Risk and health cover. Application form.

April 2018

Protecting the NZ way of life
fidelitylife.co.nz | **0800 88 22 88**
newbusiness@fidelitylife.co.nz

Please read these instructions before completing the application

Important information

This application is scanned and data is input electronically. Please follow these instructions carefully so there are no delays in processing.

- Please do not write on this page or inside the perforated section of the spine, as the front page and spine are detached and discarded for processing purposes when received by Fidelity Life and/or nib nz limited.
- Any notes should be included on the 'Additional notes and information' page (refer to page 22).
- Use a black pen where possible, printing in BLOCK CAPITALS within the spaces provided, e.g.

C	H	R	I	S		J	O	N	E	S

- Do not leave empty boxes at the start of lines containing words, but leave a space between words.
- Always attach a illustration.
- Remember to complete all questions in the required sections. Any alterations made must be initialled by the Life to be Insured and Policy Owner where applicable.
- Where information is in RED, it relates to Fidelity Life. If it is in GREEN, it relates to nib.

Please ensure the following sections are completed

If any of the benefits listed below are included, please complete:

Sections 1 to 14 for

* Health Insurance
* Life Assurance
* Survivor's Income
* Trauma Multi/Trauma/Critical Illness

Sections 1 to 15 for

* Income Protection/Defined Disability/Disability Income Cover/Rural Key Person
* Total & Permanent Disability
* Waiver of Premium
* Key Person (plus section 16)
* Business Expenses (plus section 17)

Please provide any additional details relating to this Product Application in the 'Additional notes and information' section on page 22.

FIDELITY LIFE

nib health cover

Risk and Health Application Form

For Office Use Only

Fidelity Life

Risk policy number

Adviser number

nib nz limited

Health policy number

Adviser number

1.0 Life / lives to be insured (applicants)

Is this application to add a life to an existing policy? ◯ Yes ◯ No

If 'Yes', please give Risk policy number Health policy number

PERSONAL DETAILS – LIFE TO BE INSURED (1)

Title Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other ◯

Surname

First name(s)

Date of birth Day Month Year

Gender ◯ Male ◯ Female

Marital status

Previous surname (if applicable)

Occupation

Industry

Average Gross Annual Income (net of expenses) $

CONTACT DETAILS

Home phone Daytime ◯ After hours ◯ ( )

Work phone Daytime ◯ After hours ◯ ( )

Mobile Daytime ◯ After hours ◯ ( )

Do you wish to be sent mail by Post ◯ Email ◯ or to both

Email^

ADDRESS DETAILS (PHYSICAL)

Street number

Street name

Suburb

Town / City

Postcode

ADDRESS DETAILS (MAILING – IF DIFFERENT FROM ABOVE)

Street / Box number

Street name

Suburb

Town / City

Postcode

Is the Life to be Insured a Policy Owner? ◯ Yes ◯ No

PERSONAL DETAILS – LIFE TO BE INSURED (2) (IF APPLICABLE)

Title Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other ◯

Surname

First name(s)

Date of birth Day Month Year

Gender ◯ Male ◯ Female

Marital status

Previous surname (if applicable)

Occupation

Industry

Average Gross Annual Income (net of expenses) $

CONTACT DETAILS

Home phone Daytime ◯ After hours ◯ ( )

Work phone Daytime ◯ After hours ◯ ( )

Mobile Daytime ◯ After hours ◯ ( )

Do you wish to be sent mail by Post ◯ Email ◯ or to both

Email^

ADDRESS DETAILS (PHYSICAL)

Street number

Street name

Suburb

Town / City

Postcode

ADDRESS DETAILS (MAILING – IF DIFFERENT FROM ABOVE)

Street / Box number

Street name

Suburb

Town / City

Postcode

Is the Life to be Insured a Policy Owner? ◯ Yes ◯ No

^A valid email address is required in order to be eligible for nib Ultimate Health Travel Insurance.

Tear here

2.0 Additional Policy Owners

Note: *For Health Insurance there is a maximum of two Policy Owners and they must be individuals aged 18 and over.*

POLICY OWNER (1)

Title Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other ◯

Surname
(or registered company name)

First name(s)

Relationship to Life to be Insured

Date of birth Day Month Year

Gender ◯ Male ◯ Female

CONTACT DETAILS

Home phone Daytime ◯ After hours ◯ ( )

Work phone Daytime ◯ After hours ◯ ( )

Mobile Daytime ◯ After hours ◯ ( )

Do you wish to be sent mail by Post ◯ Email ◯ or to both

Email

ADDRESS DETAILS (PHYSICAL)

Street number

Street name

Suburb

Town / City

Postcode

ADDRESS DETAILS (MAILING – IF DIFFERENT FROM ABOVE)

Street / Box number

Street name

Suburb

Town / City

Postcode

POLICY OWNER (2)

Title Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other ◯

Surname
(or registered company name)

First name(s)

Relationship to Life to be Insured

Date of birth Day Month Year

Gender ◯ Male ◯ Female

CONTACT DETAILS

Home phone Daytime ◯ After hours ◯ ( )

Work phone Daytime ◯ After hours ◯ ( )

Mobile Daytime ◯ After hours ◯ ( )

Do you wish to be sent mail by Post ◯ Email ◯ or to both

Email

ADDRESS DETAILS (PHYSICAL)

Street number

Street name

Suburb

Town / City

Postcode

ADDRESS DETAILS (MAILING – IF DIFFERENT FROM ABOVE)

Street / Box number

Street name

Suburb

Town / City

Postcode

Select one Policy Owner's mailing address to be used: Life to be Insured (1) ◯ Life to be Insured (2) ◯ Policy Owner (1) ◯ Policy Owner (2) ◯

3.0 Children to be insured

* CHILDREN TO BE COVERED FOR HEALTH INSURANCE (under age 16)
* CHILDREN'S FUTURE INSURABILITY COVER (15 years or under)

Surname	First name(s)	For ages 12 and over		Gender	Date of birth
		Height (cm)	Weight (kg)		
1.				M ◯ F ◯	Day Month Year
2.				M ◯ F ◯	Day Month Year
3.				M ◯ F ◯	Day Month Year
4.				M ◯ F ◯	Day Month Year

4.0 Adviser to complete

Adviser declaration

- I confirm that all relevant information discussed with me by the applicant(s), at the time this application was completed, has been recorded on this application form.
- To the best of my knowledge and belief, the answers given on this application form for risk insurance, and any attached personal statements, are true and correct and in accordance with all the information given to me.
- I have provided the applicant(s) with verbal disclosure of their right to cancel the policy within 14 days of receipt of the policy, by contacting Fidelity Life 0800 88 22 88 or nib on 0800 123 642. If pages of the application form have not been submitted, I confirm that those pages are blank pages that contain no information.

FOR RISK

Adviser name	Adviser number	I/C% split	R/C% split
1.		%	%
2.		%	%

See Apollo Illustration attached

Amount collected $

Name of Adviser AFA ◯ RFA ◯ (please tick one)

FOR HEALTH

Adviser name	Adviser number
1.	

Upfront ◯ Hybrid ◯ or Spread ◯ Note: If left unticked, Upfront will be selected by default.

4.1 JOINT LIFE APPLICATIONS FOR RISK

Where the policy comprises more than one life, do you wish the policy to be issued on acceptance of any one life? ◯ Yes ◯ No

4.2 COMMENCEMENT DATE FOR HEALTH

The commencement date is the date the application is received by nib or an alternative date nominated by you or nib. The nominated commencement date is subject to the following provisions:

- no later than six weeks from the date this application is signed;
- no earlier than the date the application is received by nib; and
- the application is accompanied by a valid, signed Direct Debit Authority or credit card information.

Nominated commencement date Day Month Year

4.3 COMMENCEMENT FOR DIRECT DEBITS

Please also complete the Fidelity Life / nib Direct Debit Authority on page 29/31.

For Fidelity Life Direct Debits (Risk Insurance)

Fortnightly ◯ Quarterly ◯ Half-yearly ◯ Yearly ◯ Please select day between the 1st and 31st for commencement of payments to be deducted: Day Month

Monthly ◯ Please select day between the 1st and 28th for commencement of payments to be deducted: Day

For nib nz limited Direct Debits (Health Insurance)

Weekly ◯ Fortnightly ◯ Please select day of the week for payments to be deducted:

Mon Tue Wed Thu Fri (Please circle)

Monthly ◯ Quarterly ◯ Half-yearly ◯ Yearly ◯ Please select day between the 1st and 28th for commencement of payments to be deducted: Day

4.4 CREDIT CARD PAYMENTS

Fidelity Life

If you have requested to pay by credit card we will send you an email containing a link to Pay Station, a secure website where you can complete your payment online. For security reasons, the link will only remain active for five days from the receipt of the email. (Please ensure your email address is included on page 3 of this application form).

Your financial adviser will receive a notification that an email has been sent to you with the payment details. You are able to contact Fidelity Life at any time should you have technical difficulty with the system. If you do not pay within the time frame, then our Client Services and New Business teams will receive a notification. In this case we will contact your adviser to ensure that you complete the payment.

Please note:

1. Credit card payments will be accepted for all yearly and half-yearly, initial monthly premiums and advance payment of risk premiums only.
2. Fidelity Life does not accept credit card payments for regular monthly premiums, savings or investment premiums.

If you have any questions about the credit card payment system, please call New Business on telephone 0800 88 22 88 option 5.

nib nz limited

If you would like to pay by credit card to nib nz limited, please tick here: ☐

The nib new business team will contact you to arrange your credit card payments. Please note nib will accept Visa/Mastercard only for payments that are either monthly, half yearly or annual.

Tear here

5.0 Duty of disclosure

Please read BEFORE completing this application.

WHAT YOU NEED TO TELL US

1. **ALWAYS TELL THE TRUTH –** You must tell us everything that may affect our decision to insure you. 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 commences. For example, you are required to tell us if you experience any signs or symptoms or are diagnosed with a medical condition, or if you undergo any treatment, investigations or surgery after the date of your application, but before we agree 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 –** Be aware the law does not distinguish between innocent or deliberate non-disclosure. If you are uncertain of the relevance of any information, please 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 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 your adviser or us before signing the declaration. By completing and signing the declaration, you are agreeing to be bound to Fidelity Life's terms.
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 we may avoid your policy and decline your claim or at our discretion 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 avoid your policy from its inception, this means that you would not be able to make a claim as no policy would exist. In addition, all premiums paid will be forfeited.
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 have 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, you have the right to access the information we hold about you 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. Contact your adviser, or phone Fidelity Life on 0800 88 22 88 or nib on 0800 123 642.

6.0 Medscreen (Fidelity only)

- ***Medscreen (a medical service company) provides a convenient way for you to supply Fidelity Life with personal medical information sometimes required for insurance cover.***
- ***The service uses qualified nurses to conduct medical assessments and/or blood tests for Fidelity Life.***
- ***It is available for applications which are over non-medical limits, or outside our normal build range.***

Are you happy for Medscreen to contact you if we need more information? Yes ○ No ○

7.0 Telephone underwriting

To speed up the acceptance of this application, if we need further information we will contact you directly (e.g. via email or telephone) unless you indicate otherwise	○ No - please do not contact me
	○ Yes - when is the best time? a.m ○ / p.m ○

8.0 Medical records

		Name:	*Name:*
a.	Please give details of your usual doctor below:		
	Doctor's name		
	Doctor's address		
	Doctor's telephone	( )	( )
b.	How long have you been with your doctor?	months years	months years
c.	Please advise date, reason for and outcome of your last consultation with any doctor or other health provider	Day Month Year	Day Month Year
	Reason		
	Outcome of last consultation		
d.	Are your medical records held under the same doctor's name as shown in a. above?	Yes ○ No ○	Yes ○ No ○
	If 'No'. please give details of the doctor who holds your records		

9.0 Other insurance arrangements

Note: *Please complete the 'Replacement Policy Advice' if the Risk component of this application replaces any of the insurances listed here, or any insurance has been cancelled within the last six months.*

		Name:	*Name:*
a.	Are you currently proposing to any other company?	Yes ○ No ○	Yes ○ No ○
b.	Do you have any life or trauma/critical illness or disability insurance?	Yes ○ No ○	Yes ○ No ○
c.	Is this application replacing an existing policy, or a policy discontinued within the last six months, with Fidelity Life or any other company?	Yes ○ No ○	Yes ○ No ○

If 'Yes' to questions a. to c. please give details below

Q #	Insured's name	Company	Year Issued	Type	Sum Insured	Indicate Normal terms, Declined, Deferred, Loaded (indicate reasons)

10.0 Residence and travel

	Residency Status	*Name:*	*Name:*
a.	Citizen or Permanent Resident of New Zealand?	Yes ○ No ○	Yes ○ No ○
	If 'No', do your work permits add up to at least two consecutive years, with 12 months or more left until expiry? If 'Yes', please provide evidence (i.e. a copy of your passport and permits).	Yes ○ No ○ *If 'Yes', please provide evidence (i.e. a copy of your passport and permits).*	Yes ○ No ○ *If 'Yes', please provide evidence (i.e. a copy of your passport and permits).*
	Applied for Permanent Residency	Yes ○ No ○	Yes ○ No ○
	Work Visa/valid for more than 12 months	Yes ○ No ○	Yes ○ No ○
	Other (please provide details e.g. Australian citizen)		
b.	Do you intend to travel to (other than on holidays) or live in another country?	Yes ○ No ○ *If 'Yes', please give details*	Yes ○ No ○ *If 'Yes', please give details*

Name:

Country	*City/province*	*Purpose*	*Duration*

Name:

Country	*City/province*	*Purpose*	*Duration*

11.0 Hazardous pursuits and activities

If answer to any of these questions is 'Yes', please complete the Hazardous occupation or pursuits questionnaire. (If more than two pursuits or activities please use the notes pages also).

Do you participate or intend to participate in any of the following	*Name:*	*Name:*
• Aviation (other than as a fare-paying passenger)	Yes ○ No ○	Yes ○ No ○
• Hang-gliding/kiting		
• Motor sport – any form, including off-road activities or power boat racing		
• Scuba diving		
• Mountaineering, rock climbing, abseiling or caving		
• Parachuting		
• Any other hazardous sports/pastimes/activities (e.g. martial arts, competitive horse riding, hunting, etc.)		

Tear here

12.0 Lifestyle

		Name:			*Name:*		
a.	What is your height?	cms	ft	ins	cms	ft	ins
	What is your weight?	kg		lbs	kg		lbs
b.	Has your weight changed in the last year?	◯ Yes ◯ No			◯ Yes ◯ No		
	If 'Yes', did your weight	increase by	kg	lbs	increase by	kg	lbs
		or decrease by	kg	lbs	or decrease by	kg	lbs
	If any weight change, please provide reason						
c.	Do you smoke tobacco or any other substance or use nicotine replacement (incl e-cigarettes)?	◯ Yes ◯ No			◯ Yes ◯ No		
	If 'Yes', what and how much?	What?			What?		
		How much?			How much?		
d.	Have you ever smoked?	◯ Yes ◯ No			◯ Yes ◯ No		
	If 'Yes', date last smoked	Day Month Year			Day Month Year		
e.	Have you used marijuana, heroin, cocaine, narcotics, barbiturates, or any other recreational, non-prescription drugs, or psychoactive drugs? *If 'Yes', please give details*	◯ Yes ◯ No			◯ Yes ◯ No		
f.	Do you drink alcohol (including kava)?	◯ Yes ◯ No			◯ Yes ◯ No		
	If 'Yes', please state number of standard drinks * a standard drink = 1 nip of spirits or 1 glass of wine or 1 glass of beer.	per day			per day		
		per week			per week		
		per month			per month		
g.	Have you ever been advised by a medical practitioner to reduce or stop your alcohol consumption, or have you ever had a consultation or been treated for addiction to or abuse of alcohol and/or drugs? *If 'Yes', please give details*	◯ Yes ◯ No			◯ Yes ◯ No		
h.	Have you ever been convicted of a crime involving dishonesty or do you have any charges pending (e.g. fraud or theft)? *If 'Yes', please give details*	◯ Yes ◯ No			◯ Yes ◯ No		
i.	Have you ever been declared bankrupt or are you pending bankruptcy? *If 'Yes', please give details*	◯ Yes ◯ No			◯ Yes ◯ No		

13.0 Your health history

To be completed in respect of Life 1, Life 2, and any children named in section 3.0.
Important: This is a material part of your application. You must disclose details of any health condition or sign, symptom, treatment, investigation or surgery occurring or existing before the start date / commencement date. When in doubt, disclose (please refer to Duty of Disclosure on pages 6 and 23). We treat all information confidentially.
For applications for nib's Easy Health cover, please note that your medical history is not reviewed by nib on application. Future claims will be assessed for pre-existing conditions at the time of claiming.

13.1 HEALTH CONDITIONS

Are you currently being, or have you ever: * experienced signs or symptoms, suffered from or sought medical advice for; * had a consultation, investigation, test or been diagnosed with; or * taken regular medication, had a medical procedure, operation or treatment for any of the following, from any health professionals including chiropractors, physiotherapists, naturopaths, osteopaths, councellors, or alternative health practitioners. ***(If you have answered 'Yes' to any of these questions then either complete the section indicated OR give full details in Section 26.0 on pages 20 and 21).***	Life 1 name:	Life 2 name:	Child 1 name:	Child 2 name:	Child 3 name:	Child 4 name:
a. Asthma – ***go to section 19*** Bronchitis, emphysema, sleep apnoea or any other respiratory disorder – ***go to section 26***	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
b. High blood pressure – ***go to section 24*** or raised cholesterol – ***go to section 25***	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
c. Chest pain, heart murmur, heart attack, angina, palpitations, coronary artery disease, rheumatic fever or any other heart condition	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
d. Gastric or duodenal ulcer, reflux, indigestion or difficulty with swallowing	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
e. Bowel disorder, rectal bleeding, haemorrhoids, ulcers, colitis, ongoing abdominal pain, or any other disease / disorder of the gastro-intestinal tract, pancreas, or gall bladder or hernia (e.g. hiatus, inguinal, umbilical or incisional)	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
f. Depression, breakdown, stress or anxiety disorder, panic attack, sleeplessness, post traumatic stress disorder or any other mental or nervous disorder – ***go to section 23***	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
g. Liver disease or disorder, e.g. hepatitis A, B, or C, abnormal liver function tests or cirrhosis	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
h. Diabetes, abnormal blood sugar, insulin resistance – ***go to section 20*** Thyroid disorder or any other glandular condition – ***go to section 26***	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
i. Back or neck problems, spinal condition, sciatica, whiplash, OOS/RSI or any kind of joint problem – ***go to section 22***	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
j. Varicose veins, psoriasis, eczema or any other disorder of the skin, or any other allergic or chemical sensitivity reaction	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
k. Cancer or tumour including skin growths or lesions, moles, cysts or growths of any kind – ***go to section 21***	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
l. Arthritic disorders, gout, rheumatism, osteoarthritis or rheumatoid arthritis	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
m. **Male** – Prostate condition, increased urinary frequency or urgency, slow urinary stream or problems passing urine, or sexual dysfunction likely to require treatment	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
Female – Endometriosis, irregular, heavy or painful menstrual bleeding, miscarriages, complications of pregnancy, pelvic floor prolapse or abnormal mammogram, cervical smear, or ultrasound	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
n. Other genito-urological disorders, including urinary tract infections, diseases or disorders of the bladder, kidneys (including kidney stones), urethra, ureters or testicles	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
o. Sexually transmitted illness or virus	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
p. Anaemia, haemophilia, leukaemia, haemochromatosis or any other blood disorder(s)	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
q. Any brain or neurological disorder, e.g. epilepsy, multiple sclerosis, paralysis or stroke, dizzy spells, migraines, head injury or transient ischaemic attack	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
r. Eye disease or vision disorder other than wearing glasses (e.g. cataracts or glaucoma)	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○

Continued over page

		Life 1		Life 2		Child 1		Child 2		Child 3		Child 4	
s.	Disease of the ears, nose or throat including, sinusitis, recurrent sore throat, tonsillitis, adenoid disorders, ear infections, or hay fever	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
t.	Disease or disorder of the mouth / oral cavity including unerupted or impacted wisdom teeth (do not declare routine / orthodontic dental treatments)	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
u.	i) Are you currently pregnant? *If 'Yes', please give estimated date of delivery:* Day Month Year	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
	ii) If currently pregnant have you had any complications with this or past pregnancies?	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
v.	Any other illness, injury, condition, medical treatment, surgery or medication not covered previously	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
w.	In the past five years have you ever had more than five consecutive days off work due to illness or injury	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
x.	Have you or your sexual partner(s) i) received or do you expect to receive any medical treatment, advice, counselling or blood tests in connection with AIDS or an AIDS related condition	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
	ii) engaged in sexual activity with person(s) whose previous or current sexual behaviour puts them at increased risk of HIV	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○

14.0 FAMILY HISTORY SECTION

Has any blood-related immediate family member (father, mother, brother, sister) had or been diagnosed with:

a. Diabetes, high blood pressure, heart disease, stroke, high cholesterol, kidney disease, mental health condition (including depression), breast, cervical, ovarian, colon or other cancer?

b. Multiple Sclerosis, muscular dystrophy, motor neurone disease, cystic fibrosis, familial polyposis, haemochromatosis, Huntington's chorea or any familial disease or inherited disorder?

If 'Yes' to either 'a' or 'b' above, please complete the table below

Name:	*Name:*
○ Yes ○ No	○ Yes ○ No
○ Yes ○ No	○ Yes ○ No

	Name:				*Name:*			
Relation	**List ALL conditions and cause of death if applicable* (if cancer, please give type and site)**	**Age at diagnosis**	**Current Age**	**OR Age at death**	**List ALL conditions and cause of death if applicable* (if cancer, please give type and site)**	**Age at diagnosis**	**Current Age**	**OR Age at death**
Mother								
Father								
Brothers								
Sisters								

Note: If you need more space, please use Section 27.0 'Additional notes and information' on page 22.

15.0 Your occupation

For Income Protection/Defined Disability/Disability Income Cover/Business Expenses/Key Person/Monthly Mortgage Repayment*, complete questions 15a. to 15u.

For all Agreed Value, and any Indemnity Value policies with a benefit in excess of $10,000 per month, evidence of income is required as follows;

1. For self-employed persons please provide evidence of the last three years income e.g. copy of accounts.
2. For wage or salary earners please provide a copy of a recent wage/salary advice or copy of employment contract.
3. Bonus/commission – to ascertain whether eligible for inclusion please refer to Underwriting Department.

**** For MMR cover less than $4000 per month, please complete complete questions 15a. to 15q.***

For Total and Permanent Disability and Waiver of Premium, complete questions 15a. to 15q.

For Rural Key Person Cover, please complete question 15a to v.

			Name:	*Name:*
a.	What is your principal income-earning occupation?			
b.	Do you hold a professional or trade qualification relevant to your occupation? *If yes please provide details*		Yes ○ No ○	Yes ○ No ○
c.	Are you self-employed?		Yes ○ No ○	Yes ○ No ○
	or a shareholder-employee?		Yes ○ No ○	Yes ○ No ○
	If a shareholder-employee		% of shares owned	% of shares owned
d.	What is the name of your employer?			
e.	What is the nature of the business?			
f.	How long have you been with this employer or in your current self-employment? *(If self-employed less than 12 months, please contact the Underwriting Department)*		years months	years months
g.	What is the start date of the business?		Day Month Year	Day Month Year
h.	If you have been in your current occupation for less than five years, give details of your occupation(s) during the past five years (attach separate sheet if necessary)			
i.	Describe your exact duties, the tasks involved (including details as applicable of heights, depth and locations at which you work, and chemicals, gases or any toxic substances used) and provide the percentage of time spent on each duty and the percentage of time that each duty requires manual or physical work, including driving.			
j.	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?			
k.	Is your income derived from	▸ **Salaried employment**	○ Full-time ○ Part-time ○ Seasonal	○ Full-time ○ Part-time ○ Seasonal
		▸ **Self-employment**	○ Sole proprietor ○ Partnership ○ Other – if other, please specify below (e.g. Trust, Directors Fees)	○ Sole proprietor ○ Partnership ○ Other – if other, please specify below (e.g. Trust, Directors Fees)
		▸ **If partnership**	number of partners % Profit share entitlement	number of partners % Profit share entitlement
l.	If you are self-employed, or a shareholder/shareholder employee with 20% or more shares, what is the total number of employees?		Full-time / Part-time	Full-time / Part-time
m.	How many hours per week do you spend at your principal occupation?		hours per week	hours per week

Tear here

n.	How much of your income would continue if you were disabled? How long would it continue for? What would be the source of income? E.g. Sick leave, outstanding accounts, retainers, superannuation benefits, ongoing profits or entitlements		
o.	Do you work at home? *If 'Yes', please give full details of work activities performed away from home and average weekly hours of such activities*	Yes ◯ No ◯	Yes ◯ No ◯
p.	Do you have a second occupation or financial interest in any other business entity? *If 'Yes', please give full details*	Yes ◯ No ◯	Yes ◯ No ◯
	Please give details of your occupations during the past five years *(attach separate sheet if necessary)*	From To	From To
	Occupation		
	Duties		
	Hours per week		
	Income per annum	$	$
q.	Do you intend to change your occupation or duties in the next two years? *If 'Yes', please give full details*	Yes ◯ No ◯	Yes ◯ No ◯
r.	Annual income details (from personal exertion in principal occupation only)		
	i) **Employed**		
	Annual Salary or Wages (before tax)	$	$
	Plus Fringe Benefits (e.g. car)	$	$
	Please specify:	$	$
	Please specify:	$	$
	Please specify:	$	$
	Please specify:	$	$
	Plus bonus/commission *(see note 3. at the beginning of this section)*	$	$
	Total insurable income	**$**	**$**
	ii) **Self-employed or a Shareholder employee**		
	a. Total gross income of the business	$	$
	b. *Less* total expenses	$	$
	c. Net profit	$	$
	d. Your share of net profit	$	$
	e. *Plus* your shareholder salary/wages	$	$
	Total insurable income (d. + e.)	**$**	**$**
s.	Is your income split for tax purposes with your spouse or partner? *If 'Yes', please advise the percentage split and the hours and nature of work they do in the business*	Yes ◯ No ◯	Yes ◯ No ◯
		% split	% split
		Number of hours	Number of hours
		Nature of work:	Nature of work:

t.	Do you have net assets in excess of $5 million or investment income greater than $100,000 per year? *If 'Yes', please complete a Confidential Financial Questionnaire*	Yes ○ No ○	Yes ○ No ○
u.	Have you previously made any claim under Accident Compensation, sickness or accident policies or any other disability policies for a period of more than two weeks? *If 'Yes', please give details*	Yes ○ No ○	Yes ○ No ○
v.	If you are applying for a Rural Key Person only benefit and you are a sharemilker, what type of sharemilker are you?		
	Own herd/50:50		
	Contract		
	Lower order		
	Other (please state %)	%	%

16.0 Key Person

For Key Person, please complete the following using the last business year accounts

i) Gross income of business	$	$
ii) Cost of goods sold (if applicable)	$	$
iii) Percentage of gross income for which applicant is responsible	%	%

Note: To calculate monthly benefit for Key Person: (Gross income (i), less Cost of goods sold (ii)) x Percentage responsible (iii) ÷ 12

17.0 Business expenses

	Business Expense Analysis (annually)	*Name:*	*Name:*
a.	Rent or mortgage interest payments	$	$
b.	Rates, taxes and/or other government levies	$	$
c.	Electricity, gas, water, heating, telephone, cleaning and security	$	$
d.	Depreciation of plant and business equipment	$	$
e.	Non-income producing employees – position:		
		$	$
		$	$
f.	Interest on Business Loans	$	$
g.	Lease payments on business vehicles and equipment	$	$
h.	Accountants and legal fees	$	$
i.	Insurance premiums	$	$
j.	Other fixed costs usually incurred in your business (please detail)	$ Detail:	$ Detail:
k.	Total business expenses	$	$
l.	Percentage of total business expense for which you are responsible	%	%
m.	Estimated cost of locum	$	$

Approved Business Expenses do not include personal income, repayments of mortgage principal, cost of goods or merchandise, cost of implements of profession and salaries of employees who would continue to produce revenue during the disability of the life assured or cost of goods, merchandise, furniture or depreciation of items acquired after commencement of disability.

18. Hazardous occupation or pursuits

		Name:	*Name:*
a.	Name of occupation or pursuit		
b.	How long have you participated in this activity?		
c.	Are you a member of a club or association?	Yes ○ No ○	Yes ○ No ○
	If yes, please give details.		
d.	Are you a certified instructor?	Yes ○ No ○	Yes ○ No ○
e.	What formal qualifications or licence do you have for this activity?		
f.	Please advise the number of hours you engaged in this activity in the last 12 months?		
g.	How often do you intend to participate in the future?		
h.	Have you ever competed in this activity?	Yes ○ No ○	Yes ○ No ○
	If 'Yes', please give details (e.g. Pro/Amateur/Comp Amateur)		
i.	Do you intend to participate alone or in a group?		
j.	Where do you participate in this activity (geographically)?		
k.	Is the use of an aircraft involved? *If 'Yes', please give details*	Yes ○ No ○	Yes ○ No ○
	Number of hours flown - Total		
	Number of hours flown - This year		
	Number of hours flown - Last year		
	Number of hours expected next year		
	Have you had any previous flying accident(s) and/or charges relating to violating Civil Aviation Regulations. *If 'Yes', please give details*	Yes ○ No ○	Yes ○ No ○
l.	What safety precautions are taken?		
m.	Do you have any plans to become a professional or change current licence/qualification?	Yes ○ No ○	Yes ○ No ○
n.	Please give details of maximum heights, speeds and depths.		
o.	Please give full details including the engine size and model for any cars, motorbikes, boats, planes or other equipment used.		
p.	Have you ever required medical attention following participation in this pursuit/occupation? *If 'Yes', please give details.*	Yes ○ No ○	Yes ○ No ○

19.0 Asthma questionnaire (for other respiratory conditions go to section 26.0)

		Name:	*Name:*
a.	When did you first develop asthma?	Day Month Year	Day Month Year
b.	When did you last experience symptoms?		
c.	How frequently did those symptoms occur in the last two years?		
d.	What is your present treatment? *(Please give names of inhalers and/or tablets and dosage)*		
e.	How many inhalers do you use in a year?		
f.	Have you ever been admitted to a hospital for asthma treatment? *If 'Yes', please give details*	Yes ○ No ○	Yes ○ No ○
g.	Have you had treatment with cortisone or prednisone in the last two years? *If 'Yes', please give details*	Yes ○ No ○	Yes ○ No ○
h.	Have you required any time off work / school in the last five years as a result of this condition? *If 'Yes', please give details*	Yes ○ No ○	Yes ○ No ○

20.0 Diabetes questionnaire (for Thyroid/Glandular conditions go to section 26.0)

		Name:	*Name:*
a.	When was diabetes diagnosed?	Day Month Year	Day Month Year
b.	How often do you see your doctor for diabetic supervision?		
c.	State date of last visit	Day Month Year	Day Month Year
d.	How often does your doctor carry out blood tests for control of diabetes?		
e.	If taking insulin or tablets, please give name, dose and frequency	*Name* *Dose* *Frequency*	*Name* *Dose* *Frequency*
f.	Do you take your own blood sugar readings?	Yes ○ No ○	Yes ○ No ○
g.	*If 'Yes', how often, and what is the usual range?*		
h.	Have you required any time of work / school in the last five years as a result of this condition? *If 'Yes', please give details*	Yes ○ No ○	Yes ○ No ○
i.	Have you suffered a diabetic or insulin coma?	Yes ○ No ○	Yes ○ No ○
j.	Have you suffered any complication of diabetes affecting your circulation, heart, vision or kidney function?	Yes ○ No ○	Yes ○ No ○
	If 'Yes' to i. or j., please give details		

21.0 Cancer, tumour or skin growth / lesion questionnaire

		Name:	*Name:*
a.	Please state the nature of the cancer or lesion including location and date(s) diagnosed		
b.	If the cancer or lesion has been treated, please give details of treatment and diagnosis		
c.	Was the cancer or lesion benign, pre-malignant or malignant?		
d.	Have any follow up checks or treatment been required?	Yes ◯ No ◯	Yes ◯ No ◯
e.	*If 'Yes', please provide dates, further details, results (if known) and the name and full address of attending doctor/specialist*		
f.	Have you fully recovered from this condition?	Yes ◯ No ◯	Yes ◯ No ◯
	If 'Yes', please advise date	*Day* *Month* *Year*	*Day* *Month* *Year*
	If 'No', please give details of ongoing issues		

22.0 Musculoskeletal questionnaire

(Please complete this section for disorder, disease or injury to muscles, bones or joints, including hips, shoulders, back, neck, knees, wrists or arthritis, gout, rheumatism, OOS)

			Name:		*Name:*	
a.	When did you first suffer from any of the above problems?		*Day* *Month* *Year*		*Day* *Month* *Year*	
b.	Please state	i) the cause				
		ii) the symptoms / exact nature of the problems				
c.	Please indicate the area or joint involved and specify which side *(if applicable)*					
		Cervical spine (neck)	◯		◯	
		Lumbar spine (low back)	◯		◯	
		Thoracic spine (mid back)	◯		◯	
		Knee joint	*L* ◯	*R* ◯	*L* ◯	*R* ◯
		Hip joint	*L* ◯	*R* ◯	*L* ◯	*R* ◯
	Other *(Please specify)*		*L* ◯	*R* ◯	*L* ◯	*R* ◯
d.	What was the severity of the pain?		*Mild* ◯ *Moderate* ◯ *Severe* ◯		*Mild* ◯ *Moderate* ◯ *Severe* ◯	

e.	How many recurrences have you had of the problems?		
	When?		
	Duration of episode(s)		
f.	Are you now free of all symptoms? *(e.g. no pain or stiffness)*	Yes ◯ No ◯	Yes ◯ No ◯
	If 'Yes', for how long?		
	If 'No', what is the current severity of pain?	*Mild* ◯ *Moderate* ◯ *Severe* ◯	*Mild* ◯ *Moderate* ◯ *Severe* ◯
g.	Have you required any time off work / school in the last five years as a result of this condition? *If 'Yes', please give details*	Yes ◯ No ◯	Yes ◯ No ◯
h.	Please describe the treatment(s) received including details of any pins/plates/wires etc		
	Date of removal	*Day* *Month* *Year*	*Day* *Month* *Year*
i.	If you are still undergoing treatment, please give details		
j.	If treatment has ceased, please give date	*Day* *Month* *Year*	*Day* *Month* *Year*
k.	Please advise diagnosis (e.g. slipped disc, arthritis, etc.)		
l.	Have you ever had any associated depression?		
m.	Please give the dates, names and address of doctor(s) or other health provider(s) or adviser(s) consulted for these problems		

23.0 Mental health questionnaire

		Name:	*Name:*
a.	Please indicate which of these apply to you:		
	Depression	◯	◯
	Stress	◯	◯
	Anxiety disorder	◯	◯
	Panic attack	◯	◯
	Phobia	◯	◯
	Compulsive Disorder	◯	◯
	Chronic Fatigue	◯	◯
	Other (Please specify)	◯	◯
b.	Date of onset or dates if you have suffered more than one episode	*Day* *Month* *Year* *Day* *Month* *Year*	*Day* *Month* *Year* *Day* *Month* *Year*
c.	Did this issue arise as a result of particular circumstances? *If 'Yes', please outline those circumstances*	Yes ◯ No ◯	Yes ◯ No ◯

d.	Has your condition ever led you to intentionally or unintentionally consider harming yourself or have you ever had suicidal thoughts? *If 'Yes', please give details*	Yes ◯ No ◯	Yes ◯ No ◯
e.	Please provide the name of any doctor(s) or health provider(s) you have consulted regarding your symptoms		
f.	Please give details of any medication or treatment prescribed, date(s) and duration(s)		
g.	Are you still on treatment for this issue? *If 'Yes', please give details*	Yes ◯ No ◯	Yes ◯ No ◯
	If 'No', please give date of cessation of treatment	Day Month Year	Day Month Year
h.	How much time have you had off work for this issue?		
i.	Date(s) of last symptoms (if applicable)	Day Month Year	Day Month Year

24.0 Blood pressure questionnaire

		Name:	*Name:*
a.	When were you first diagnosed as being hypertensive?	Day Month Year	Day Month Year
b.	What investigations have been done and what were the results? *Please give details*		
c.	Please give details of all medication(s), dosage frequency and date(s) commenced		
d.	What was the pre-treatment Blood Pressure reading?	*Reading:*	*Reading:*
	Please provide the last three Blood Pressure readings and dates	Day Month Year *Reading:*	Day Month Year *Reading:*
		Day Month Year *Reading:*	Day Month Year *Reading:*
		Day Month Year *Reading:*	Day Month Year *Reading:*
	Is your Blood Pressure under control? *If 'No', why not*	Yes ◯ No ◯	Yes ◯ No ◯
e.	Has your treatment been discontinued? *If 'Yes', please give dates and reasons*	Yes ◯ No ◯	Yes ◯ No ◯

f.	Have you had any complications of hypertension? *If 'Yes', please give dates and details*	Yes ○ No ○	Yes ○ No ○
g.	Please give the dates and results of any chest x-ray, ECG, cholesterol or other tests that have been performed since your treatment started		
h.	Please attach copies of any specialist reports and test results	Attached ○	Attached ○

25.0 Hypercholesterolaemia questionnaire

		Name:	*Name:*
a.	When were you first diagnosed with raised cholesterol?	Day Month Year	Day Month Year
b.	What investigations have been done and what were the results? *Please give details*		
c.	Please give details of all medication(s), dosage frequency and date(s) commenced		
d.	What was the pre-treatment cholesterol reading?	*Reading:*	*Reading:*
	Please provide the date and details of your most recent test results	Day Month Year	Day Month Year
	(Please note, we require all five enzyme readings) **Total cholesterol**		
	HDL		
	LDL		
	Triglycerides		
	Ratio		
	Is your cholesterol under control? *If 'No', why not*	Yes ○ No ○	Yes ○ No ○
e.	Has your treatment been discontinued? *If 'Yes', please give dates and reasons*	Yes ○ No ○	Yes ○ No ○
f.	Have you had any complications of hypercholesterolaemia? *If 'Yes', please give dates and details*	Yes ○ No ○	Yes ○ No ○
g.	Please give the dates and results of any chest x-ray, ECG, or other tests that have been performed since your treatment started		
h.	Please attach copies of any specialist reports and test results	Attached ○	Attached ○

26.0 General health questionnaire

GENERAL HEALTH QUESTIONNAIRE (1)

		Name:	Name:
a.	Please describe your particular health condition, sign or symptom		
b.	When did this condition first occur?	Day Month Year	Day Month Year
c.	Please describe the location on the body and the severity and nature of symptoms, eg. left leg.		
d.	When were the most recent symptoms?	Day Month Year	Day Month Year
e.	Have you had time off work/school as a result? *If 'Yes', when and for how long?*	Yes ◯ No ◯	Yes ◯ No ◯
f.	Have you ever been hospitalised or attended a clinic as a result of this condition? *If 'Yes', when and for how long?*	Yes ◯ No ◯	Yes ◯ No ◯
g.	Please advise full details of treatment, medication, tests, investigations and advice you have had for this condition, eg. x-rays, ECGs, physio, etc. *Please name any medication and dosage*		
h.	Which doctor(s) or health professional(s) did you consult and on what dates?		
i.	On what date did you last receive treatment/ medication for this condition?	Day Month Year	Day Month Year
j.	Has further treatment been recommended? *If 'Yes', please give details*	Yes ◯ No ◯	Yes ◯ No ◯
k.	Have you fully recovered from this condition?	Yes ◯ No ◯	Yes ◯ No ◯
	If 'Yes', please advise date	Day Month Year	Day Month Year
	If 'No', please give details of ongoing issues		

GENERAL HEALTH QUESTIONNAIRE (2)

		Name:	*Name:*
a.	Please describe your particular health condition, sign or symptom		
b.	When did this condition first occur?	*Day* *Month* *Year*	*Day* *Month* *Year*
c.	Please describe the location on the body and the severity and nature of symptoms, eg. left leg.		
d.	When were the most recent symptoms?	*Day* *Month* *Year*	*Day* *Month* *Year*
e.	Have you had time off work/school as a result? *If 'Yes', when and for how long?*	Yes ◯ No ◯	Yes ◯ No ◯
f.	Have you ever been hospitalised or attended a clinic as a result of this condition? *If 'Yes', when and for how long?*	Yes ◯ No ◯	Yes ◯ No ◯
g.	Please advise full details of treatment, medication, tests, investigations and advice you have had for this condition, eg. x-rays, ECGs, physio, etc. Please name any medication and dosage		
h.	Which doctor(s) or health professional(s) did you consult and on what dates?		
i.	On what date did you last receive treatment/ medication for this condition?	*Day* *Month* *Year*	*Day* *Month* *Year*
j.	Has further treatment been recommended? *If 'Yes', please give details*	Yes ◯ No ◯	Yes ◯ No ◯
k.	Have you fully recovered from this condition?	Yes ◯ No ◯	Yes ◯ No ◯
	If 'Yes', please advise date	*Day* *Month* *Year*	*Day* *Month* *Year*
	If 'No', please give details of ongoing issues		

27.0 Additional notes and information

Question Number	*Applicant's /Child's name*	

Declarations

The disclosures made in this application are to both Fidelity Life and to nib. Even if any applicant has previously applied for insurance with Fidelity Life and/or nib, you must provide in this application all the information that is required to satisfy the duty of disclosure described below. Fidelity Life and nib are separate insurers and each will consider the application separately. Neither Fidelity Life nor nib will be bound by disclosures made to either of them in the past. If either Fidelity Life or nib seeks additional information as part of its separate underwriting process, that information does not become knowledge of the other insurer.

FIDELITY LIFE

Your Duty of Disclosure for the Life to be Insured and Policy Owner(s)

Before you enter a contract of insurance you have a duty to disclose to Fidelity Life every matter that is relevant to Fidelity Life's decision whether to accept the risk of insurance and if so on what terms. You have the same duty to disclose those matters to Fidelity Life that occur after signing this application and before your contract of insurance commences. You also have the same duty to disclose those matters to Fidelity Life before you apply to increase or reinstate your insurance. If you fail to comply with your duty of disclosure, Fidelity Life may cancel your policy from inception, or at its discretion, alter the amounts and terms of the insurance or decline to consider any claim/s. If Fidelity Life cancels your policy from inception, all premiums paid may be forfeited.

Privacy Act 1993 and The Health Information Privacy Code 1994

- This application collects personal information about you, **the Life to be Insured and the Policy Owner(s)**. You have the right of access to, and correction of, your information.
- The personal information and any additional information obtained, (including medical and financial information) will be used by Fidelity Life, its subsidiaries, its officers, its advisers, reinsurers and other companies for processing on Fidelity Life's behalf, to calculate and administer the insurance you apply for and for the purposes and promotion of insurance and investment services to you. The information may also be used for statistical purposes provided you are not identified.
- Your personal information is securely held by Fidelity Life Assurance Company Limited at 81 Carlton Gore Road, Newmarket, Auckland, or at a secure location to be determined by us and through cloud-based services who store information on our behalf in New Zealand or Australia.
- The information may be disclosed outside of the Fidelity Life group of companies where the disclosure is necessary for one or more purposes for which the personal information was collected, to the adviser named on this application (or allocated to your business), where required by law, to the policy owner or with your consent.
- If blood tests are required in connection to this application, results will be provided to your general practitioner named in this application.

Declaration and Authority by Life to be Insured and Policy Owner(s)

- I/We have read the notice explaining my/our duty of disclosure and have had an opportunity to discuss it with my/our adviser. I/We understand the contents in the Duty of Disclosure and wish to proceed with my/our application with that understanding. I/We have completed the sections in this application required to be completed. If I/we have not done this, I/we declare that I/we have read the completed application and the information given (including any personal statement) is true, accurate and complete. I/we have not withheld or misstated any material fact.
- No statement affecting this insurance has been made to any representative of Fidelity Life that is not recorded in this application.
- I/We acknowledge that the information I/we have provided and the information provided by anyone else on my/our behalf in this application will form the basis of the contract of insurance between me/us and Fidelity Life.
- I/We understand if additional information is required to process my/our application for insurance, I/we may be telephoned by an underwriter. The information that I/we provide to the underwriter will form part of my/our application for insurance.
- I/We will immediately notify Fidelity Life of any circumstances affecting the risk that may occur after signing this application and before the contract of insurance commences.
- I/We understand that the contract of insurance with Fidelity Life will not commence until this application has been accepted by Fidelity Life, acceptance terms have been agreed to by the policy owner(s) and

nib health cover

nib nz limited – important information and declaration

All information is true, correct and complete

- Although we may obtain information from other parties (see nib Privacy Policy) or from our historic files, we are not required to do so. All information must be disclosed in this application. We may request further information from you and your doctor.
- Each policyowner and insured person declares that all information given by them is true, correct and complete. If it is not, we may, at our discretion, cancel this policy from the commencement date, effective date or join date (as applicable). If we cancel the policy, any premiums paid may be retained by us. If we have already made any claims payments, we may recover these from the policyowner.
- If you have provided information on behalf of another person, you confirm that you are authorised to do so.
- For applications for nib's Easy Health cover, please note that your medical history is not reviewed by nib on application. Future claims will be assessed for pre-existing conditions at the time of claiming.

Privacy Act 1993 and The Health Information Privacy Code 1994

- This application collects your personal and health information. The information we collect is used to:
  - provide benefits for health, travel^ and related services;
  - determine eligibility to provide or receive an nib health, travel^ or related service;
  - administer this policy; and
  - promote or market our current and future health and related services.
- In providing our health and related services and using personal information in accordance with this policy, we may be required to collect information from or disclose an insured person's personal information to:
  - Other nib companies, including Cerberus Special Risks Pty Limited and nib Travel Insurance Distribution Pty Limited for the issue and administration of the nib Ultimate Health Travel Insurance.^
  - Your financial adviser and the dealership group that they are a member of.
  - Health service providers including private health insurers, recognised private hospitals and public hospitals and professional medical authorities, including the ACC and Ministry of Health.
  - Our contractors and service providers performing services including (but not limited to) legal services, marketing, market research, mail house services, and product development services.
  - Our existing and future strategic partners in respect of covers and services provided under a distribution arrangement.
- Each policyowner and insured person authorises the collection of this information from and the disclosure of this information to such parties for the purposes set out above.
- We may also be required to disclose an insured person's personal information to other individuals on their nib policy, or to individuals to whom the insured person has granted authority to act on their behalf. You authorise us to share information with other individuals on the policy.
- The accuracy of personal information is important to us. We will take reasonable steps to ensure an insured person's personal information is accurate, complete and up-to-date. We rely on the insured person to advise of any changes to their current contact details and any other personal information. Where possible please provide an email address. If an insured person believes that any personal information we hold is not accurate, complete or up-to-date, the insured person should contact us immediately.
- Your personal information is collected and held by nib nz limited, 48 Shortland Street, Auckland.

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FIDELITY LIFE

nib health cover

- If I/we have provided my/our email address in this application, or if I/we provide it at some stage in the future, I/we consent to receive emails from Fidelity Life in respect of Fidelity Life and any further services.
- I/We have read and understand the sections in this application headed Privacy Act 1993 and The Health Information Privacy Code 1994, and Statement of Consent by Life to be Insured. I/we authorise Fidelity Life to disclose any personal information that it holds about me, to any person where the disclosure is necessary for one or more purposes for which the personal information was collected.

Statement of Consent by Life to be Insured

- I/We authorise Fidelity Life to obtain any information about me from any person and/or entity including, but not limited to, any and all health treatment providers (i.e. medical practitioner, specialist, hospital, clinic, counsellor, psychologist, therapist, dentist, alternative health practitioner), insurers, Accident Compensation Corporation, or any similar organisation, employers (whether current or not), accountants, consultants, financial advisers, banks, financial institutions, any credit rating agencies and public authorities.
- I/We authorise any person and/or entity, including any of those listed above, to give any information about me to Fidelity Life, or to other companies for collection on Fidelity Life's behalf.
- I/We agree that a photocopy of this statement of consent shall be as valid as an original and is sufficient evidence of my consent and authority to the disclosure of my information.

Acceptance of Fidelity Life's Policy Terms

- I/We understand that Fidelity Life decides whether to accept my/our application and, if so, on what terms. Subject to the 14-day Free Look period described below, I/we agree in advance to always accept Fidelity Life's terms including but not limited to the premium, any exclusions and any other variations to the standard terms. If my/our application is acceptable on terms that differ from those originally requested by me/us, my/our adviser/broker will contact me/us for approval of any changes.

14-day Free Look

- I/We understand that my/our contract of insurance can be cancelled during the 14-day Free Look period and all premiums refunded to me/us.

Signatures

Signature of Life to be Insured (1)

_____ Day Month Year

Signature of Life to be Insured (2)

_____ Day Month Year

Signature of parent/guardian/employer for person under age 18

_____ Day Month Year

Signature of additional Policy Owner(s)

(If company-owned, authorised signatory must sign and indicate they are signing on behalf of the company and their position in the company)

1. _____ Day Month Year
2. _____ Day Month Year
3. _____ Day Month Year
4. _____ Day Month Year
5. _____ Day Month Year
6. _____ Day Month Year

Financial strength rating

Fidelity Life has an A- (Excellent) financial strength rating given by A.M. Best

A- Excellent

Secure		Vulnerable		
A++, A+	(Superior)	B, B-	(Fair)	E (Under Regulatory Supervision)
A, A-	(Excellent)	C++, C+	(Marginal)	F (In Liquidation)
B++, B+	(Good)	C, C-	(Weak)	S (Suspended)
		D	(Poor)	

The A.M. Best financial strength rating relates to Fidelity Life's insurance and investment business. For the latest ratings, visit www.ambest.com. The rating should not be read as a recommendation. The scale of which this rating forms part of is available from Fidelity Life.

Policy Terms

The illustration attached to this application forms part of the application and sets out the nib cover that you are applying for. The terms of your policy are set out in the Contract of Insurance for the nib cover you have selected. nib may accept the application on non-standard terms and this will be set out in the acceptance certificate or renewal certificate (whichever is the later). A 14-day free-look period applies to all nib covers. Each nib cover can be amended from time to time in accordance with its terms.

nib Ultimate Health Travel Insurance^

- I/we agree to receive all travel insurance related documents electronically at the email address provided on the application form;
- I/we confirm that I/we have unrestricted right of entry into New Zealand and I/we agree to be repatriated, if required, back to New Zealand under the nib Ultimate Health Travel Insurance.^

Signatures

Policyowner(s) and applicants age 16 or over

To be signed by all applicants aged 16 and over, including the policyowner(s).

Note: The Policyowner(s) must be age 18 and over. Policyowner(s) are also signing on behalf of all dependent children under age 16.

Full Name of applicants	Date	Signature of applicants
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	
	D D M M Y Y Y Y	

^only applies to applications for Ultimate Health and Ultimate Health Max

Financial strength rating

nib nz limited has an A- (Strong) financial strength rating given by S&P Global Ratings Australia Pty Ltd.

A- Strong

AAA	(Extremely Strong)	B	(Weak)	SD or D	(Selective Default or Default)
AA	(Very Strong)	CCC	(Very Weak)	R	(Regulatory Action)
A	(Strong)	CC	(Extremely Weak)	NR	(Not Rated)
BBB	(Good)				

For more information, visit www.spratings.com/understanding-ratings

Replacement Policy Advice for Advisers

Adviser to complete

A 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.

Policy number(s)

Contact phone number ( )

Name(s) of Life Insured

Date of birth

Day Month Year

Day Month Year

Details of New Policy or Benefit

Name of Insurer	Type of Policy/Benefit	Sum Insured	Annual Premium
		$	$ Level ◯ Stepped ◯

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

Details of Policy or Benefit being replaced

Name of Insurer	Type of Policy/Benefit	Policy number	Sum Insured	Annual Premium
			$	$ Level ◯ Stepped

Reasons for replacement

The current policy/benefit is being replaced because (tick all applicable):

◯ 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.

Name of Adviser Adviser signature

Company name Date Day Month Year

Telephone ( ) Email

RPAA MF 1117

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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 three months of the commencement of the policy/benefit.
- **Definitions** – there can be subtle differences in the definitions used between policies (e.g. 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. Yes ◯ 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. Yes ◯ No ◯
3. I/We acknowledge that this information was provided and explained to me/us before I/we signed the application for the new policy/benefit. Yes ◯ No ◯

Name of the Policy Owner

Date of birth

Day *Month* *Year*

Signature of the Policy Owner

Name of the Policy Owner

Date of birth

Day *Month* *Year*

Signature of the Policy Owner

RPAPO MF 1117

Please complete and return:

- By email: scan and send to customerservice@fidelitylife.co.nz
- By post: Fidelity Life, PO Box 37-275 Parnell, Auckland 1151

STB

Office use only

Policy number(s)

Contact phone number

( )

I would like to pay: ○ Fortnightly ○ Monthly ○ Quarterly ○ Half-yearly ○ Annually

Direct Debit Authority

Name on my account to be debited (acceptor):

Name of my bank:

My bank account number:

Bank Branch Account Suffix

Initiator's authorisation code

0 6 0 4 9 0 2

Approved

490 | 08/15

From the acceptor to my bank:

I authorise you to debit my account with the amounts of direct debits from **Fidelity Life Assurance Company Limited** with the authorisation code specified on this authority in accordance with this authority until further notice.

I agree that this authority is subject to:

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

Please include the following information on my bank statement:

Authorised signature(s):

Date: / /

SPECIFIC CONDITIONS RELATING TO NOTICES AND DISPUTES

1. For scheduled payments the initiator is required to give you a written notice of the amount and date of each direct debit in a series of direct debits no less than 10 calendar days before the date of the first direct debit in the series. The notice is to include:
   - The dates of the debits, and
   - The amount of each direct debit.
   - If the initiator proposes to change an amount or date of a direct debit specified in the notice, the initiator is required to give you notice no less than 30 calendar days before the change, or

   For variable payments the initiator is required to give you a written notice of the amount and date of each direct debit no less than 10 calendar days before the date of the debit, or

   For customer-initiated payments the initiator may only send a direct debit if you have:
   - Asked the initiator to send it, and
   - Agreed the amount of the direct debit, and

   The initiator is required to give you a written notice of the amount and date of each direct debit no less than the date of the debit.
2. I may ask my bank to reverse a direct debit up to 120 calendar days after the debit if:
   - I don't receive a written notice of the amount and date of each direct debit from the initiator, or
   - I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.
3. If the bank dishonours a direct debit but the initiator sends the direct debit again once within 5 business days of the dishonour, the initiator is not required to give you a second notice of the amount and date of the direct debit.

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nib Direct Debit Authority

Your personal details

Policy Number:

Office use only: STB ☐

Policyholder name:

I would like to pay: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Annually

Preferred start date: D D / M M / Y Y Y Y

Account information

Name of my account to be debited (acceptor)

Name of my bank:

Bank | Branch | Account | Suffix

Initiator's Authorisation Code

0 6 5 4 4 8 3

Approved

5448 | 11/17

From the acceptor to [insert name of acceptor's bank] **(my bank):**

I authorise you to debit my account with the amounts of direct debits from nib with the authorisation code specified on this authority in accordance with this authority until further notice.

I agree that this authority is subject to:

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

Account Holders signature/s

Authorised signature/s:

X

Date D D / M M / Y Y Y Y

Specific conditions relating to notices and disputes

I may ask my bank to reverse a direct debit up to 120 calendar days after the debit if:

- I don't receive a written notice of the amount and date of each direct debit from the initiator, or
- I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.

The initiator is required to give a written notice of the amount and date of each direct debit in a series of direct debits no later than the date of the first direct debit in the series. The notice is to include:

- the dates of the debits, and
- the amount of each direct debit.

If the bank dishonours a direct debit but the initiator sends the direct debit again within 5 business days of the dishonour, the initiator is not required to give you a second notice of the amount and date of the direct debit.

If the initiator proposes to change an amount or date of a direct debit specified in the notice, the initiator is required to give you notice:

- no less than 30 calendar days before the change, or
- if the initiator's bank agrees, no less than 10 calendar days before the change.

Please return completed form to: **newbusinessteam@nib.co.nz**

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Fidelity Life

Certificate of Free Temporary Cover

Fidelity Life provides Free Temporary Cover on the life to be insured named in a completed application while the application is being assessed.

The life to be insured is covered if he or she dies, or is diagnosed with one of the Trauma conditions below, as a result of accidental injury, sickness, or illness, before this Free Temporary Cover ends.

Free Temporary Cover starts

The Free Temporary Cover starts from the date the application is signed and is valid for 60 days, provided the first premium being paid or a valid payment instruction being received by Fidelity Life.

Free Temporary Cover ends

The Free Temporary Cover ends on the earliest of the following happening:

- The expiry of 60 days since the Free Temporary Cover started;
- Fidelity Life is in receipt of a request to cancel the application;
- The date on which Fidelity Life seeks facultative reinsurance in respect of the Cover applied for in order to secure better terms for the life to be insured;
- The date the Policy Owner is advised that that the application has been accepted or refused.

When there is no Free Temporary Cover

There is no Free Temporary Cover if:

- The life to be insured is under the age of 10;
- The life to be insured is over the age of 65;
- The life to be insured has had an insurance application refused, deferred or assessed as non-standard by any life insurer or life insurance company;
- The life to be insured has in the past had an insurance policy avoided due to non-disclosure;
- If the Cover(s) being applied for in the application for the life to be insured would have been refused, deferred, or assessed as non-standard in anyway;
- The life to be insured has non-disclosed any material information on the application;
- If a similar application has been accepted and a policy issued by another company since this application was completed.

Trauma conditions covered

Blindness, Coma, Deafness, Severe burns, Major Head Trauma, Paralysis and Total and Permanent loss of use of two limbs, as defined in Fidelity Life's Platinum Plus Trauma Cover wording.

The amount of Free Temporary Cover

Irrespective of the number of Certificates issued for any one life to be insured, the amount of Free Temporary Cover is the sum insured being applied for in the application, but limited to the following:

- A maximum of $500,000 for Death;
- A maximum of $250,000 for Trauma conditions covered;
- A maximum of $5,000 where the Cover being applied for does not include Life Cover or Trauma Cover.
- A maximum combined amount payable on a life to be insured of $500,000.

In terms of this Certificate and other concurrent Certificates, no Free Temporary Cover is payable if any proposed Covers becomes payable.

Exclusions

Accidental injury, sickness, or illness excludes death or trauma caused by or resulting from:

- A self-inflicted act, whether sane or insane;
- Taking drugs, alcohol or any intoxicating substance;
- Participation in a criminal activity;
- Aviation other than as a fare paying passenger on a recognised airline;
- Taking part in risks or occupation which would exclude the life to be insured from insurance Cover for death or trauma;
- Any accident, sickness or illness which occurred on or before the date of the application; and
- Any sickness or illness that arose from a pre-existing condition or symptom before the date of application.

Accident means external or internal bodily injury caused solely and directly by violent, accidental, external or visible means. The injury must be unintended and unexpected.

Application means the completed application form for the Cover(s) being applied for by the persons named in the application form.

Pre-existing condition means any sickness that the policy owner or the life to be insured were aware of, or the life to be insured had sought advice or medical treatment or surgery, or a reasonable person in the same position should have been aware of, before the Free Temporary Cover starts.

Fidelity Life

Alteration Advice

Policy number

Please attach this form to appropriate support documentation

Life Insured

Surname

First name(s)

Surname

First name(s)

Policy Owner(s)

Surname

First name(s)

Surname

First name(s)

I/We request that the policy be altered as follows (please tick which action is required)

	Benefit...	Change from...	to...
Increase/addition ○			
Decrease ○			
Other ○			

With effect from Date Day Month Year

New total premium $

Payable Monthly ○ Half yearly ○ Annual ○ or Other ○

Paying by Direct Debit Existing ○ New ○ (attached)

I understand and agree that:

- this application, together with the proposal shall be the basis of the contract for the altered insurance.
- any endorsement, and/or terms and conditions on the current policy benefits will also apply to any change in those benefits unless advised otherwise by Fidelity Life Assurance Company Limited.

Life Assured signature(s)

Policy Owner signature(s)

Date Day Month Year

Tear here

For risk applications:

Fidelity Life Assurance Company Limited

PO Box 37 275, Parnell,
Auckland 1151
Phone: 0800 88 22 88 (option 5)
Fax: 09 303 5136
newbusiness@fidelitylife.co.nz

fidelitylife.co.nz

For health applications:

nib nz limited

PO Box 91630, Auckland 1142
Phone: 0800 123 nib
(0800 123 642)
Fax: 0800 345 134
newbusiness@nib.co.nz

nib.co.nz

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