/or statistical analysis
   - **e.** comparing information about you with publicly available information or information held by government agencies or other companies or organisations that we have a continuing relationship with
   - **f.** complying with any policy, legal and/or regulatory requirements.
6. You consent to our disclosure of your personal information (whether provided by you or someone else) for any of the purposes stated in paragraph 5 to: any other life assured and/or policy owner under any insurance resulting from this application, our related companies, reinsurers, your adviser, agents, credit agencies, government agencies, any company or organisation that we have a continuing relationship with, third party service providers or any other person, company or organisation that we may use. You consent to any such credit agency including your personal information on their agency databases and disclosing it to their clients.
7. You authorise us to request, and be given, your personal information for any purpose stated in paragraph 5 from any of the following:
   - **a.** any and all health treatment providers
   - **b.** any and all medical information providers
   - **c.** insurers
   - **d.** Accident Compensation Corporation
   - **e.** employers (whether current or not)
   - **f.** government agencies, organisations and enterprises
   - **g.** accountants and other financial advisers
   - **h.** banks and other financial institutions
   - **i.** any credit rating agencies

   and you authorise the persons and organisations listed in paragraph 7a. to i. above to disclose your personal information to us for those purposes.
8. You authorise your adviser named on this application form to receive and access your personal information including financial, medical and other matters, whether contained in this application form or obtained from third parties (e.g. doctors, accountants) for any of the purposes stated in paragraph 5.
9. You will notify us when there is a change to any authority regarding your personal information under paragraphs 5 to 8 of this declaration and consent, and if your adviser changes.
10. You understand that all personal information we hold about you is your information. You have the right to access that information, and ask us to correct it if it's wrong.

Replacement insurance policy

11. You consent and give authority to us to cancel any Chubb Life covers and/or Chubb Life policies noted for discontinuance or replacement in this application form immediately when any insurance under this application form is issued.

General

12. A photocopy of this application can be treated as being as valid as an original.
13. If acting:
    - **a.** on behalf of a company or a trust, you confirm you have the capacity and authority to act on its behalf
    - **b.** as a guardian on behalf of a minor, you confirm you consent to this application and that you have consulted with all other guardians of the minor.

Our Financial Strength Rating

14. Chubb Life Insurance New Zealand Limited has an **A (Excellent)** financial strength rating given by A.M. Best Company Inc.

    The rating scale is: A++, A+ Superior | **A**, A- Excellent | B++, B+ Good | B, B- Fair | C++, C+ Marginal | C, C- Weak | D Poor | E Under Regulatory Supervision | F In Liquidation | S Suspended. For more rating information visit www.ambest.com/ratings/guide.pdf

Name of life to be assured (please print)

Today's Date DD / MM / YYYY

Signature of life to be assured ✗

Name(s) of policy owner(s) (please print)

Today's Date DD / MM / YYYY

Signature(s) of policy owner(s) ✗

If the policy owner is a company, partnership, incorporated society or club, the authorised signatory(s) who signs on behalf of the entity must be identified below.

I/We acknowledge that we are signing on behalf of the policy owner and that I/we have authorisation to do so.

Name(s) of authorised signatory (signatories)

Today's Date DD / MM / YYYY

Signature(s) of authorised signatory (signatories) ✗

Name(s) of authorised signatory (signatories)

Today's Date DD / MM / YYYY

Signature(s) of authorised signatory (signatories) ✗

Parent/Guardian consent where life 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 this application are true and complete to the best of my knowledge.

Relationship Parent ☐ Guardian ☐

Name of parent or guardian of the life to be assured

Today's Date DD / MM / YYYY

Signature of parent or guardian of the life to be assured ✗

CHUBB®

Direct debit authority

Please email to Getintouch.NZ@chubb.com or send to Chubb Life, Private Bag 92131, Victoria Street West, Auckland 1142.

Bank Instructions

Name of account

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

Bank account from which payments are made
(Please attach an encoded deposit slip to ensure your number is loaded correctly)

Bank | Branch | Account number | Suffix

Authorisation code 0 1 0 8 7 0 4

To: The Bank Manager

Bank

Branch

Town/City

I authorise you to debit my account with the amounts of direct debit instructions received from Chubb Life Insurance New Zealand Limited with the authorisation code specified on this authority and in accordance with this authority until further notice from me. I agree that this authority is subject to:

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

Policy details

Name of policy owner(s)

Policy number(s) for which this authority applies

Payment frequency

Use existing payment date and frequency ☐

OR

Preferred date of first payment

Day | Month | Year

Weekly ☐ Fortnightly ☐ Monthly ☐ Half-yearly ☐ Annually ☐

Information to appear on my/our bank statement:

CHUBB LIFE

Signature ✗

Date

Day | Month | Year

Conditions of this authority

1. Chubb Life is required to give written notice of the amount and date of each direct debit in a series no less than 10 calendar days before the date of the first direct debit in the series. The notice is to include the dates of the debits and the amount of each direct debit.
2. If Chubb Life proposes to change an amount or date of a direct debit specified on the notice, Chubb Life is required to give you written notice:
   - no less than 30 calendar days before the change, or
   - if the initiator's bank agrees, no less than 10 calendar days before the change.
3. 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 Chubb Life, or
   - I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.
4. If the bank dishonours a direct debit but Chubb Life sends the direct debit again within 5 business days of the dishonour, Chubb Life is not required to give you a second notice of the amount and date of the direct debit.
5. All notices must be in writing, but can be delivered electronically, if I have agreed that with Chubb Life.

PLEASE ATTACH DEPOSIT SLIP

Approved

0870 | 01/23

For Bank use only Original – retain at branch

Date received:	Checked by:	Recorded by:

Bank Stamp

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Section I - Questionnaires

Questionnaire A - Respiratory Condition

A1. What is the name of the condition?

Asthma ☐ Bronchitis/chest infection ☐ Chronic obstructive lung disease ☐
Pneumonia ☐ Sleep apnoea ☐ Persistent cough ☐

Other chest/lung/breathing problem, if so please state

A2. When did you first experience any signs or symptoms of this condition?

In childhood, before age 12 ☐ As an adult ☐

A3. How frequent are your symptoms?

Daily ☐ Weekly ☐ Occasionally ☐
One off Episode ☐ Childhood only ☐

A4. How severe are your symptoms?

Nil symptoms, childhood only, or one off event ☐ Mild, e.g. Exercise induced only ☐
Seasonal (related to hay fever, allergy, colds or flu) ☐ Moderate, all year round, no specific triggers ☐
Severe, reduced lung capacity, restriction of lifestyle or work duties ☐

A5. How much time have you had off work, school, university or polytechnic for this condition in the last 5 years?

None ☐ I am currently off work ☐ 1 week or less ☐
2-4 weeks ☐ 1-3 months ☐ More than 3 months ☐

A6. How long ago did you last go to hospital or have emergency treatment for your condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ Never ☐

A7. Have you, over the last three years, required (select all that apply)?

Inhalers, e.g. Ventolin ☐ Nebuliser ☐ Oral steroids e.g. Prednisone ☐
Mouth Splint ☐ CPAP Machine ☐ None of the above ☐

If you selected Inhalers, please advise the type

Frequency of use Daily ☐ Weekly ☐ Monthly ☐
One off course due to illness ☐ Other (please provide details) ☐

If you selected Oral steroids, please advise how many times you have been prescribed these in the last 3 years?
Frequency of use

Once ☐ Twice ☐ Three or more ☐

If you selected Nebuliser, please advise how many times you have been prescribed these in the last 3 years?
Frequency of use

Once ☐ Twice ☐ Three or more ☐

Questionnaire B – Blood Pressure/Cholesterol

B1. What is the name of the condition?

High blood pressure (hypertension) – start at B2 ☐ High cholesterol – go to question B7 ☐ Both ☐

High Blood Pressure

B2. When was this condition first diagnosed?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

B3. Have you ever taken medication for high blood pressure? Yes ☐ No ☐

If **yes**, then are you still taking this medication? Yes ☐ No ☐

If you are no longer taking the medication, please advise the date and reason you stopped taking the medication

B4. Have you been referred to a specialist for treatment or investigations? Yes ☐ No ☐

If **yes**, then please advise

Name of Doctor/Medical Facility

Date last consulted DD / MM / YYYY

Tests performed

B5. When was your last blood pressure reading taken?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ I don't know ☐

B6. What was your blood pressure reading at that time?

High Cholesterol

B7. When was this condition first diagnosed?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ I don't know ☐

B8. Have you ever taken medication for high cholesterol? Yes ☐ No ☐

If **yes**, then are you still taking this medication? Yes ☐ No ☐

If you are no longer taking the medication, please advise the date and reason you stopped taking the medication

B9. Have you been referred to a specialist for treatment or investigations? Yes ☐ No ☐

If **yes**, then please advise

Name of Doctor/Medical Facility

Date last consulted DD / MM / YYYY

Tests performed

B10. When was your last cholesterol test?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ I don't know ☐

B11. What was your cholesterol reading at that time?

Questionnaire C – Heart Complaint

C1. Please describe the condition, illness, disability or symptoms

C2. What investigations have you had for this condition?

Investigations

Results

C3. When did you first experience signs or symptoms of this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ I don't know ☐

C4. How often have you experienced this condition?

Once ☐ Twice ☐ Three or more times ☐

C5. When did you last experience signs or symptoms of this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ I don't know ☐

C6. What treatment have you had for this condition?

C7. How much time have you had off work, school, university or polytechnic for this condition in the last 5 years?

None ☐ I am currently off work ☐ 1 week or less ☐
2-4 weeks ☐ 1-3 months ☐ More than 3 months ☐

C8. Have you been referred to a specialist for treatment or investigations? Yes ☐ No ☐

If **yes**, then please advise

Name of Doctor/Medical Facility

Date last consulted DD / MM / YYYY

Tests performed

Questionnaire D – Diabetes/Impaired Glucose Tolerance

D1. What is the name of the condition?

Type 1 diabetes ☐ Type 2 diabetes ☐ Impaired glucose tolerance ☐
Gestational diabetes ☐ Elevated blood sugar ☐

Other (please specify)

D2. When were you first diagnosed with this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

D3. How do you control your condition?

Insulin ☐ Diet ☐
Oral medications ☐ Not applicable ☐

D4. If you are taking oral medication for your condition, please advise the name of the medication(s)

D5. Are you still taking this medication? Yes ☐ No ☐

If you are no longer taking the medication, please advise the date and reason you stopped taking the medication

D6. Have you ever had any complications of diabetes such as insulin reactions, diabetic coma, heart, kidney, or eye problems, peripheral vascular disease or protein in your urine? Yes ☐ No ☐

If **yes**, please provide further details.

D7. When did you last have your glucose levels (HbA1c) checked?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐ I don't know ☐

D8. Result of your last HbA1c test?

53 mmol/mol (7.0%) or less ☐ 54-68 mmol/mol (7.1% - 8.4%) ☐
69 mmol/mol (8.5%) and over ☐ I don't know ☐

Questionnaire E – Mental Health

E1. Please select any conditions that you have experienced, sought medical advice or treatment for, been prescribed any medication or treatment for, or received any counselling for:

- Depression or low mood ☐
- Anxiety disorder ☐
- Panic disorder ☐
- Phobia or fears ☐
- Hyperventilation ☐
- Fatigue or chronic tiredness ☐
- Sleeplessness or Insomnia ☐
- Stress ☐
- Obsessive compulsive disorder ☐
- Bi-Polar disorder (manic depression) ☐
- Schizophrenia ☐
- Post traumatic stress disorder ☐
- Psychosis ☐
- Alcohol or other substance abuse or addiction ☐
- Eating disorders including anorexia or bulimia ☐

E2. When did you first experience any signs or symptoms of any of the above conditions?

- More than 10 years ago ☐
- 6-10 years ago ☐
- 2-5 years ago ☐
- 6 months – 2 years ago ☐
- Less than 6 months ago ☐

E3. When did you last experience any signs or symptoms of any of the above conditions?

- More than 10 years ago ☐
- 6-10 years ago ☐
- 2-5 years ago ☐
- 6 months – 2 years ago ☐
- Less than 6 months ago ☐

E4. Have you experienced any of these conditions more than once? Yes ☐ No ☐

If **yes**, please provide further details

E5. Have you ever been recommended, prescribed or received treatment for any of these conditions e.g. medication or counselling? Yes ☐ No ☐

Please advise the type of treatment and the start and end dates

Medication (please specify names and dosage of medications)

Counselling	Start Date	DD / MM / YYYY	End Date	DD / MM / YYYY
Electro Convulsive Therapy	Start Date	DD / MM / YYYY	End Date	DD / MM / YYYY
Other (please specify)	Start Date	DD / MM / YYYY	End Date	DD / MM / YYYY

E6. Has this condition ever led you to intentionally or unintentionally harm yourself or have suicidal thoughts? If **yes**, please provide further details Yes ☐ No ☐

E7. How much time have you had off work, school, university or polytechnic for this condition (including any recurrences)?

- None ☐
- I am currently off work ☐
- 1 week or less ☐
- 2-4 weeks ☐
- 1-3 months ☐
- More than 3 months ☐

E8. Have you ever consulted a Psychiatrist or a Psychologist for this condition? Yes ☐ No ☐

If **yes**, then please advise

Name of Doctor/Medical Facility

Date last consulted DD / MM / YYYY

E9. Have you ever been hospitalised or admitted to a care facility due to this condition? (including attending Accident and Emergency). If **yes**, please provide further details Yes ☐ No ☐

Questionnaire F – Musculoskeletal – Condition 1

Please complete a separate questionnaire for each body part

F1. Which area of your body was affected?

Shoulder ☐ Elbow ☐ Hand ☐
Wrist ☐ Hip ☐ Knee ☐
Ankle ☐ Lower Back ☐ Middle Back ☐
Upper Back/Neck ☐ Neck ☐ More than one part of my back/neck ☐

F2. Which side of your body was affected? Left ☐ Right ☐

F3. What is the name of the condition?

F4. Cause of your symptoms? Illness ☐ Injury ☐

F5. When did you first experience any signs or symptoms of, or receive any advice or treatment for this condition/pain/discomfort/injury?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

F6. Have you had surgery for your condition? Yes ☐ No ☐

F7. How much time have you had off work, school, university or polytechnic for this condition (including any recurrences)?

Years ☐ Months ☐ Days ☐

F8. How often have you experienced this condition?

Once ☐ Twice ☐ Three or more times ☐

F9. Do you still experience symptoms or have any ongoing effects, pain, limitation of movement or restrictions of any kind as a result of this condition or are your duties or activities limited/affected by this condition? Yes ☐ No ☐

If **yes**, please provide further details

F10. When did you last experience any signs or symptoms of, or receive any advice or treatment for this condition/pain/discomfort/injury?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

Questionnaire F – Musculoskeletal – Condition 2

Please complete a separate questionnaire for each body part

F1. Which area of your body was affected?

Shoulder ☐ Elbow ☐ Hand ☐
Wrist ☐ Hip ☐ Knee ☐
Ankle ☐ Lower Back ☐ Middle Back ☐
Upper Back/Neck ☐ Neck ☐ More than one part of my back/neck ☐

F2. Which side of your body was affected? Left ☐ Right ☐

F3. What is the name of the condition?

F4. Cause of your symptoms? Illness ☐ Injury ☐

F5. When did you first experience any signs or symptoms of, or receive any advice or treatment for this condition/pain/discomfort/injury?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

F6. Have you had surgery for your condition? Yes ☐ No ☐

F7. How much time have you had off work, school, university or polytechnic for this condition (including any recurrences)?

Years ☐ Months ☐ Days ☐

F8. How often have you experienced this condition?

Once ☐ Twice ☐ Three or more times ☐

F9. Do you still experience symptoms or have any ongoing effects, pain, limitation of movement or restrictions of any kind as a result of this condition or are your duties or activities limited/affected by this condition? Yes ☐ No ☐

If **yes**, please provide further details

F10. When did you last experience any signs or symptoms of, or receive any advice or treatment for this condition/pain/discomfort/injury?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

Questionnaire G – Females Only

G1. Which area of your body was affected? Please select all which apply:

Abnormal Cervical Smear (G2 to G9) ☐ Breast Ultrasound (G10 to G18) ☐ Mammogram (G10 to G18) ☐
Cervix – Other (G10 to G18) ☐ Ovary (G10 to G18) ☐ Breast – Other (G10 to G18) ☐
Endometrium (G10 to G18) ☐

Abnormal Cervical Smear

G2. When was your last abnormal smear?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

G3. What were the results of that smear?

CIN 1 ☐ CIN 2 ☐ CIN 3 ☐ Cervical cancer ☐ Don't know ☐ Other (please provide details) ☐

G4. What was your HPV result?

HPV negative ☐ HPV positive – Low Risk Strain ☐ HPV positive – High Risk Strain ☐
Don't know ☐ Other (please provide details) ☐

G5. Were you referred for a Colposcopy or any other treatment or investigations? If **yes**, then Yes ☐ No ☐

G6. What investigations or treatment did you have?

G7. What were the results?

G8. Have further investigations or treatment been planned? If **yes**, please provide further details Yes ☐ No ☐

G9. Dates and results of your last 2 smear tests:

Date DD / MM / YYYY Result
Date DD / MM / YYYY Result

All other conditions

G10. Please describe the condition, illness or symptoms:

G11. When did you first experience any signs or symptoms of this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

G12. Please describe the frequency of symptoms?

Daily ☐ Weekly ☐ Monthly ☐ Annually ☐ One-off episode ☐

G13. What investigations have you had for this condition?

G14. What were the results of the investigations?

G15. Have you had any treatment? If **yes**, please advise the Yes ☐ No ☐

Type of treatment
Date of treatment DD / MM / YYYY

G16. Has further treatment, investigations or referrals been recommended? Yes ☐ No ☐

G17. Have you completely recovered? If **no**, please provide further details Yes ☐ No ☐

G18. When did you last experience any signs or symptoms of, or receive any advice or treatment for this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

Questionnaire H – General – Condition 1

H1. Please describe the condition, illness, disability or symptoms

H2. What investigations have you had for this condition?

Investigations

Results

H3. When did you first experience signs or symptoms of this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

H4. How often have you experienced this condition?

Once ☐ Twice ☐ Three or more times ☐

H5. When did you last experience signs or symptoms of this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

H6. What treatment have you had for this condition?

H7. How much time have you had off work, school, university or polytechnic for this condition in the last 5 years?

None ☐ I am currently off work ☐ 1 week or less ☐
2-4 weeks ☐ 1-3 months ☐ More than 3 months ☐

H8. Have you been referred to a specialist for treatment or investigations? If **yes**, then please advise Yes ☐ No ☐

Name of Doctor/Medical Facility Date of treatment DD / MM / YYYY

Tests performed

Questionnaire H – General – Condition 2

H1. Please describe the condition, illness, disability or symptoms

H2. What investigations have you had for this condition?

Investigations

Results

H3. When did you first experience signs or symptoms of this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

H4. How often have you experienced this condition?

Once ☐ Twice ☐ Three or more times ☐

H5. When did you last experience signs or symptoms of this condition?

More than 10 years ago ☐ 6-10 years ago ☐ 2-5 years ago ☐
6 months – 2 years ago ☐ Less than 6 months ago ☐

H6. What treatment have you had for this condition?

H7. How much time have you had off work, school, university or polytechnic for this condition in the last 5 years?

None ☐ I am currently off work ☐ 1 week or less ☐
2-4 weeks ☐ 1-3 months ☐ More than 3 months ☐

H8. Have you been referred to a specialist for treatment or investigations? If **yes**, then please advise Yes ☐ No ☐

Name of Doctor/Medical Facility Date of treatment DD / MM / YYYY

Tests performed

Questionnaire I - Pastimes

I1. What pastimes do you participate in? (select all that apply)

Aviation, other than as a fare-paying passenger (Please complete I2) ☐
Scuba Diving or Free Diving (Please complete I3) ☐
Hunting (Please complete I4) ☐
Motocross, Motorcycle Racing, Motor Racing (Please complete I5) ☐

For the below pastimes, please complete I6

Mountaineering ☐ Parachuting/Skydiving ☐ Gliding/Hang Gliding ☐
Surf Lifesaving ☐ Equestrian ☐ Boxing/Martial Arts ☐
Caving/Canyoning ☐ Powerboat Racing ☐ Other ☐

I2. Aviation

A. Do you hold a Civil Aviation Safety Authority (CAA) Licence Yes ☐ No ☐
If **yes**, please provide the following details

B. Type of Licence

C. Period held: Less than 12 months ☐ 12 months to 2 years ☐ 2 years or more ☐

D. Do you intend to change the scope of your present licence? If **yes**, please provide further details Yes ☐ No ☐

E. Have you ever had an accident or been charged with violating CAA regulations? Yes ☐ No ☐
If **yes**, please provide further details

F. Do you always use authorised landing areas? If **no**, please provide further details Yes ☐ No ☐

G. Please advise the number of hours flown in the last 12 months (select all that apply).

Type of Flying	Hours as Crew	Hours as Passenger
Commercial		
Charter		
Private		
Aeroclub/Flying school		
Agriculture		
Helicopter		
Ultralight		

H. Please advise the number of hours you intend to fly per annum on average in future (select all that apply).

Type of Flying	Hours as Crew	Hours as Passenger
Commercial		
Charter		
Private		
Aeroclub/Flying school		
Agriculture		
Helicopter		
Ultralight		

I. Do you intend to engage in any form of aviation other than the above categories? Yes ☐ No ☐
If **yes**, please provide further details

I3. Diving

A. What type of diving do you participate in? Scuba ☐ Freediving ☐ Other (please specify) ☐

B. Average Depth 40m or less ☐ 41-59m ☐ 60+ metres ☐

C. Maximum Depth 40m or less ☐ 41-59m ☐ 60+ metres ☐

D. How many dives do you take each year?

E. Do you use explosives, dive in wrecks, caves or potholes or dive alone? Yes ☐ No ☐
If **yes**, please provide further details

F. What qualifications do you hold?

G. On what basis do you participate in this activity? Recreational ☐ Amateur ☐ Professional ☐

I4. Hunting

A. How many times do you hunt per year?

B. Do you hunt outside the territorial boundaries of New Zealand? Yes ☐ No ☐

C. Are you involved in aviation as part of your hunting activities?

Yes – hunting from a helicopter or plane ☐ Yes – but only ever as transport to and from the site ☐ No ☐

D. On what basis do you participate in this activity? Recreational ☐ Professional ☐

I5. Motor Racing

A. Vehicle type?

B. Engine size?

C. Races per annum?

D. Maximum speed?

E. Class you participate in?

F. On what basis do you participate in this activity? Recreational ☐ Amateur ☐ Professional ☐

I6. All Other Pastimes

A. What is the name of the activity?

B. How many times do you participate per year?

C. On what basis do you participate in this activity? Recreational ☐ Amateur ☐ Professional ☐

A. What is the name of the activity?

B. How many times do you participate per year?

C. On what basis do you participate in this activity? Recreational ☐ Amateur ☐ Professional ☐

Interim Cover

Thanks for choosing Chubb Life to be your insurer. Your application is currently being assessed by our underwriting team.

We'll provide you with free Interim Cover while your application is being assessed.

We're pleased to offer you interim cover while we assess your application and get your policy in place. This interim cover is a limited insurance policy which provides cover for up to 90 days to protect you and your loved ones in the event the worst was to happen while we consider your application.

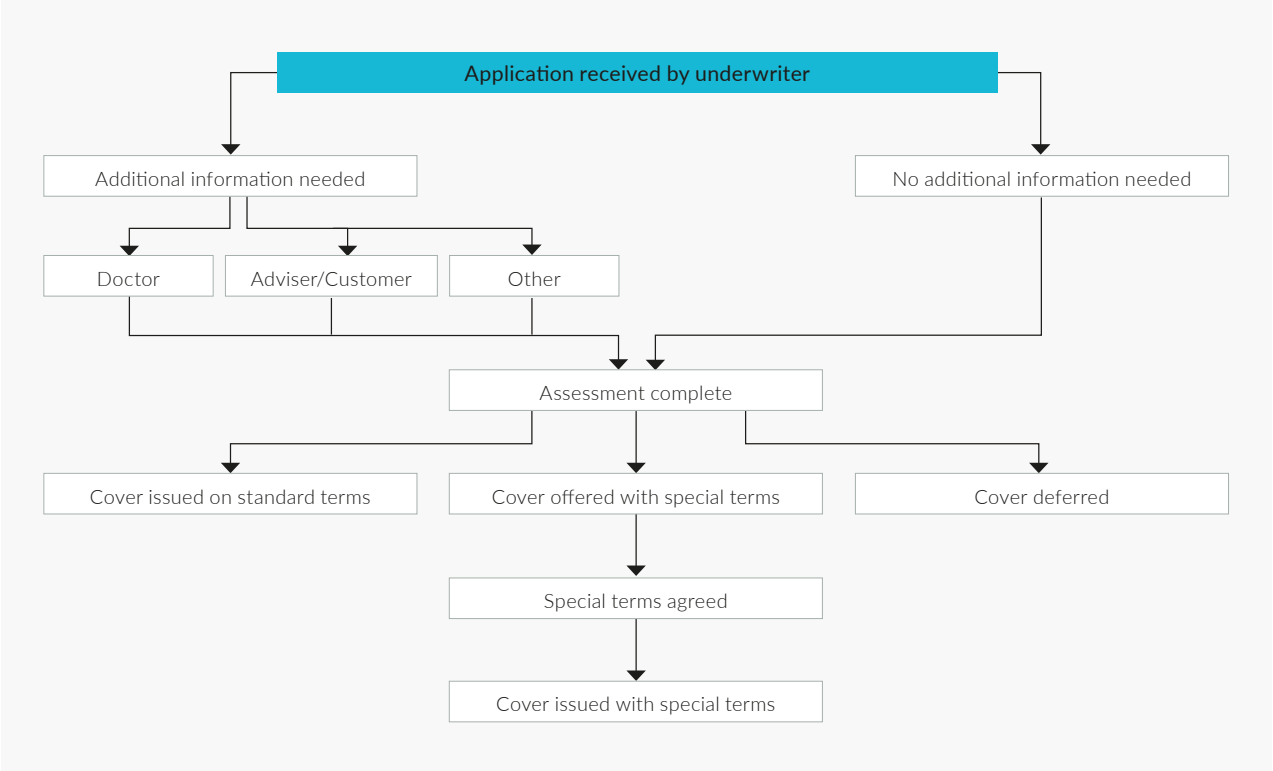
Please note that eligibility for interim cover is dependent upon the life assured and the policy owner(s) providing complete and truthful answers in the application for insurance and complying with the duty of disclosure, and other eligibility criteria. The duty of disclosure continues until your policy or cover has been issued.

For full eligibility criteria, limits, exclusions and full terms and conditions see the Certificate of Interim Cover on the following pages.

What happens next?

An underwriter will review your application form. It's the underwriter's job to review the answers you provided on this application form to make sure that you've been charged the correct premium and that you qualify for the cover you're applying for. Sometimes we need to clarify something we've been told on an application form, and in these instances we'll make a request for additional information.

Below is the route we'll follow to get your cover in place as quickly as possible.



What are 'standard terms'?

This is when we've assessed an application for cover and have accepted it without any special terms. Your premium will match what we quoted for your policy and there will be no changes to your terms of cover.

What are 'special terms'?

In some cases, we can't offer cover on standard terms so we would look to offer 'special terms'. This may result in an additional premium or we may place one or more exclusions or endorsements on your policy due to risk factors, so you wouldn't be able to claim anything for those specific things (like a medical condition or a pastime).

What does 'cover deferred' mean?

Occasionally we're unable to offer cover due to the uncertainty surrounding an applicant's current situation (their risk profile or any pending medical tests, for instance). In this case, we would defer our final decision for a period of time, until results are available or the applicant's health improves, and invite the applicant to re-apply if their situation improves.

If you have any questions, please don't hesitate to contact your adviser or call us on 0508 464 999.

Chubb Life Certificate of Interim Cover

This insurance is a contract between the policy owner(s) noted on the application for the policy being applied for ("policy owner(s)", "you", "your") and Chubb Life Insurance New Zealand Limited ("Chubb Life", "we", "us", "our"). References to the "life assured" are to the life assured or life insured named on the application by the policy owner(s) ("Application").

Eligibility for Interim Cover

To be eligible for cover under this Certificate of Interim Cover all of the following must apply:

- we must have received your completed Application for cover under a new eligible insurance policy and this certificate has been issued to you. Applications for increases or other changes to existing policies are not eligible.
- you and the life assured must have provided complete and truthful answers in the Application and comply with the duty of disclosure. The duty of disclosure continues until your policy has been issued.
- we need to have received either payment of the initial premium, your completed direct debit authority form, or submission of your credit/debit card details via our secure payment portal at the date we receive your completed Application.

Period of Interim Cover

This cover starts on the date we receive your completed Application.

This cover ends without prior notice at the earliest of:

- the policy commencement date of the policy applied for
- 90 days from the date we receive your completed Application
- the date you advise us that you wish to cancel or withdraw your Application
- the date we advise you that your Application has been deferred or that we're unable to offer you the policy you applied for.

What's covered?

If your Application includes cover for the life assured under a Qualifying Cover in the table below, this certificate provides cover under the applicable Benefit included in that Qualifying Cover for the associated Claimable Events. If your Application doesn't include a Qualifying Cover below you aren't covered under this certificate for the Claimable Events associated with that Qualifying Cover.

Qualifying Cover	Benefit	Claimable Events *	Maximum benefit amount
Life Cover, Life Income Cover	Life Cover Benefit	Death of the life assured solely and directly as a result of: › an injury caused by an accident; or › illness.	$500,000
Critical Illness Cover / Trauma Cover	Full Critical Illness Benefit / Full Trauma Benefit	The life assured meeting the Full Critical Illness Benefit / Full Trauma Benefit criteria for one of the conditions listed below ** solely and directly as a result of an injury caused by an accident	$200,000
Complete Disablement Cover	Complete Disablement Benefit	Complete disability of the life assured solely and directly as a result of an injury caused by an accident.	$200,000
Expenses Cover Income Cover (Agreed Value, Loss of Earnings, Indemnity) Mortgage Repayment Cover Monthly Disability Cover Start-up Monthly Disability Cover	Disability Benefit / Total Disability Benefit	Total disability of the life assured solely and directly as a result of an injury caused by an accident.	$2,500 per month (24-month maximum payment period)

* To be covered for a Claimable Event all of the following must occur for the first time within the period of this interim cover:

(a) the accident and injury, or the illness; and

(b) the death of the life assured, or the life assured meeting the criteria for the critical illness / trauma condition, complete disability, or total disability (as appropriate).

** Critical Illness Cover / Trauma Cover conditions covered are: hemiplegia, diplegia, paraplegia, quadriplegia, tetraplegia, major head trauma, coma, intensive care, loss of speech, major burns, loss of hearing, loss of independent existence, loss of two limbs, combined loss of limb and sight, and blindness. See the applicable policy wording for full definitions and criteria.

What terms apply?

The terms, conditions, criteria, exclusions and definitions in the policy wording for the policy applied for will apply in addition to those stated in this certificate. Policy wordings are available from us on request or from your financial adviser.

You and the life assured must meet all applicable terms, conditions and criteria under both this certificate and the policy wording for the policy being applied for to be eligible to claim under this certificate of interim cover.

How much we'll pay

The amount we'll pay under this certificate of interim cover is the lesser of:

- the amount payable for that Benefit under the policy applied for based on the sum insured proposed in the Application, and
- the maximum benefit amount in the table above.

For Claimable Events under Life Income Cover we may at our discretion pay a present value lump sum instead of monthly payments as proposed on the Application.

The maximum period of time that we'll pay a Disability Benefit or Total Disability Benefit for under this certificate of interim cover is 24 months. If your Application for the Qualifying Cover that includes the Disability Benefit or Total Disability Benefit is for a payment term of less than 24 months, the maximum payment period under this interim cover will be the same as the payment term you applied for.

Where the life to be assured can claim total disability under more than one cover, then Chubb Life will pay up to a maximum of $2,500 per month.

If you're eligible to claim under more than one Benefit under this certificate of interim cover, the maximum amount payable across all Benefits is $500,000.

We only pay once

If the life assured is covered with us under more than one certificate of interim cover, then we'll only pay cover under one of those certificates, and at our discretion.

For covers being replaced

If the policy you're applying for is intended to replace an existing policy with us or another insurer, any amount payable under this certificate will be reduced by the amount payable under that existing policy for the same Claimable Event.

Who we'll pay

All claims under this certificate of interim cover will be payable to the policy owner(s).

When we won't pay

We won't pay a Benefit under this certificate of interim cover (excluding death solely and directly as a result of an injury caused by an accident) if, in our opinion, we would have deferred or declined your application for the Qualifying Cover, or if we would have issued it on special terms (for example, with additional premiums, exclusions or other modified terms) for medical, financial or occupational reasons. However, if we would have issued the Qualifying Cover with exclusions only (that is, without additional premiums or other modified terms), we'll consider a claim for a Benefit subject to those exclusions.

We also won't pay a Benefit under this interim cover if the Claimable Event occurs as a direct or indirect result of any of the following:

- an illness (unless it results in death)
- any illness or injury, or signs or symptoms of any illness or injury, which occurred before the date that we receive your Application
- the life assured deliberately taking or using non-prescribed drugs, other than for proper therapeutic or medical purpose and in accordance with the manufacturers' directions for use, or the deliberate misuse by the life assured of prescribed drugs
- flying in an aircraft (except as a fare-paying passenger or ticketholding passenger on a regular airline or established charter service, or as a commercial pilot who would have been assessed by Chubb Life at standard rates without the terms of acceptance modified)
- scuba-diving, parachuting, skydiving, bungy jumping, hang-gliding, mountaineering or rock climbing, or any participation or practice in any form of racing (except on foot)
- intentional self-injury or suicide, whether sane or insane
- participation in any criminal act.

Assessment or reassessment of the policy applied for

If we receive a claim for or pay a Benefit under this interim cover before issuing the policy you applied for, we may assess or reassess your Application taking into account the information provided to us in relation to the Claimable Event. As a result, we may withdraw any offer of cover previously made, and we may defer or decline cover, or offer cover on 'special terms'.

If we've issued the policy you applied for and then become aware of a claim or potential claim under this interim cover, we may reassess the cover provided under the policy taking into account the information provided to us in relation to the claim. As a result we may avoid all or part of the policy, remove one or more covers or benefits, alter the terms on which cover is provided under the policy, and/or not pay any further claims under the policy directly or indirectly related to the same illness or injury.

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Notes

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