



# LIFE AND HEALTH

Application form

**Life. Take charge.**

[sovereign.co.nz](http://sovereign.co.nz)

SOVEREIGN

# Guide to completing this LIFE AND HEALTH Application

We understand that the questions we ask in this form may be sensitive, but it is very important that you give us all the information that may affect your application for insurance. If we find out at a later time that you have not disclosed all material information, your policy can be avoided altogether.

If you prefer, you can complete this form in private and post it directly to:  
Sovereign Assurance Company Limited, Private Bag Sovereign, Victoria Street West, Auckland 1142.

Please complete a separate Application for each Life to be Assured, using **BLOCK LETTERS**.

	Section 1-5	Section 6	Section 7	Section 8	Section 9	Section 10	Section 11
> Life	✓	✗	✓ If YES to any health question in Section 5	✓ If YES to question (i) in Section 5	✗	✗	✓
> Living Assurance - Early Cancer Upgrade	✓	✓ (optional Children's and Maternity Benefit only)	✓ If YES to any health question in Section 5	✓ If YES to question (i) in Section 5	✓ (optional TPD condition is added only)	✗	✓
> Progressive Care	✓	✓ (optional Children's and Maternity Benefit only)	✓ If YES to any health question in Section 5	✓ If YES to question (i) in Section 5	✓ (optional TPD condition is added only)	✗	✓
> Disability Income Protection - Retirement Protection benefit							
> Essential Disability Income Protection							
> Total Permanent Disablement							
> Mortgage and Income Protection							
> Redundancy	✓	✗	✓	✓ If YES to question (i) in Section 5	✓	✗	✓
> Start-Up Income Protection							
> Locum Cover							
> Business Overheads							
> Rural Continuity - Business Income Support							
> Waiver of Premium							
> Business Continuity	✓	✗	✓ If YES to any health question in Section 5	✓ If YES to question (i) in Section 5	✓	✓	✓
> Private Health Cover Private Health Plus	✓	✓ Children Only	✓ If YES to any health question in Section 5	✓ If YES to question (i) in Section 5	✓ (optional Waiver of Premium is added only)	✗	✓
> Specialist and Diagnostic Testing (TotalCareMax benefit only)	✓	✓ Children Only	✓ If YES to any health question in Section 5	✓ If YES to question (i) in Section 5	✗	✗	✓

Please indicate how you would like us to refer to this policy in future correspondence

(eg John's Protection Plan):

Would you like this policy to be grouped with another Sovereign policy for correspondence purposes?

YES  NO

If YES, please list policy numbers

(NB: Not all policies can be grouped. Contact the Operations Team for details)

Is this application part of a joint policy?

YES  NO

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

## 1 Life to be Assured

Mr/Mrs/Miss/Ms

Last name	First names
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Previous name (if changed)

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Mailing address

Street		
Suburb	Town/City	Postcode

Home address (if different)

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Contact details

Home phone ( )	Business phone ( )	Mobile ( )
Email		

Date of birth

Day / Month / Year	Place of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Occupation

	Industry
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Do you smoke, or have you been a smoker in the past 12 months?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, for how many years have you smoked?	_____ years
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If yes, please state the type and quantity smoked eg Cigarettes, Tobacco, Cigars.

Cigarettes (average per day)	Tobacco (average per day)	Cigars (average per day)
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We may need to contact you for more information about your application. Can we contact you directly?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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What is the preferred method of contact?

<input type="checkbox"/> Telephone	<input type="checkbox"/> Email	<input type="checkbox"/> Through my adviser
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## 2 Policy Owner(s)

If the policy is owned by a business, a company director should complete this section and provide his/her authorisation in SECTION 11

POLICY OWNER (1)

Mr/Mrs/Miss/Ms

<input type="checkbox"/> as above, <b>or</b>	Last name	First names
<b>or</b>	Company name	

Mailing address

Street		
Suburb	Town/City	Postcode

Home address (if different)

--

Contact details

Home phone ( )	Business phone ( )	Mobile ( )
Day / Month / Year	Email	

Date of birth

POLICY OWNER (2)

Mr/Mrs/Miss/Ms

<input type="checkbox"/> as above, <b>or</b>	Last name	First names
<b>or</b>	Company name	

Mailing address

Street		
Suburb	Town/City	Postcode

Home address (if different)

--

Contact details

Home phone ( )	Business phone ( )	Mobile ( )
Day / Month / Year	Email	

Date of birth

### 3 Payment Details

Premium amount  Deposit enclosed

Payment frequency  Weekly (direct debit only)  Fortnightly (direct debit/ credit card only)  Monthly  Annual

Payment method  Direct debit (please complete the attached Payment Authority)  
 Credit/Debit card (please complete the attached Payment Authority)  
 Annual cheque Please make cheques payable to Sovereign Services Limited. Cheques should be marked 'not transferable' or 'account payee only'  
 Use existing Sovereign payment details

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

### 4 Benefit Details Please attach Illustration setting out benefits applied for.

### 5 Personal Statement

Should you need more space to provide answers to any of the questions in this form, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

(a) Do you have, or are you currently applying for, any other Life, Income Protection, Trauma, Total Permanent Disablement or Health cover with Sovereign or any other company?  YES  NO  
 If YES, please give details below

Type of Insurance	Benefit Amount	New Cover		Existing Cover		Company
		Applied for	To remain in force	To be replaced*		
Life	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Total Permanent Disablement	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Disability Income	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mortgage and Income Protection	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Redundancy	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Retirement Protection Benefit	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Living Assurance	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Progressive Care	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	\$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist and Diagnostic Testing**	Excess level \$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	Excess level \$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Private Health Cover	Excess level \$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	Excess level \$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Private Health Plus	Excess level \$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
	Excess level \$ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\* If 'To be replaced' has been ticked, please complete the Replacement Policy Advice form at the back of this Application.  
 \*\* TotalCareMax only

#### IMPORTANT NOTES:

- › To assess your eligibility for the level of cover for which you are applying, Sovereign needs to know your level of existing cover and whether this cover is being replaced by the insurance you are applying for.
- › If this application for insurance is intended to replace the existing cover listed above, you must cancel that existing cover. If you do not cancel the existing cover listed above, any claim made by you to Sovereign for the insurance applied for and accepted may not be considered.

THIS SECTION MUST BE COMPLETED >

**5 Personal Statement (continued)**

(b) If you do not currently have any Life, Income Protection, Trauma, Total Permanent Disablement or Health cover with Sovereign, have you ever had any life, income protection, trauma or health cover with Sovereign?  YES  NO

(c) What is your height and weight?  cm/feet/inches  kg/stone/lb

(d) Has any insurance you currently have, or have applied for (eg Life, Income Protection), ever been declined, deferred or modified including any loadings or exclusions?  YES  NO  If YES, please give full details

(e) Have you ever claimed benefits from ACC/WINZ or an insurer due to sickness, injury or treatment for injury (eg physiotherapy)?  YES  NO  If YES, please give name of condition below, and give details in the **General Health Questionnaire** in SECTION 7

(f) i. Please indicate your New Zealand residency status  Citizen/Permanent resident  Work permit - Please enclose a copy  Long-term business visa and permit  Other

ii. How long have you resided in New Zealand?  /  Years/Months

(g) Do you intend to live, work or travel overseas within the next 12 months?  YES  NO  If YES, please tick purpose and give details below  Live  Work  Travel

Country  Start date  Duration

(h) Do you drink alcohol?  YES  NO  If YES, please give details below

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

(i) Do you participate, intend to participate, or in the last three years have you participated, in any hazardous occupation or pursuit (eg motor racing, aviation, martial arts, parachuting, scuba diving, or motor boat racing)?  YES  NO

If YES, please complete the **Hazardous Occupation or Pursuit Questionnaire** in SECTION 8

(j) i. **Family history**  
Please indicate whether, before the age of 60, a parent, sister or brother has suffered from one of the following conditions: (Please tick YES or NO, if YES please give details)

CONDITION	YES	NO	RELATIONSHIP TO YOU	AGE when diagnosed (if known)	Current AGE	If deceased, AGE at death
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cancer*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Polycystic kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Any hereditary or familial disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

ii. If you ticked one of the above conditions, and your family member is not deceased, please give details of his/her current state of health

\* For cancer please specify type

THIS SECTION MUST BE COMPLETED

**5 Personal Statement (continued)**

(k) Have you ever used any drug, not prescribed by a doctor, or received medical advice, counselling or treatment for the use of alcohol, drugs or gambling?

YES     NO   

(l) In the last five years, have you had any medical examinations by a doctor or specialist, tests (including blood tests) or X-rays?

YES     NO    If YES, please give details in the **General Health Questionnaire** in SECTION 7

(m) Have you had surgery or been in hospital before?

YES     NO    If YES, please give details in the **General Health Questionnaire** in SECTION 7

(n) Are you currently experiencing any health problems or are you receiving or considering seeking medical advice, counselling, tests, treatment or an operation from a health professional or awaiting any screening or tests results?

YES     NO    If YES, please give details in the **General Health Questionnaire** in SECTION 7

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

If YES, please complete the **General Health Questionnaire** in SECTION 7. If your symptom is underlined, please refer to the questionnaire specific to that condition.

Chest pain, heart complaint (eg heart murmur or irregular heart beat), high blood pressure or high cholesterol	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thyroid disease or disorder or any other glandular condition (eg hypothyroidism, Graves disease)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles or any other lesion</u>	<input type="checkbox"/> YES please complete <b>questionnaire i</b>	<input type="checkbox"/> NO
Skin disorder (ie a part of the skin that has an abnormal growth or appearance) or any other lesion	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Any disease or disorder of the gastrointestinal tract or bowel eg irritable bowel, Crohn's disease, ulcers, colitis, reflux etc.</u>	<input type="checkbox"/> YES please complete <b>questionnaire ii</b>	<input type="checkbox"/> NO
Obesity eg stomach stapling or liposuction	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Mental, nervous disorder, stress, depression, fatigue or phobia</u>	<input type="checkbox"/> YES please complete <b>questionnaire iii</b>	<input type="checkbox"/> NO
Blood disorders eg anaemia, varicose veins, blood clots, bleeding tendencies, leukaemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Kidney disease or disorder, prostate, bladder or urinary condition eg kidney stone, elevated prostate test, or urinary incontinence	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy, stroke or other neurological disorders eg motor neurone disease, multiple sclerosis, paralysis or seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Asthma</u> or lung complaint eg bronchitis, sleep apnoea, or breathing problems	<input type="checkbox"/> YES please complete <b>questionnaire iv</b>	<input type="checkbox"/> NO
<u>An injury, disease or disorder of your:</u> · muscle, or · joint, or · bone. eg arthritis, rheumatism, SLE, gout	<input type="checkbox"/> YES please complete <b>questionnaire v</b>	<input type="checkbox"/> NO
Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis, ear infections, hearing loss or blindness etc	<input type="checkbox"/> YES	<input type="checkbox"/> NO
AIDS or HIV antibodies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Liver disease or disorder eg fatty liver, hepatitis, abnormal liver function test result	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes or abnormal blood sugar level	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>FEMALES ONLY:</b> Disease or disorder of cervix, uterus, fallopian tube, ovary, vagina or vulva eg endometriosis etc.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other illness, injury or condition not already stated	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Health questions**

If you are applying for Health in conjunction with TotalCareMax or Start-Up Income Protection, please answer the following questions. If children are to be insured as part of your Health policy, please complete SECTION 6.

(p) Do you suffer from, or have you ever suffered from, or have you ever had treatment or surgery or medical tests or prescribed medication for, any of the following?

If YES, please complete the **General Health Questionnaire** in SECTION 7

Oral surgery or wisdom teeth problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence.	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Doctors' details**

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

**Medical professional and clinic**

Doctors name		Does this professional hold your records?	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Clinic name		Business phone ( )	
Clinic address		Business fax ( )	
Years attended		Last date you attended in the last 12 months	
Reason and outcome - please provide full details in the General Health Questionnaire in section 7			

**Medical professional and clinic**

Doctors name		Does this professional hold your records?	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Clinic name		Business phone ( )	
Clinic address		Business fax ( )	
Years attended		Last date you attended in the last 12 months	
Reason and outcome - please provide full details in the General Health Questionnaire in section 7			

**Medical professional and clinic**

Doctors name		Does this professional hold your records?	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
Clinic name		Business phone ( )	
Clinic address		Business fax ( )	
Years attended		Last date you attended in the last 12 months	
Reason and outcome - please provide full details in the General Health Questionnaire in section 7			

I/We understand that Sovereign may require my/our medical records from the last five years or longer, depending on the information I/we have disclosed

YES  NO

Your consent to Sovereign accessing these records is set out in Section 11 (n).

**HealthScreen**

(r) If we require that you undergo medical tests, would you use our HealthScreen® service?

YES  NO

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

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

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

**Telephone Underwriting**

(s) If we require further information to process your application quickly, can we use our Telephone Underwriting service?

YES  NO

Phone number ( )	Best time to call	am/pm
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Telephone Underwriting is a service that helps us process your Application quickly and simply. If we require further information, a Sovereign Telephone Underwriter will phone you at a time and place that is convenient for you. They may ask you questions about your health, your occupation or hazardous pursuits so we can process your Application. We use this additional information to assess the acceptance terms of your Application.

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

THIS SECTION MUST BE COMPLETED >

## 6 Children To Be Assured

Please complete this section if you are applying for **Private Health, Optional Children's & Maternity Benefit for Comprehensive Living Assurance or Progressive Care, or Specialist & Diagnostics Testing benefit**. Answers to all questions should be given by the parent or guardian on the basis that they relate to the child to be assured.

Child one

Last name		First names	
Date of birth	Day / Month / Year	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

Child two

Last name		First names	
Date of birth	Day / Month / Year	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

Child three

Last name		First names	
Date of birth	Day / Month / Year	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

Child four

Last name		First names	
Date of birth	Day / Month / Year	Place of birth	Male <input type="checkbox"/> Female <input type="checkbox"/>

### Children's personal statement

Please complete the following section 6 (a) to 6 (f) if you are applying for **Private Health and Specialist & Diagnostic Testing Benefit** only.

#### (a) Doctors' details

	Child one	Child two	Child three	Child four
i. Please give the name and mailing address of any doctors the child has consulted in the last five years				
ii. and the doctor holding the child's records				

#### (b) Does the child smoke, or have they been a smoker in the past 12 months?

	Child one	Child two	Child three	Child four
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type				
Average per day				

If YES, please state the type and quantity smoked (eg Cigarettes, tobacco or cigars)

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

	Child one	Child two	Child three	Child four
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If NO, please give details				

#### (d) Has the child had any medical examination or consultation, test, X-rays, treatment or surgery in the last five years, or is the child currently undergoing treatment, tests or observations or considering seeking advice, treatment or counselling for their health? (Disregard minor ailments such as colds or flu.)

	Child one	Child two	Child three	Child four
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If YES, please give details in the **General Health Questionnaire** in SECTION 7

THIS SECTION MUST BE COMPLETED



**6 Children To Be Assured (continued)**

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

If YES, please complete the **General Health Questionnaire** in SECTION 7.

If the child's symptom is underlined>, please refer to the questionnaire specific to that condition.

	Child 1	Child 2	Child 3	Child 4
Chest pain, heart complaint (eg heart murmur or irregular heart beat), high blood pressure or high cholesterol	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Thyroid disease or disorder or any other glandular condition eg hypothyroidism, Graves disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Cancer, abnormal cervical smear, tumour, cyst, breast lump, moles or any other lesion</u> If YES – please complete <b>questionnaire i</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Skin disorder (ie a part of the skin that has an abnormal growth or appearance) or any other lesion	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Any disease or disorder of the gastrointestinal tract or bowel eg irritable bowel, Crohn's disease, ulcers, colitis, reflux etc.</u> If YES – please complete <b>questionnaire ii</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Obesity eg stomach stapling or liposuction	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Mental, nervous disorder, stress, depression, fatigue or phobia</u> If YES – please complete <b>questionnaire iii</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood disorders eg anaemia, varicose veins, blood clots, bleeding tendencies, leukaemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney disease or disorders, prostate, bladder or urinary condition eg kidney stone, elevated prostate test, or urinary incontinence	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epilepsy, stroke or other neurological disorders eg motor neurone disease, multiple sclerosis, paralysis or seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Asthma or lung complaint eg bronchitis, sleep apnoea, or breathing problems</u> If YES – please complete <b>questionnaire iv</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>An injury, disease or disorder of your:</u> • muscle, or • joint, or • bone. <u>eg arthritis, rheumatism, SLE, gout.</u> If YES – please complete <b>questionnaire v</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Disease or disorder of the eyes, ears, nose or throat including sinusitis orrhinitis, recurrent sore throats, tonsillitis, ear infections, hearing loss or blindness etc	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
AIDS or HIV antibodies	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver disease or disorder eg fatty liver, hepatitis, abnormal liver function test result	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes or abnormal blood sugar level	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>FEMALES ONLY:</b> Disease or disorder of cervix, uterus, fallopian tube, ovary, vagina or vulva eg endometriosis etc.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any other illness, injury or condition not already stated	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

(f) Does the child suffer from or has the child ever suffered from or ever had treatment or surgery or medical tests or prescribed medication for, any of the following:

If YES, please complete the **General Health Questionnaire** in SECTION 7.

	Child 1	Child 2	Child 3	Child 4
Oral surgery or wisdom teeth problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Reproductive organs, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and / or abnormal periods, endometriosis and / or fibroids, Urinary incontinence.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

## 7 General Health Questionnaire

Please complete this section if you answered YES to any of the selected questions in SECTIONS 5 or 6. If you need extra space to provide your response, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

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

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

**7 General Health Questionnaire (continued)**

If you need extra space to provide your response, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

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

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

**7 General Health Questionnaire (continued)**

If you need extra space to provide your response, please use the NOTES on page 30 and write 'refer to notes' next to the original question.

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

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

**7 General Health Questionnaire (continued)**

**i. Tumour questionnaire**

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

Life to be Assured / Child

(a) What was the site of the tumour?

(b) Histology of the tumour if known  Benign  Malignant or pre-malignant  Unknown

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

(d) Have you received treatment within the last three years?  YES  NO

(e) Has there been any recurrence?  YES  NO

(f) Are you undergoing any ongoing follow-up or have you been advised that follow-up treatment is required?  YES  NO

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

**ii. Gastrointestinal tract/bowel questionnaire**

Please complete this section if you answered YES for **any disease or disorder of the gastrointestinal tract or bowel eg irritable bowel, Crohn's disease, ulcers, colitis or reflux.**

Life to be Assured / Child

(a) Do you suffer, or have you ever been advised by a medical practitioner that you suffer, from:  
 Indigestion  Heartburn  Gastro-oesophageal reflux  Hiatus hernia  
 Gastritis  Ulcer  Ulcerative colitis  Crohn's disease  
 Irritable bowel syndrome  Other

(b) Have you ever consulted a specialist about symptoms of any of the above?  YES  NO

(c) Are you on continuous medication?  YES  NO If YES, is your medication prescribed by your GP/specialist?  YES  NO

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

Name of investigation	Result		
	Normal	Abnormal	Unknown
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

Name of investigation	Result		
	Normal	Abnormal	Unknown
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(e) How frequently do you suffer from symptoms?

(f) When were your last symptoms?

**7 General Health Questionnaire (continued)**

**iii. Mental health questionnaire**

Please complete this section if you answered YES for mental, nervous or stress disorder, depression, fatigue or phobia.

Life to be Assured / Child

Last name	First names
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(a) Do you suffer, or have you ever been advised by a medical practitioner that you suffer, from:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Compulsive disorder	<input type="checkbox"/> Headaches	<input type="checkbox"/> Irritability
<input type="checkbox"/> Stress	<input type="checkbox"/> Fear or phobia	<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Depression
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleeplessness	<input type="checkbox"/> Post-traumatic stress disorder	<input type="checkbox"/> Other

If OTHER, please give name of condition

(b) How long ago were the first symptoms?

<input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/>	Years	<input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/>	Months
--	-------	--	--------

(c) How long ago were the last symptoms?

<input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/>	Years	<input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/>	Months
--	-------	--	--------

(d) Have you had any recurrence of the symptoms?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details
------------------------------	-----------------------------	-----------------------------

(e) Have you ever been hospitalised or had time off work or school as a result of this condition?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details
------------------------------	-----------------------------	-----------------------------

(f) Has your condition ever led you to intentionally or unintentionally harm yourself or have suicidal thoughts?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details
------------------------------	-----------------------------	-----------------------------

(g) Have you ever been recommended, prescribed or received treatment for any of the conditions or symptoms listed above eg medication or counselling?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details
------------------------------	-----------------------------	-----------------------------

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

(h) Have you ever been assessed by a psychiatrist or a psychologist?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details
------------------------------	-----------------------------	-----------------------------

**iv. Asthma questionnaire**

Please complete this section if you answered YES for asthma.

Life to be Assured / Child

Last name	First names
-----------	-------------

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

<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Occasionally	<input type="checkbox"/> One-off episode	<input type="checkbox"/> None - childhood only
--------------------------------	---------------------------------	---------------------------------------	--	--

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

<input type="checkbox"/> Nil symptoms - childhood only	<input type="checkbox"/> Mild, eg exercise-induced only, seasonal (related to hayfever allergy, colds or flu)	<input type="checkbox"/> Moderate, eg all year around, no specific triggers	<input type="checkbox"/> Severe, eg constant, reduced lung capacity, restriction of lifestyle or work duties
--	---	---	--

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

<input type="checkbox"/> YES Daily preventative inhalers, eg ventolin	<input type="checkbox"/> YES Occasional use of a nebuliser or oral steroid medication eg prednisolone	<input type="checkbox"/> YES Hospitalisation/ emergency treatment
<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO

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

<input style="width: 100%; height: 20px;" type="text"/> Days
--



## 8 Hazardous Occupation Or Pursuit

Please complete this section if you answered YES to question (i) in SECTION 5.

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



## 9 Occupation And Income Details

If you are applying for **Disability Income Protection (DI)** including **Essential DI, Loss of Earnings, Retirement Protection, Redundancy, Mortgage and Income Protection, Business Continuity, Locum Cover, Business Overheads, Rural Continuity** and **Start Up Income Protection** please complete questions (a) to (u).

If you are applying for the **Total Permanent Disablement (TPD), Optional TPD under Comprehensive Living Assurance or Progressive Care, or Waiver of Premium**, please complete question (a) to (n). (For TPD applications Sovereign may request additional financial information as necessary.)

(a) What is your current main occupation?

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

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

**i. Salaried employment**

Full-time  Part-time  Seasonal

**ii. Self-employment**

Sole proprietor  Name of business

Partnership  Name of business

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

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

(d) If self-employed, please state

	Number of partners/shareholders	<input style="width: 60px; height: 25px;" type="text"/>	Year your business was established	<input style="width: 60px; height: 25px;" type="text"/>
	Number of part-time employees	<input style="width: 60px; height: 25px;" type="text"/>	Number of full-time employees	<input style="width: 60px; height: 25px;" type="text"/>
	Profit share entitlement	<input style="width: 60px; height: 25px;" type="text"/> %		
	50:50	<input style="width: 60px; height: 25px;" type="text"/>	Variable order	<input style="width: 60px; height: 25px;" type="text"/>
	Casual	<input style="width: 60px; height: 25px;" type="text"/>	Contract	<input style="width: 60px; height: 25px;" type="text"/>
	Please state percentage:	<input style="width: 60px; height: 25px;" type="text"/> %		

(e) If you are applying for a Rural Continuity benefit and you are a sharemilker, what type of sharemilker are you?

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

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

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

Exact duties	% of time on each duty	% that requires manual or physical work, including driving
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>	<input style="width: 60%; height: 25px;" type="text"/>

(i) Number of hours worked?  per week

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

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

(l) Have you ever been convicted of fraud or any offence involving dishonesty?  YES  NO  If YES, please give details

(m) Have you ever been adjudged bankrupt, been under administration or in receivership?  YES  NO  If YES, please give details

**9 Occupation And Income Details (continued)**

	From	To	Occupation	Employer
(n) Give details of your current and previous occupations during the last five years?				

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

(p) Annual earned income details

Have you selected the Retirement Protection Benefit

YES  NO

Salary/wage	\$
Fringe benefits (eg company car)	\$
Commission income	\$
Bonus	\$
Share of profits	\$
Other (please specify)	\$
<b>Total earned income</b>	<b>\$</b>
Less business expenses	\$
<b>Net earned income - before tax</b>	<b>\$</b>

(q) Do you have any unearned income?  YES  NO

(r) Annual unearned income details

Interest	\$
Rental	\$
Dividend	\$
Annuity	\$
Other (please specify)	\$
<b>Total unearned income</b>	<b>\$</b>
Less related expenses	\$
<b>Net unearned income - before tax</b>	<b>\$</b>
<b>NET INCOME (earned and unearned)</b>	<b>\$</b>

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

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


(t) Have you attached evidence of income?  YES  NO

(u) Have you attached evidence of mortgage?  YES  NO

Please speak to your adviser for requirements

**10 Totalcare Max Business Continuity (Supplementary Proposal)**

Only complete the following if you are applying for Business Continuity

(a) What are the duties of the income producing employees/Partners?

**Income producing employee/Partner**                      **Duties of employee/Partner**


(b) Are you aware or have you been advised that you are likely to be made redundant, or that your business will cease to trade?

Yes       No      If Yes, please explain:

(c) How has the percentage of Gross Profit attributable to the life assured been calculated

  


(d) What would happen to the business if the life assured were disabled for a short-term period of 3-12 months?

  


(e) Does the Life Assured have any personal or business cover? For example - Income protection, Locum Cover, Business Overheads, Key Person, Business Revenue Cover.

Yes       No      If Yes, please complete below:

	Policy One	Policy Two	Policy Three
(f) Owner	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>
Policy Type	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>
Amount of Cover	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>
Reason for Cover	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>

(z) Can we contact your Accountant direct for financial evidence?

Yes       No

Name of Accountant

	Name of Firm
--	--------------

Address

Street		
Suburb	Town/City	Postcode
Phone number	E-mail Address	

## WHAT YOU NEED TO TELL US

**1. ALWAYS TELL THE TRUTH.** Insurance is based on the principle of utmost good faith. Put simply you have a positive duty to provide truthful, complete and correct information about yourself, including your health and medical history. Your duty of disclosure extends to the date the contract of insurance is concluded between us. For example, you are required to tell us if you are diagnosed with a medical condition after the date of your application but before you agree to any terms of cover we may offer. If we offer to cover you, you will be insured on the basis of the information you have provided.

**2. ANSWER QUESTIONS AS FULLY AS YOU CAN.** Applying for insurance involves responding to a number of questions. Your answers need to include as much detail relating to your current and past circumstances as possible. While this may take time, it is important to ensure that we have all the information we need when we make the decision to insure you and on what terms.

**3. IF IN DOUBT, TELL US.** If you are uncertain of the relevance of any information, our advice is to include it on your form because, even if you aren't sure, it may be important to us. If someone else is completing the form on your behalf, it is important that you check that the information is correct and nothing has been left out.

**4. IF YOU DON'T KNOW SOMETHING, SAY SO.** If you say that you don't know what the answer to a question is and we think we need more information about your answer to a question so we can offer you insurance, we will need to obtain the information from somewhere else. By signing the declaration and consent, you give us your consent to get this information.

**5. KNOW WHAT YOU'RE SIGNING.** By signing the declaration on your form, you are saying that you have answered all the questions completely and to the best of your knowledge, as well as providing any other information that may influence our decision about your policy. If you are uncertain about any of your answers, ask us or your adviser before signing the declaration.

**6. HOW NON-DISCLOSURE AFFECTS CLAIMS.** When you make a claim we may look further into your personal history. If we discover that you did not provide us material information that would have changed our decision to insure you or the terms of that insurance, we may amend the terms of your insurance policy. It does not matter if the new information is about a condition unrelated to your claim. If we discover that you haven't told us something material, we may either alter the terms of your policy – which might affect your claim, or we may avoid your policy from its inception which means that you would not be able to make a claim as no policy would exist.

**7. HELP US TO HELP YOU WHEN YOU NEED TO CLAIM.** Depending on what you tell us on your claim form, we might need more information to make a decision about your claim. We may get this information by calling you, asking you to fill out another form or asking you to take a medical test. Sometimes we will need to get information from other people who may include your doctor, your employer, ACC or other government departments.

By signing the consent form you give us the consent to do this.

**8. KNOW WHAT YOU ARE CONSENTING TO.** We can only request information that we need to assess your application for insurance or for payment of a claim. At all times, the information we hold about you is your information, you have the right to access and, if it is wrong, to ask us to correct it.

**9. DON'T BE AFRAID TO ASK.** If there is anything you're not sure of, don't be afraid to ask us for help. Contact your adviser, or phone Sovereign on **0800 500 108**.

## 11 Declaration and Consent

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

### IMPORTANT NOTICE: Your Duty of Disclosure

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

Please note, in some cases, Sovereign may request a copy of your entire medical file from your General Practitioner and other medical providers, when you make a claim.

IF IN DOUBT - DISCLOSE. WE TREAT ALL INFORMATION CONFIDENTIALLY.

### Life assured:

I/We understand the importance of full disclosure of all information required in this application for Insurance

YES

NO

I/We consent to Sovereign obtaining my medical records from my doctor and other medical providers and have read the "My personal information" section below.

YES

NO

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

#### Disclosure:

- I/We have read the notice explaining my/our duty of disclosure and all the statements contained in this application for insurance ("Application") are true and complete to the best of my/our knowledge.
- Should the Life to be Assured undergo any alteration in mental or physical health or have a change of occupation between the date of this Application and the issue of the insurance, I/we agree to notify Sovereign immediately as this information is relevant to any decision Sovereign may make to accept this Application.
- I/We understand that statements made in this Application, including statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf, forms the entire basis of the insurance contract between me/us and Sovereign.
- I/We acknowledge that my/our adviser receives commission from Sovereign.
- I/We acknowledge that I/we are signing on behalf of any children and declare that I/we have disclosed all health information, including any pre-existing conditions, for such children and ourselves.

#### Underwriting:

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

#### Replacement Policy:

- I/We consent and give authority to Sovereign to cancel the policy/ies and/or benefits selected by me/us under Section 5(a) above, and that are to be replaced by the policy issued under this Application. Such cancellation is to take effect as at the date of issue of the new/replacement policy.

#### Premiums:

- I/We understand the insurance proposed in this Application shall not commence until this Application has been accepted by Sovereign and the initial premium or a completed Direct Debit Authority or premium payment direction (such as a Credit Card) has been received by Sovereign.
- I/We authorise Sovereign to debit the nominated credit card account with the premiums payable for the insurance. Sovereign may debit the credit card account with an Insurance premium even where there may be insufficient clear funds in the credit card account, but Sovereign shall not be obliged to do so. If there are insufficient funds but Sovereign debits the credit card Sovereign may also debit the credit card account with any applicable fees and charges. If the insurance premium cannot be recovered from me/us, then Sovereign may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and Sovereign may be entitled to cancel the insurance in accordance with the insurance terms relating to non-payment of premiums.

#### My personal information:

- I/We consent to the use of the personal information provided in this Application or obtained from any source indicated in paragraph (n) by Sovereign and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application, for the processing of this Application and administration of my/our insurance cover and any claims including assessing if I/we have met my/our duty of disclosure under this Application or any prior applications, for promotion of insurance and investment services to me/us and for market research purposes. I/We understand that my/our personal information will be stored at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I/We understand that Sovereign will take reasonable steps to keep such information secure. I/We understand that Sovereign may be required to disclose my/our personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I/We understand access to and correction of my/our personal information may be requested by me/us.
- I/We consent and give authority to Sovereign and/or any of its related companies to seek from, and for all and any of the following, its officers and employees, to disclose to Sovereign and/or any of its related companies, their advisers, reinsurers, and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me/us:
  - Dentists - Advisers - Employers (whether current or not) - Medical laboratories - Accident Compensation Corporation - Banks and other financial institutions
  - Accountants and other financial advisers - Insurers or reinsurers (whether public or private) - Counsellors, psychologists and therapists
  - Government departments, agencies, organisations and enterprises - Registered medical practitioners and specialists (which may include an entire copy of my/our medical file)
- I/We understand that the supply of the information gathered from the above sources is voluntary and that Sovereign and/or any of its related companies may or may not seek information from the above agencies - whether they seek information is dependent on what information is required to make a decision on my/our insurance.
- I/We understand that in collecting information that is relevant to this Application Sovereign may also receive/collect information that is not relevant to the assessment of this Application or the assessment and administration of my claim and Sovereign will not use this non-relevant information for any purpose.
- I/We consent to the release of my/our name/s and basic contact details to Business Mentors under my/our Business Continuity Benefit, if applicable.

#### Insurance Policy:

- The above answers have/have not been entered by me/us in this Application but they have been checked by me/us and no statement affecting this insurance has been made to any representative of Sovereign that is not recorded in this Application.
- I/We acknowledge that the Illustration attached to Section 4 of this Application forms part of the Application and sets out the insurance benefits I/we are applying for.
- I/We have been advised that a Specimen Policy Document and the financial statements of Sovereign are available to me/us on request from Sovereign's Head Office.

#### General:

- I/We understand that none of ASB Bank Limited or its subsidiaries, the Commonwealth Bank of Australia, or any other company in the Commonwealth Bank of Australia Group, or any of their directors, or any other person, guarantees Sovereign Assurance Company Limited or its subsidiaries, or any of the products issued by Sovereign Assurance Company Limited or its subsidiaries.

Please print full names of  
Life to be Assured

Signature of  
Life to be Assured

Date

**11 Declaration and Consent (continued)**

Please print full names of Child / Children to be Assured for Private Health

CHILD ONE
CHILD TWO
CHILD THREE
CHILD FOUR

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

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

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

Relationship (please tick)  Parent  Guardian

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

Date 

Day	/	Month	/	Year
-----	---	-------	---	------

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

**Where deceased minor is under the age of 10 years**

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

**Where deceased minor is under the age of 16 years**

Sovereign is prohibited from paying on the death of a minor under the age of 16 years, any

sum under any policy issued on or after the 1st day of April 1986 to any person other than:

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

**Signature of Individual policy owner(s)**

(if other than Life to be Assured and as named in SECTION 2 of this application form)

	Date <table border="1" style="display: inline-table;"><tr><td>Day</td><td>/</td><td>Month</td><td>/</td><td>Year</td></tr></table>	Day	/	Month	/	Year
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Day	/	Month	/	Year		

**Signature of company policy owner(s)**

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

Name (please print)								
Job title								
Signature		Date	<table border="1" style="display: inline-table;"><tr><td>Day</td><td>/</td><td>Month</td><td>/</td><td>Year</td></tr></table>	Day	/	Month	/	Year
Day	/	Month	/	Year				
Name (please print)								
Job title								
Signature		Date	<table border="1" style="display: inline-table;"><tr><td>Day</td><td>/</td><td>Month</td><td>/</td><td>Year</td></tr></table>	Day	/	Month	/	Year
Day	/	Month	/	Year				



## 1 Personal Details

Title  Other  Policy Number

Mr Mrs Miss Ms

First Name of policy owner  Telephone Home

Surname of policy owner  Email Address (optional)

Date of first payment (between 1st and 28th of the month)

Start Date  Frequency (please tick one)  fortnightly  monthly

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

## 2 Authority to Accept Direct Debits

Name of Account

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

Bank Branch number Account number Suffix

Authority to Accept Direct Debits  
(Not to operate as an assignment or agreement)

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

Address (PO Box):  Town/City:

(Hereinafter referred to as the Bank)

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

Authorisation Code

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

Information to appear in my/our Bank Statement

Payer Particulars:  Payer Code:  Payer Reference:

S O V E R E I G N

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

Authorised signature(s) Authorised signature(s)

Date  Date

**Conditions of Authority to Accept Direct Debits**

**1. The Initiator:**

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

**2. The Customer may:**

- 2.1. At any time, terminate this Instruction as to future payments by giving written (or by the means previously agreed in writing) notice of termination to the Bank and to the Initiator.
- 2.2. Stop payment of any Direct Debit to be initiated under this Instruction by the Initiator by giving written notice to the Bank prior to the Direct Debit being paid by the Bank.
- 2.3. Where no advance notice is provided under clause 1.4 a variation to the amount agreed between the Initiator and the Customer from time to time to be Direct Debited had been made without notice being given in terms of clause 1.4 above, request the Bank to reverse or alter any such Direct Debit initiated by the Initiator by debiting the amount of the reversal or alteration of Direct Debit back to the Initiator through the Initiator's Bank PROVIDED such request is made not more than 120 days from the date when the Direct Debit was debited to my/our account.

**3. The Customer acknowledges that:**

- 3.1. This Instruction will remain in full force and effect in respect of all Direct Debits passed to my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this Instruction until actual notice of such event is received by the Bank.
- 3.2. In any event this Instruction is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.
- 3.3. Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the Direct Debit has not been paid in accordance with this Instruction. Any other disputes lie between me/us and the Initiator.
- 3.4. Where the Bank has used reasonable care and skill in acting in accordance with this Instruction, the Bank accepts no responsibility or liability in respect of:
  - 3.4.1. the accuracy of information about Direct Debits on Bank statements; and
  - 3.4.2. any variations between notices given by the Initiator and the amounts of Direct Debits.
- 3.5. The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give notice in accordance with clauses 1.1 to 1.4. nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.
- 3.6. Where notice given by the Initiator in terms of clause 1.4 to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.

**4. The Bank may:**

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

**FOR BANK USE ONLY**

<p style="text-align: center; font-size: 1.2em;">Approved</p> <p style="text-align: center;">0036 ----- 02   02</p>	<p>Date Received</p> <table border="1" style="width: 100%; text-align: center; font-size: 0.8em;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> <p>Recorded by</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	D	D	M	M	Y	Y	Y	Y	<p>Bank Stamp</p>
D	D	M	M	Y	Y	Y	Y			
	<p>Checked by</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>									





Full name of policy owner

Residential phone number

Business phone number

Email

For which policies do you want this authority to apply?

Date of first payment (between 1st and 28th of the month)

**Credit card or debit card details**

Card type  MasterCard  Visa  Debit Card

Payment frequency  Monthly  Quarterly  Half-yearly  Annually

Account number

Name on card

Expiry date

I/We declare and agree that:

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

Card holder's signature





**Replacement Policy Advice for Advisers**

**Adviser to Complete**

This form is to be completed whenever an existing Term Life, Disability, Trauma, and/or Income Protection policy or benefit is to be replaced, exchanged or converted. This includes all situations where a new policy is issued within six (6) months of another policy being discontinued and the life insured (or one of the lives insured) is the same.

**Details of New Policy or Benefit**

Name(s) of Life Insured

Date(s) of Birth of Life Insured

Name of Insurer  Type of Policy/Benefit:

Sum Insured \$  Annual Premium: \$  (Level/Stepped)

Will the Adviser receive something from the Insurer in return for arranging the new contract/benefit?  Yes  No

**Details of Policy or Benefit Being Replaced**

Name(s) of Life Insured

Name of Insurer\*

Policy Number  Type of Policy/Benefit:

Sum Insured \$  Annual Premium: \$  (Level/Stepped)

**\*If a Sovereign policy or benefit is being cancelled or altered due to replacement, please describe the change(s) below.**

Cancel full policy  Alter or change existing policy (provide details below)

Existing benefit	Life assured	Sum assured	Changes	Is this benefit being replaced?

**Reasons for Replacement**

The current policy/benefit is being replaced because (tick all applicable and please provide details):

the Policy Owner's needs have changed and a new policy/benefit is required

the Policy Owner's needs have not changed but the same cover is available at a lower premium

the Policy Owner's needs have not changed but the new insurer offers better service

the Policy Owner's needs have not changed but the new insurer has a better claims rating/experience

Other (please provide details)

**NOTE:** The Policy Owner is intended as a broad term in this form, including the life insured, the premium payer and any nominated beneficiary.

**The following risks are covered by the current policy/benefit but will NOT be covered by the new policy/benefit:**

**Declaration of Advice** (delete if not applicable)

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

**Declaration of No Advice** (delete if not applicable)

I confirm that I have not given any advice to the Policy Owner in respect of this replacement.

Although I have not made any comparison between the new policy/benefit and the existing policy/benefit I have advised the Policy Owner of the types of adverse circumstances which might occur as a result of changing products.

Adviser Name:  Signature:  Date:

**Replacement Policy Advice for Policy Owners**

**Policy Owner to Read and Complete** (Please read before you sign the Acknowledgement and Declaration below)

**Making an Informed Decision**

**Before you replace your existing policy/benefit with a new one it is important you have all the relevant information to help you make the best decision.**

**The Financial Advisers Act requires Advisers to exercise care, diligence and skill when providing clients with financial advice. That advice should include an accurate explanation of the differences between your existing and proposed policy/benefit, the advantages and disadvantages of switching, and the reasons why replacement is your best option.**

This comparison should consider key aspects of your policy/benefit, such as:

- › **Your personal situation** – changes in your health, leisure activities or occupation may mean your new policy contains restrictions or exclusions that your old policy doesn't have. Similarly, any improvements in your health or lifestyle may mean improved terms and conditions.
- › **Cover** – understand what your existing policy/benefit covers and what you'll be covered for under the new policy/benefit. Also understand any loss of benefits such as value or type of cover, and any unusual features.
- › **Medical Conditions** – different policies, while covering similar risks, often cover significantly different conditions (particularly policies that cover disablement or serious illness).
- › **"Stand down" periods** – a new policy/benefit can have initial "stand down periods" so you may temporarily lose some of your cover if you switch to a new policy/benefit. For example, new trauma policies/benefits often exclude cover for cancer within 3 months of the commencement of the policy/benefit.
- › **Definitions** – there can be subtle differences in the definitions used between policies (eg medical conditions, employment, occupation, income, etc).
- › **Cost** – if there have been changes to the insured person's personal situation since the policy was taken out, the new policy/benefit may cost more to get the same or similar benefits. If their personal situation has improved or remained the same, the premiums for the new policy/benefit may even be lower.
- › Differences in financial strength ratings between the old and new insurers.

As well as policy comparisons, Advisers are also required to disclose any other material information that may influence their recommendation and any potential conflicts of interest, such as whether or not they are receiving some form of payment from the Insurer.

A copy of this completed form will be given to the new insurer who will send you a copy for your records.

**PLEASE NOTE: You must contact the old insurer directly to cancel your existing policy/benefit. DO NOT cancel your existing policy/benefit until you have disclosed everything necessary to your new insurer, the new policy/benefit has been issued and you are happy that you are appropriately insured.**

**Policy Owner(s) Acknowledgement and Declaration** (on behalf of all affected parties)

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. I/We acknowledge that my/our adviser has provided me/us with a detailed comparison between my/our existing and proposed policies/benefits that covers the key aspects outlined above, and that I/we understand the consequences of my/our adviser's recommendation. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. I/We acknowledge that my/our adviser has not provided us with advice in respect of this replacement but I/we have been advised of the types of adverse circumstances which might occur as a result of changing products.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I/We acknowledge that a copy of the brochure 'Get the most out of life' has been given to me/us and I/we have read it and understand what it means to me/us.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. I/We acknowledge that this information was provided and explained to me/us before I/we signed the application for the new policy/benefit.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Only applicable if Sovereign Policy or Benefit is being cancel or altered as described.**

- 5 I/we request that the policy(ies) listed above be cancelled/altered immediately.
- 6 I/we acknowledge that where my/our existing policy(ies) is/are cancelled or altered, the cover that I/we had in place has changed and therefore I/we may no longer be covered for any event that was previously covered by the policy(ies).
- 7 I/we acknowledge that any alterations to my/our policy(ies) requested by me/us will be based on the information provided in this form, together with the information provided in the original proposal.
- 8 I/we acknowledge that in the case of alteration the changes I/we have requested may mean that the values illustrated in the latest annual statement or progress report for this policy(ies) may no longer be valid.

**IMPORTANT NOTICE:** Signatures are required from ALL policy owners on joint policy(ies).

Written confirmation will be sent to the policy owners named below if a Sovereign policy or benefit is being cancelled or altered due to replacement.

Policy owner 1	Full name:	
	Signature:	Date:
Policy owner 2	Full name:	
	Signature:	Date:
Policy owner 3	Full name:	
	Signature:	Date:

Based on the Financial Services Council Replacement Best Practice Guidelines.



**FOR ADVISER USE ONLY special instructions**

This Application form should be used for all TotalCareMax applications. This form can also be used for Start-Up Income Protection applications. If the Life to be Assured is applying for Private Health, in addition to TotalCareMax and Start-Up Income Protection, this form can be used for all products. If children are to be insured as part of Private Health, this form can also be used.

**Adviser Checklist**

To avoid delays in processing this Application, please check the following have been received as required, before submitting the form to Sovereign:

- Personal statement complete
- Evidence of income
- Payment method identified
- Declaration signed
- Illustration attached
- Copy of any Advice on Replacement Business form (original to remain with client)
- Details of doctor holding medical records
- Payment form complete
- Commencement date identified

Credit this case to Sovereign adviser code

FSPR number or QFE name

Group Voluntary Code

Initial	Renewal
---------	---------

Adviser's company

Adviser name

Please tick one

<input type="checkbox"/> Variable %	<input type="checkbox"/> Pendulum %	<input type="checkbox"/> As earned
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**SECOND ADVISER** (if applicable)

Credit this case to Sovereign adviser code

FSPR number or QFE name

Group Voluntary Code

Initial	Renewal
---------	---------

Adviser's company

Adviser name

Please tick one

<input type="checkbox"/> Variable %	<input type="checkbox"/> Pendulum %	<input type="checkbox"/> As earned
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**Scanned/faxed?**  YES Date







0800 500 108



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