Asteron Life

Application

Guide to completing this application form

- We need a separate application form completed for each adult life that is to be insured. Each adult life accepted for cover will be issued a separate policy.
- Most of this application needs to be read and completed by the person who is going to be insured. However, there are some sections that the policy owner needs to answer, and these are clearly marked.
- When we refer to 'you' in this form, we mean the person to be insured unless we note otherwise.
- When completing this application, please write in pen and use **BLOCK letters**.

What parts of the form do you need to complete?

There are three parts to this application form. You will only need to complete part 2, your adviser will complete parts 1 and 3.

You should complete this application personally, but if your financial adviser completes this form on your behalf using the information you have provided, you must read all the questions and answers carefully before signing the declaration at the end.

To help you complete this application you will need:

- Information relating to your existing or previous life insurance.
- Details of your medical history including medications and recent test results, your height and weight, smoking status, and alcohol consumption.
- Information relating to your occupation, travel, and pursuits.
- Your doctor's name, the name of the practice, and address details.
- Your payment details.

We may need additional medical or financial information to assess your application due to your medical history or the amount of cover you have requested. Your adviser will let you know if this applies to you.

Genetic testing

As part of this application, you must tell us if you are having treatment for or are experiencing symptoms of a condition that may be genetic. We will also ask you about your family history and if there are any medical conditions that run in your family for which screening has been offered.

Regarding genetic tests, Asteron Life will never:

- ask or incentivise you to have a genetic test
- ask you or your doctor for the result of a genetic test if the test was part of medical research and the result will not be disclosed to you
- ask you or your doctor for the results of a genetic test that is not your own individual test, such as a close relative's genetic test results.

Do you need help?

You can talk to your adviser or call us on 0800 737 101.

Insurer Financial Strength Rating

The Insurance (Prudential Supervision) Act 2010 requires all licensed insurers to have a current financial strength rating that is given by an approved rating agency. **Asteron Life Limited** has been given an **A** Insurer Financial Strength Rating by Standard & Poor's.

The rating scale is:

AAA Extremely Strong	**B** Weak
AA Very Strong	**CCC** Very Weak
A Strong	**CC** Extremely Weak
BBB Good	**SD** Selective Default
BB Marginal	**D** Default

Ratings from 'AA' to 'CCC' may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories.

The rating scale above is in summary form. The full version of this rating scale can be obtained from www.asteronlife.co.nz.

Declaration and Privacy Statement

For the purpose of the Privacy Act, we confirm that we collect and use your personal information and may disclose your personal information to third parties for the purpose of administering your policy or in order to comply with legal requirements. Your details are stored securely within Asteron Life and may also be securely stored electronically on servers located in New Zealand or overseas, by third parties on our behalf. You can contact us at any time to request access to and correction of your personal information. The collection of this information is required under the terms of your policy.

For further information about how we deal with your personal information, please refer to Asteron Life's Privacy Policy. It is available online at www.asteronlife.co.nz by phoning 0800 737 101, or by writing to Asteron Life Limited, PO Box 894, Wellington 6140.

Why accurate information matters to us

To run an insurance business that is here for the long term, we need to predict what our future expenses will be so that we can minimise premiums, pay valid claims, meet the costs of running our business, and encourage investment in our future. It is very important that you provide us with accurate information to help us assess the likelihood and potential cost of future claims under your policy.

Your duty of disclosure

Please read carefully

You have a duty to disclose to us all information about you, your personal circumstances and history to allow us to accurately assess the insurance we can provide to you. This is **material** information relevant to your application for insurance. **Material** information is information that might influence our decision to insure you and the terms and amount of premium of your insurance policy.

The information you need to tell us depends on what you are applying for. Typically, it includes information about your background, occupation, medical history and current health, personal habits and finances. There may be other types of **material** information about you which should also be disclosed. It is important that you tell us even if you have separately discussed something with your financial adviser.

You meet your duty of disclosure by providing us with complete and correct answers to all the questions that we ask, and by telling us anything else that might be **material**, even if we don't specifically ask you about it.

It is important that you answer all questions accurately in the application form, even if you need to go away and find the information from other sources.

This application for insurance forms part of your proposed insurance contract. The person to be insured and the policy owner(s) must answer all the questions asked of them accurately and disclose all **material** information, whether asked for in the application form or not.

The person to be insured and the policy owner(s) must also tell Asteron Life of any change in circumstances that is material to the application from the time the application form is submitted until the commencement date of the insurance policy. This duty of disclosure also applies if in future you ask to extend or alter the policy or ask to reinstate it if it lapses for non-payment of premiums.

Risks to you from non-disclosure

If you don't provide us with accurate or complete information, even if you accidentally provide inaccurate information, you may be affected in the following ways:

- Claims that you make under the policy may not be paid.
- Your insurance policy may be cancelled or treated as if it never existed.
- You may not be able to obtain other insurance in the future.
- You could experience other financial hardship.

If you are unsure about whether you should disclose something it is always safer to include it in your application form or call our Customer Service Team on 0800 737 101 to check.

Replacement Business Risks

Although there may be good reasons for replacing an existing life insurance policy, you should also be aware of risks that may arise when doing so.

- Benefits that you might have received under the existing policy may not be covered by the new policy.
- Initial premiums in the new policy may appear lower but be higher over the long term.
- Exclusions, limitations or increased premium in the new policy due to changes in health, lifestyle or occupation that have occurred since the existing policy was taken out.
- Wait periods for benefits under the new policy which had already elapsed under the existing policy.
- Non-disclosure may reduce claims payable or result in the new policy being treated as if it never existed.

Your financial adviser should be able to provide you with an analysis of these risks and ways to manage them.

Important – must be completed

Person to be insured:

☐ Please tick the box and sign to confirm that you have read the duty of disclosure information above, and will answer the questions in this application form honestly.

	Full name	Signature	Date
Person to be Insured			

Sign here

PART 1: Cover details

(Adviser to complete)

Adviser Number ☐☐☐☐

Please attach AsteronConnect illustration(s) to front page

1. Purpose of cover

1. What is the purpose of this application?

Please tick all that apply.

- ☐ New Personal Insurance application
- ☐ New Business Insurance application
- ☐ Transfer or Upgrade to policy
- ☐ Increase to policy
- ☐ Review of terms

If you've included 'New Business Insurance application' please indicate the reason for cover.

- ☐ Shareholder protection
- ☐ Buy/Sell agreement
- ☐ Key Person cover
- ☐ Debt / Loan protection
- ☐ Other

Details of other reason.

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

If 'yes', please provide details of the linked applications, including names and policy numbers (if known).

PART 2: Insured person and policy holder details

1. Details of the policy owners

(Must be completed by the owner of the policy)

1. Is the person to be insured also a policy owner? Yes ☐ No ☐

If 'yes', which policy will they be the owner of?

- ☐ Personal insurance
- ☐ Business insurance
- ☐ Both

2. Do you intend to nominate beneficiaries for your insurance? Yes ☐ No ☐

If 'yes', please complete the 'Nominated Beneficiary Form'.

If the person to be insured is the sole policy owner, please go to Section 2, 'Details of person to be insured'.

Otherwise please complete the ownership details relevant to this application on the next page.

Notes for completing the policy owner section

Regarding Trusts, please note that a Trust itself cannot own the policy but the Trustees of a Trust can own a policy jointly 'in trust' for the beneficiaries of the Trust. All Trustees, including the director of any Corporate Trustee, must be noted under the 'Trustee Ownership' section and individually sign the application as policy owners. The name of the Trust must also be documented in the 'Trustee Ownership' section below.

Where an owner of the policy is a limited liability company, the application form must be completed and signed by all directors or an authorised signatory of the company.

If there are more than two policy owners, please attach an additional sheet with their details.

For personal ownership

Policy Owner 1

Title

Family name

Given name(s)

Date of birth

Relationship to the person to be insured

Postal address

Post Code

Preferred phone

Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

Policy Owner 2

Title

Family name

Given name(s)

Date of birth

Relationship to the person to be insured

Postal address

Post Code

Preferred phone

Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

Preferred contact person

Please select the main contact to receive policy and general communications from Asteron Life.

Policy Owner 1 ☐ Policy Owner 2 ☐

For company ownership

(All directors' signatures are required. Alternatively, one director can sign to place the company as owner of the policy, providing this person is an authorised signatory for the company named.)

Company Name

Full name of Director or Authorised Signatory

Are you the only Director signing on behalf of the company? Yes ☐ No ☐

If 'yes', do you confirm that you are an authorised signatory for the company named? Yes ☐ No ☐

Full name of Director 2 (if required)

Full name of Director 3 (if required)

Name of main contact person

Postal address

Post Code

Prefered phone

Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

For trustee ownership

(All trustees required)

Name of Trust

Full name of Trustee 1

Date of birth

Full name of Trustee 2

Date of birth

Full name of Trustee 3

Date of birth

Name of main contact person

Postal address

Post Code

Prefered phone

Email

Which policies will you own? *Please tick one or both.*

Personal Insurance ☐ Business Insurance ☐

The remainder of Part 2 must be completed by the applicant unless otherwise noted.

2. Details of the person to be insured

Personal details

Title

Family name

Given name(s)

Previous name
(if changed)

Date of birth

Male ☐ Female ☐

Contact details

Home address

Post Code

Postal address
(if different to home address

Post Code

Home phone

Work phone

Mobile

Email

3. Preferred contact details

There may be times where we need to contact you to clarify information, and/or answers provided in this application.

So we can do so, please tell us the most suitable time to contact you.

Contact hours are between the hours of 8.30am to 5pm, Monday to Friday.

Preferred day of week. *Please tick.*

☐ Monday ☐ Tuesday ☐ Wednesday
☐ Thursday ☐ Friday

Preferred time of day. *Please tick.*

☐ 8.30-10.30 ☐ 10.30-12.30 ☐ 12.30-2.30
☐ 2.30-3.30 ☐ 3.30-5.00

4. General Practitioner's contact details

We may request medical reports if we need more information to underwrite your application, or if there is a future claim.

Please be aware you still have a duty of disclosure to answer all the questions accurately and honestly whether we contact your doctor about your medical information or not.

1. What is the name and address of your usual General Practitioner (doctor) and/or medical centre?

2. Does this medical professional or centre hold all your medical records for the last 5 years? Yes ☐ No ☐

If 'no', please provide the name and address of the medical centre(s) that will have your records for the last 5 years.

5. Paramedical service

If medical and blood tests are needed, would you like to use our mobile paramedical services if available in your area? Yes ☐ No ☐

6. Kids Cover

(To be completed by owner of policy if applying for Kids Cover)

How many children are to be covered?

Policy owners, if you would like cover for more than two children, please attach an additional Kids Cover application form with their details.

Child 1

Family name

Given name(s)

Date of birth Male ☐ Female ☐

Postal address
(if different from person to be insured)
Post Code

1. Are you the child's parent? Yes ☐ No ☐

If 'no', please provide details.

2. *In the last 5 years* has the child:

- Been admitted to hospital? Yes ☐ No ☐
- Had an operation, surgical procedure, or blood transfusion? Yes ☐ No ☐
- Had an abnormal blood test or other abnormal investigation results? Yes ☐ No ☐
- Attended a clinic? Yes ☐ No ☐

Child 2

Family name

Given name(s)

Date of birth Male ☐ Female ☐

Postal address
(if different from person to be insured)
Post Code

1. Are you the child's parent? Yes ☐ No ☐

If 'no', please provide details.

2. *In the last 5 years* has the child:

- Been admitted to hospital? Yes ☐ No ☐
- Had an operation, surgical procedure, or blood transfusion? Yes ☐ No ☐
- Had an abnormal blood test or other abnormal investigation results? Yes ☐ No ☐
- Attended a clinic? Yes ☐ No ☐

You don't need to tell us about normal growth and development check-ups, immunisation, or simple bone fractures or stitches that have healed.

3. Other than what you've already told us about, does the child *currently* have any medical condition or disability? Yes ☐ No ☐

If you've answered "yes" to any part of question 2 and/or 3 above, please provide the following details.
Otherwise go to question 4.

	Child 1	Child 2
Condition		
Treatment		
Tests		
Results		
Description of current symptoms		

Is the child's General Practitioner (doctor) and/or medical centre the same as that provided in Section 4? Yes ☐ No ☐

If 'no', please provide the following details.

	Child 1	Child 2
Doctor		
Doctor's address		

4. Have any of the child's biological parents, brothers or sisters been diagnosed with any of the following *before the age of 60?*

Please tick all that apply and complete the additional information where required. You don't need to tell us about half-brothers or half-sisters.

		Child (1, 2, or both)	Relation to child	Relative's age at diagnosis
Angina, heart attack, heart disease	☐ Condition:			
Stroke	☐			
Diabetes	☐ Type:			
Polycystic kidney disease (PKD)	☐			
Haemochromatosis	☐			
Huntington's disease (Chorea)	☐			
Breast and/or ovarian cancer	☐ Type:			
Bowel or colon cancer	☐			
Another type of cancer	☐ Type:			
Familial adenomatous polyposis (FAP), or another hereditary bowel condition	☐ Condition:			
Muscular dystrophy	☐			
Any other condition that runs in the family for which screening has been offered for the child	☐ Condition:			
Don't know as adopted	☐			
None of the above	☐			

7. Insurance history

The following questions are about Personal or Business protection such as Life, Trauma, and Income Protection.
You don't need to tell us about general insurance policies such as motor or house insurance.

1. **Not including the cover you're applying for with this application, do you have or are you currently applying for any type of Life, Accident, Trauma, Lump sum disablement or Disability Insurance, with Asteron, AA Life, or any other company?** Yes ☐ No ☐

   If 'yes', please complete the following table.

Company name	Insurance type	Cover amount	Existing / In force	To be fully replaced by this policy
		$	Yes ☐ No ☐	Yes ☐ No ☐
		$	Yes ☐ No ☐	Yes ☐ No ☐
		$	Yes ☐ No ☐	Yes ☐ No ☐

2. ***In the last 5 years,* have you had any application for insurance declined or deferred?** Yes ☐ No ☐

3. ***In the last 12 months,* have you had any application for insurance provided on modified terms such as loadings or exclusions?** Yes ☐ No ☐

If you've answered "yes" to either question 2 or 3, please complete the following table.

Company name	Date commenced	Insurance type	Declined	Deferred	Modified terms	Reason(s)
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	

The following questions are about claims on any other insurance policy, or WINZ or ACC benefits, due to disability, sickness, injury, or treatment for injury (e.g. physiotherapy). You don't need to tell us about motor or general insurance claims.

4. **Are you currently receiving a WINZ or ACC benefit, claiming on an insurance policy, or expecting such a benefit or claim to be paid for the first time?** Yes ☐ No ☐

5. **Other than already stated, have you previously claimed on an insurance policy or received a WINZ or ACC benefit *within the last 5 years?*** Yes ☐ No ☐

If you've answered "yes" to question 4 or 5, please complete the following table, and provide details of any associated condition in Section 15.

Type of claim	Claim status (e.g. current, pending, ceased)	Date claim started	Duration of claim	Condition or cause

8. Residence and travel

1. **Are you a New Zealand citizen, or do you hold a visa that allows you to live in New Zealand permanently?** Yes ☐ No ☐

   If 'no', please provide the details below.

   How long have you lived in New Zealand? _____ years Visa type and expiration date _____

2. ***In the next 12 months*, do you have plans to live, work, or travel outside of New Zealand for more than 30 days?**

   You don't need to tell us about holidays of less than a month, or business trips where the total time outside of New Zealand over the next 12 months will be less than 30 days.

   Yes ☐ No ☐ *If 'yes', please complete the following table.*

Country name and areas travelling to	Purpose of trip	Length of visit	Frequency

9. Pursuits, sports, and activities

1. Do you participate in, or do you plan to participate in any of these activities *in the next 12 months?*

Please see notes, then tick all that apply.

- ☐ Flying or any aerial activity
- ☐ Motor car or motorcycle sport
- ☐ Mountaineering or rock climbing (excluding artificial walls)
- ☐ Powerboat racing
- ☐ Caving or potholing
- ☐ Diving over 30 metres or solo
- ☐ Ocean racing or long-distance open ocean sailing
- ☐ Horse riding (other than private hacking)
- ☐ Rugby or football
- ☐ Full contact martial arts, combat sport or boxing
- ☐ Any extreme sport
- ☐ Any professional or semi-professional sport not already stated
- ☐ No to all

Notes for answering this question

- Flying includes hang gliding, paragliding, micro-lighting, parachuting and skydiving.
- Don't select flying if you only fly as a fare-paying passenger, commercial pilot, or cabin crew on a scheduled aircraft (e.g. Air NZ).
- Rugby or football includes union, league, Australian rules, American football and soccer.
- Examples of extreme sport include bungee jumping, canyoning, white water rafting, heli-skiing, competitive BMX or mountain biking.
- You don't need to tell us about one-off bungee and parachute jumps.

Please complete the following section if you've ticked any of the above pursuits, sports, and activities.

For multiple pursuits please attach a separate questionnaire.

Name of pursuit, sport, activity

a. How long have you participated in this activity?
years months

b. In the last 12 months how many events / trips / climbs / dives / jumps did you participate in?

c. Please tell us the number of hours you engaged in this activity in the last 12 months.

d. Where do you participate in this activity (geographically)?

e. Please disclose maximum heights, speeds, depths.

f. Please give full details of equipment used, including the engine size for boats / cars / planes.

g. What qualifications, certificates, or licences do you currently hold relating to this activity? (e.g. PADI, C grade licence, CPL or PPL)

h. Are you a certified instructor? Yes ☐ No ☐

i. Do you ever participate in this activity alone? Yes ☐ No ☐

j. Do you take part in competitions or record attempts, or intend to in the next 12 months? Yes ☐ No ☐

k. Have you ever had any sickness or injury due to this pursuit? Yes ☐ No ☐

l. Are you paid to participate in this activity? Yes ☐ No ☐

m. Do you have plans to become a professional? Yes ☐ No ☐

n. Have you ever, or do you intend to night dive or dive in caves or wrecks, or do you use special equipment e.g. Nitrox, rebreathers? Yes ☐ No ☐

If you've answered "yes" to any of the questions h to n above, please provide the details below.

Question number	Details

Lifestyle and medical history

10. Your Lifestyle

1. What is your current height and weight?

cm | kg

If you're unsure or it has been a while since you last weighed yourself, please take a new measurement before answering.

Important reminder

Please remember that it's important you answer these questions honestly and to the best of your knowledge and understanding. If we don't receive correct or complete information in your application form, it could mean that we won't be able to pay out if you need to make a claim.

When answering the following sections, if you're not sure whether to tell us about a medical condition, tell us anyway.

2. When did you last smoke or use any tobacco, nicotine, e-cigarette, or vaporiser products?

Such products include Cigarettes, E-cigarettes or vapes (with or without nicotine), Tobacco including rolled, chewing and pipe, Cigars, Nicotine replacement therapy (NRT) including gum, lozenges, patches, and nasal sprays.

Within the past month ☐ Between 1-5 years ago ☐ Never ☐
Within the past 12 months ☐ More than 5 years ago ☐

If 'within the past month' or 'within the past 12 months' please tick what you use and provide details:

Cigarettes	☐	Number of cigarettes per day					
Tobacco rollies	☐	Grams of tobacco per day					
Pipe	☐	Grams of tobacco per day					
Cigar	☐	Number of cigars		Frequency:	Daily ☐	Monthly ☐	Yearly ☐
E-cigarettes / Vapes	☐						
Nicotine replacement	☐	Date ceased if applicable					
Other	☐	Substance		Frequency:	Daily ☐	Monthly ☐	Yearly ☐

3. Have you used marijuana/cannabis recreationally *in the last 5 years?*

You don't need to tell us here about the use of CBD oil products or cannabis used to treat a medical condition. However, you will need to disclose this later in the application along with the associated medical condition.

Yes ☐ No ☐ If 'yes', number of times used per week ☐ Date last used ☐

4. Other than marijuana/cannabis, have you used any recreational drugs *in the last 10 years?*

This includes ecstasy, cocaine, heroin, amphetamines, opiates, anabolic steroids, or any controlled drug that has not been prescribed by a doctor.

Yes ☐ No ☐ *If 'yes', please complete the following table.*

Name of drug	Date first used	Frequency	Date last used

5. Thinking back over the last 3 months, how many of the following drinks do you consume in a typical week?

Regular glass, bottle or can of beer ☐
Glass of wine ☐
Single measured shot of spirits (30 ml) ☐
Other drinks with alcohol ☐ Type of other drinks ☐
None, I don't drink alcohol (please tick) ☐

6. Have you *ever* attended or been advised to attend a support service, treatment, or counselling relating to the use of alcohol?

Yes ☐ No ☐ If 'yes', type of treatment ☐ Date of last treatment ☐

11. Mental health

1. **Have you *ever* been admitted to hospital overnight or referred to a psychiatrist due to a mental health related condition or eating disorder?**

   Yes ☐ No ☐ *If 'yes', please complete Questionnaire i, in Section 15.*

2. **Apart from anything you've already told us about, have you ever had symptoms of, been diagnosed with, or treated for depression, anxiety, stress*, panic attacks, an eating disorder, or any other mental health related condition?**

   *Only tell us about stress if it required you to consult a health professional (nurse, doctor, psychologist etc.) or prevented you from working or carrying out your normal daily activities.

   Yes ☐ No ☐ *If 'yes', please complete Questionnaire i, in Section 15.*

12. Physical health – Ever

1. **Do you have or have you *ever* had any symptoms, investigations, treatment, or received a diagnosis for any of the following?**

   Please note you should still tell us about any symptoms even if you have not seen a medical professional.

A. Disease or disorder of the heart or blood vessels? Examples include heart attack, heart murmur, angina, chest pain, irregular heartbeat or pulse, heart valve disorders, cardiomyopathy, peripheral vascular disease.	Yes ☐ No ☐
B. A stroke, mini-stroke, brain haemorrhage or aneurysm, brain injury or disorder, any bleeding within the skull?	Yes ☐ No ☐
C. Epilepsy or seizures, fainting attacks, or fits of any kind?	Yes ☐ No ☐
D. Diabetes, pre-diabetes, impaired glucose tolerance, or abnormal blood sugar levels? You don't need to tell us about pregnancy related diabetes that you have fully recovered from.	Yes ☐ No ☐
E. HIV, AIDS, or any autoimmune disease or disorder such as Lupus (SLE), Scleroderma, or CREST syndrome?	Yes ☐ No ☐
F. Crohn's disease, Ulcerative colitis, Barrett's oesophagus, Polycystic kidney disease (PKD), Cirrhosis of the liver, Hepatitis B or C?	Yes ☐ No ☐
G. Any cancer, skin cancer, early-stage cancer, or carcinoma in situ? This includes Hodgkin's disease, lymphoma, leukaemia, cancerous tumours, melanoma.	Yes ☐ No ☐
H. Any benign tumour, growth, cyst, or lump, in your breast, lungs, brain, or spine?	Yes ☐ No ☐
I. Any back, spine, or neck condition, including pain or discomfort, sciatica, or whiplash? *If 'yes', please complete Questionnaire v.*	Yes ☐ No ☐
J. Multiple Sclerosis, paralysis or any other neurological disease or disorder not yet mentioned? Examples include Parkinson's disease, Alzheimer's disease, Dementia, Cerebral palsy, Muscular dystrophy, Motor neurone disease.	Yes ☐ No ☐

Unless the question instructs differently, if you've answered "yes" to any of the above, please complete Questionnaire vi, in Section 15.

13. Physical health – In the last 5 years

Apart from anything you've already told us about in this application:

1. **Do you have or *in the last 5 years* have you had any symptoms, investigations, treatment, or received a diagnosis for any of the following?**
   Please note you should still tell us about any symptoms even if you have not seen a medical professional.

K. Raised blood pressure (hypertension), or raised cholesterol? *If 'yes', please complete Questionnaire ii and/or iii.*	Yes ☐ No ☐
L. Sleep apnoea, asthma, or any other condition affecting your lungs or breathing? Examples include chronic obstructive pulmonary disease (COPD), emphysema, sarcoidosis, bronchitis, tuberculosis. You don't need to tell us about common colds or flu, hay fever, or a one-off chest infection that you've fully recovered from. *If 'yes', please complete Questionnaire iv.*	Yes ☐ No ☐
M. Chronic fatigue, sustained poor sleep or lack of energy, current or recurrent long Covid?	Yes ☐ No ☐
N. Anaemia, haemophilia, haemochromatosis, deep vein thrombosis (DVT), or any other blood, bleeding, or connective tissue disorder?	Yes ☐ No ☐
O. Fibromyalgia, osteoporosis, gout, regional pain syndrome, Ehlers-Danlos Syndrome (EHDS), or any form of arthritis? This includes osteoarthritis, rheumatoid arthritis, and psoriatic arthritis. *If 'yes', please complete Questionnaire v.*	Yes ☐ No ☐
P. Any condition affecting your bones, joints, muscles, ligaments, tendons, or limbs not already mentioned? Examples include fractures, soft tissue and cartilage tears, overuse injuries. *If 'yes', please complete Questionnaire v.*	Yes ☐ No ☐
Q. Any disease or disorder of the gastro-intestinal tract, including the mouth, oesophagus, intestines, stomach, and bowel? Examples include coeliac disease, hiatus hernia, irritable bowel syndrome (IBS), ulcers, bowel polyps, weight loss surgery, passing of blood from the bowel, vomiting blood.	Yes ☐ No ☐
R. Any disease or disorder of the kidney, bladder, prostate, or urinary tract? Examples include kidney or bladder stones, recurrent Urinary Tract Infections (UTIs), blood or protein in the urine, abnormal kidney blood tests.	Yes ☐ No ☐
S. Any disease or disorder of the liver or gall bladder? Examples include fatty liver, raised liver blood tests, gall bladder stones.	Yes ☐ No ☐
T. Any disease or disorder of the thyroid, pancreas, or any other glandular condition? Examples include hypothyroidism, hyperthyroidism, pancreatitis, Addison's disease.	Yes ☐ No ☐
U. Loss of feeling or reduced muscle power, balance or coordination problems, tremor; or persistent or recurrent numbness, pins and needles, dizziness, migraines, or headaches?	Yes ☐ No ☐
V. Any condition affecting your ears or hearing, or your eyes or vision? Examples include tinnitus, Meniere's disease, labyrinthitis, glaucoma, optic neuritis, blurred or double vision. You don't need to tell us about long or short sightedness corrected by glasses or contact lenses.	Yes ☐ No ☐
W. Skin spots or moles that have bled, changed in appearance, or become painful; or any other cyst, lump, growth, or benign tumour not already mentioned?	Yes ☐ No ☐
X. Any disease or disorder of the reproductive system; or a breast ultrasound or mammogram that was abnormal, or any abnormal smear test (including a positive HPV result)? The reproductive system includes but isn't limited to the testicles, uterus, and ovaries. You don't need to tell us about infertility, complications of past pregnancies from which you have fully recovered, or erectile dysfunction.	Yes ☐ No ☐

Unless the question instructs differently, if you've answered "yes" to any of the above, please complete Questionnaire vi in Section 15.

14. Other medical history

Apart from anything you've already told us about in this application:

1. *In the last 3 years* have you consulted or been advised to consult any medical professional about any other sickness, injury, impairment, procedure, or syndrome not previously mentioned? Includes consultations with a chiropractor, physiotherapist, osteopath. You don't need to tell us about common colds and flu.	Yes ☐ No ☐
2. *In the last 3 years* have you had surgery, been admitted overnight to hospital, or been asked to have any tests or investigations at a hospital or specialist clinic? Tests and investigations include but aren't limited to biopsy, scan, scope, ECG.	Yes ☐ No ☐
3. *In the last 3 years* have you had any other condition that has caused you to be absent from work, or unable to perform your daily activities, for more than two weeks at a time?	Yes ☐ No ☐
4. Do you have any other condition for which you *currently* receive counselling, or take medication or treatment for on a regular basis? You don't need to tell us about contraception, pregnancy related medication or treatment, marriage or couples counselling.	Yes ☐ No ☐
5. Are you *currently* waiting for a referral, investigation, results, operation, or treatment for any other condition?	Yes ☐ No ☐
6. Do you *currently* have or *in the last 12 months* have you had any of these symptoms even if you haven't consulted a medical practitioner?	
a) Unexplained or unexpected weight loss	Yes ☐ No ☐
b) Recurrent nausea or vomiting	Yes ☐ No ☐
c) Unexplained memory loss, confusion, or changes affecting your movement or mobility	Yes ☐ No ☐
d) Any persistent or recurrent fatigue, dizziness, numbness, weakness, pins and needles, tingling, or tremor	Yes ☐ No ☐
e) A cough that's lasted for 3 weeks or more, or any unusual / unexplained shortness of breath	Yes ☐ No ☐
f) Any other recurrent or unusual pain, discomfort, or bleeding	Yes ☐ No ☐
g) Any other symptom that you are planning to consult a doctor, medical professional, or therapist about for the first time.	Yes ☐ No ☐

If you've answered "yes" to any of the above, please complete Questionnaire vi in Section 15.

15. Medical condition questionnaires

For each of the medical history questions you've answered "Yes" to, please give us the following information. This will help us to assess the application, but please be aware that we may still need to ask for more information.

Questionnaire i – Mental health related conditions

Name of condition(s)

Please tick all that apply.

Anxiety	☐	Personality disorder	☐
Bereavement	☐	Phobia	☐
Bipolar disorder	☐	Post traumatic stress disorder	☐
Depression or low mood	☐	Psychosis	☐
Eating disorder e.g. anorexia or bulimia	☐	Schizophrenia	☐
Obsessive compulsive disorder	☐	Other condition	☐
Panic attacks	☐	Other condition name	

1. When did you *first* have symptoms of any of the above conditions?

Less than 6 months ago	☐	3 – 5 years ago	☐
6 months – 12 months ago	☐	6 – 10 years ago	☐
13 months – 2 years ago	☐	More than 10 years ago	☐

2. When did you *last* have symptoms of any of the above conditions?

Less than 6 months ago	☐	3 – 5 years ago	☐
6 months – 12 months ago	☐	6 – 10 years ago	☐
13 months – 2 years ago	☐	More than 10 years ago	☐

3. Which of the following you have had?

Counselling	Yes ☐ No ☐	*If 'yes', start and end date*	
Medication or other treatment	Yes ☐ No ☐		

If 'yes', please complete the following table.

Medication and/or Treatment name	Dosage and frequency	Start date	End date

4. *In the last 5 years*, have you seen or been advised to see a psychiatrist? Yes ☐ No ☐

If 'yes', please tell us the name of the psychiatrist and contact details.

5. Due to any of these conditions, have you been an inpatient at a hospital or clinic? Yes ☐ No ☐

6. Have you *ever* thought about or tried to harm yourself or take your own life? Yes ☐ No ☐

7. Have you *ever* been off work or had your normal daily activities restricted in any way due to any of these conditions? Yes ☐ No ☐

If 'yes', please advise when this was and for how long.

8. Have you any ongoing effects or restriction in your activities of any kind? Yes ☐ No ☐

If 'yes', please provide details below.

9. Is there anything else you wish to add, that you consider might assist with our assessment? Yes ☐ No ☐

If 'yes', please provide details below.

10. Does your usual doctor have details of this condition? Yes ☐ No ☐

If 'no', please tell us the name and address of the medical professional who has full details.

Questionnaire ii – High blood pressure (hypertension)

1. When was this condition first diagnosed?

Less than 6 months ago ☐
6 months – 12 months ago ☐
13 months – 2 years ago ☐
3 – 5 years ago ☐
6 – 10 years ago ☐
More than 10 years ago ☐

2. Do you take medication to manage this condition? Yes ☐ No ☐

If 'yes', Name of medication

Date medication started

3. Has your treatment changed *in the last 6 months?* Yes ☐ No ☐

If 'yes', please provide details below.

4. When was your blood pressure *last* checked?

Less than 6 months ago ☐
6 months – 12 months ago ☐
13 months – 2 years ago ☐
3 – 5 years ago ☐
6 – 10 years ago ☐
More than 10 years ago ☐

What was the reading at that time?

Or tick here if reading unknown ☐

If you've ticked "unknown" how did your doctor or nurse describe your most recent blood pressure reading?

Slightly raised ☐ High ☐ Normal ☐ Unsure ☐

5. Have you had any complications due to your blood pressure? Yes ☐ No ☐

e.g. eye, kidney, urine or blood circulation problems, heart disease or chest pain.

If 'yes', please provide details below.

6. Have you been advised to consult a specialist for treatment or investigation? Yes ☐ No ☐

If 'yes', please provide details of dates, treatments, and results (if known), and name and address of specialist.

7. Does your usual doctor have details of this condition? Yes ☐ No ☐

If 'no', please tell us the name and address of the medical professional who has full details.

Questionnaire iii – High cholesterol

1. When was this condition first diagnosed?

Less than 6 months ago	☐	3 – 5 years ago	☐
6 months – 12 months ago	☐	6 – 10 years ago	☐
13 months – 2 years ago	☐	More than 10 years ago	☐

2. Do you take medication to manage this condition? Yes ☐ No ☐

If 'yes', Name of medication

Date medication started

3. Has your treatment changed *in the last 6 months?* Yes ☐ No ☐

If 'yes', please provide details below.

4. When was your cholesterol *last* checked?

Less than 6 months ago	☐	3 – 5 years ago	☐
6 months – 12 months ago	☐	6 – 10 years ago	☐
13 months – 2 years ago	☐	More than 10 years ago	☐

What was the reading at that time? Or tick here if reading unknown ☐

If you've ticked "unknown" how did your doctor or nurse describe your most recent cholesterol reading?

Slightly raised ☐ High ☐ Normal ☐ Unsure ☐

5. Have you had any complications due to your cholesterol? Yes ☐ No ☐

e.g. chest pain, heart disease, shortness of breath or problems with blood circulation.

If 'yes', please provide details below.

6. Have you been advised to consult a specialist for treatment or investigation? Yes ☐ No ☐

If 'yes', please provide details of dates, treatments, and results (if known), and name and address of specialist.

7. Does your usual doctor have details of this condition? Yes ☐ No ☐

If 'no', please tell us the name and address of the medical professional who has full details.

Questionnaire iv – Asthma or other conditions relating to the lungs or breathing

Name of condition(s)

Please tick all that apply.

Asthma	☐	Sarcoidosis	☐
Bronchitis	☐	Sleep apnoea	☐
COPD/Emphysema	☐	Tuberculosis (TB)	☐
Persistent cough or chest infection	☐	Other condition	☐
Pneumonia	☐	Other condition name	
Recurrent chest infection	☐		

1. For each condition, please advise the date of diagnosis and when you last had symptoms.

Condition name	Date of diagnosis	Date of last symptoms

2. Thinking back over the last 12 months, how often do you experience symptoms?

Daily ☐ Weekly ☐ Monthly ☐ Seasonally ☐ One off episode ☐ Childhood only ☐ No symptoms ☐

3. Are you woken during the night with symptoms? Yes ☐ No ☐

If 'yes', please provide details including how often this occurs.

4. How much time off work have you had due to any of these conditions *in the last 2 years?*

None	☐	3 – 4 weeks	☐
Less than 1 week	☐	1 month or more	☐
1 – 2 weeks	☐	Currently off work	☐

5. Does your condition limit or restrict you in any way, or is it made worse by activities such as your work duties or sport? Yes ☐ No ☐

If 'yes', please provide details.

6. What is your *current* medication or treatment? (Includes inhalers, CPAP machine, mouth splint)

Medication/Treatment

Frequency of use

7. *Within the last 5 years* have you used a nebuliser, or needed treatment at an emergency clinic or hospital due to any of these conditions? Yes ☐ No ☐

8. Have you been prescribed oral steroids *in the last 2 years?* Yes ☐ No ☐

Oral steroids, such as prednisolone, are usually prescribed in tablet or liquid form.
This question doesn't relate to your usual preventative or reliever inhalers(s)

9. Have you been advised to consult a specialist for treatment or investigation? Yes ☐ No ☐

If 'yes', please provide details of dates, treatments, and results (if known), and name and address of specialist.

10. Does your usual doctor have details of this condition? Yes ☐ No ☐

If 'no', please tell us the name and address of the medical professional who has full details.

Questionnaire v – Musculoskeletal conditions

Name of condition(s)

1. What area of the body or joints are involved? *Please tick all that apply.*

	Left	Right
Shoulder	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand or fingers	☐	☐
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐
Foot or toes	☐	☐

Neck (cervical spine) ☐
Mid back (thoracic spine) ☐
Lower back (lumbar spine) ☐
More than one area of the back ☐
Other area/joint, *please provide details below* ☐

2. For each condition, please advise the date of your first and last symptoms, and the number of times you have had this condition.

Condition name	Date of first symptoms	Number of occurrences	Date of last symptoms

3. What was the cause of your condition? *Please tick all that apply.*

Accident / Injury ☐ Illness ☐ Name of illness if applicable

4. Have you made a full recovery from your condition(s) with no ongoing symptoms such as pain, stiffness, aches, instability, or locking? Yes ☐ No ☐

If 'no', please complete the following table for each of your conditions

Condition name	Frequency of symptoms	Description of symptoms including severity (mild, moderate, severe)

5. How much time have you had off work, or had your normal daily activities restricted, due to any of these conditions *over the last 5 years?*

None ☐
Less than 1 week ☐
1 – 2 weeks ☐
3 – 4 weeks ☐
1 month or more ☐
Currently off work ☐

6. Have you *ever* had, been advised to have, or are you considering, surgery for this condition? Yes ☐ No ☐

If 'yes', please provide details.

7. Have you *ever* had any foreign objects (e.g. pins, plates, screws, metalware) inserted to treat your condition(s)? Yes ☐ No ☐

If 'yes', please indicate if these have been removed or if they are still present. Removed ☐ Still present ☐

8. Please tell us what treatment and medication you have received *in the last 5 years.*

Condition name	Treatment or medication name	Dosage and frequency	Start date	End date

9. Have you been advised to consult a specialist for treatment or investigation? Yes ☐ No ☐

If 'yes', please provide details of dates, treatments, and results (if known), and name and address of specialist.

10. Does your usual doctor have details of this condition? Yes ☐ No ☐

If 'no', please tell us the name and address of the medical professional who has full details.

Questionnaire vi – General medical questionnaire

Question Number	Condition name	Date of first symptoms MM/YY	Date of last symptoms MM/YY	Symptoms, Investigations, Surgery, Medication/Treatment etc.	Degree of recovery (%)	Time off work in last 5 years	Doctor (If different to Section 4)

16. Family history

Have any of your biological parents, brothers or sisters been diagnosed with any of the following before the age of 60?

Please tick all that apply and complete the additional information where required. You don't need to tell us about half-brothers or half-sisters.

		Relation to you	Relative's age at diagnosis
Angina, heart attack, heart disease	☐ Condition:		
Stroke	☐		
Diabetes	☐ Type:		
Polycystic kidney disease (PKD)	☐		
Haemochromatosis	☐		
Huntington's disease (Chorea)	☐		
Breast and/or ovarian cancer	☐ Type:		
Bowel or colon cancer	☐		
Another type of cancer	☐ Type:		
Familial adenomatous polyposis (FAP), or another hereditary bowel condition	☐ Condition:		
Multiple sclerosis	☐		
Muscular dystrophy	☐		
Motor neurone disease	☐		
Parkinson's disease	☐		
Alzheimer's disease or dementia	☐		
Any other condition which runs in your family for which you've received or been offered screening for	☐ Condition:		
Don't know as adopted	☐		
None of the above	☐		

17. Occupation

1. Which of the following best describes you?

- ☐ Self-employed
- ☐ Contractor
- ☐ Employed by own company or trust
- ☐ Employed
- ☐ Student, Not employed or Retired (*If ticked, please go to Section 18)*
- ☐ Houseperson / Home duties (*If ticked, please go to Section 18)*

2. What is your current primary job?

3. What industry is this in?

4. In your current role, have you been self-employed, employed by own company, or contracting for less than 2 years? Yes ☐ No ☐

If 'yes', please complete the following table.

Previous occupation	Date from	Date to	Employed	Self-employed / Contractor
			☐	☐
			☐	☐
			☐	☐

5. As part of your job, are you involved in any of the following?

Note that you don't need to tell us about using common cleaning products.

a. Working at heights above 10 metres Yes ☐ No ☐
b. Offshore, at sea, or underwater work Yes ☐ No ☐
c. Tunnelling, mining, or any work underground Yes ☐ No ☐
d. Working with weapons or explosives Yes ☐ No ☐
e. Working with dangerous substances or chemicals Yes ☐ No ☐
f. Any other hazardous duties not already mentioned Yes ☐ No ☐

If you've answered "yes" to any of the above, please provide the details below.

Please complete the remainder of this section if you are applying for any of the following: Income Protection Cover, Workability Cover, Mortgage and Living Cover, Business Disability Cover, Farmers Disability Cover, Business Expenses cover, Total Permanent Disability with Any or Own definition.

Otherwise please go to Section 18.

6. Occupation code for primary job

To be completed by your financial adviser.
Information relating to occupations and occupation codes can be found on AdviserNet.

AM – Medical Health Prof. ☐ AA – Professional ☐
A1 – Clerical office work only ☐ A2 – Clerical mobile ☐
B – Light manual/skilled ☐ C – Heavy manual/skilled ☐
S – Special skills ☐

If you've selected occupation code C or S, please go to question 8.

7. Does your primary job involve driving, performing any manual duties such as lifting objects more than 10 kgs, or working with machinery or powered tools? Yes ☐ No ☐

Only include driving that is part of your job, excluding any commuting to and from work, site visits, and customer facing meetings.

If 'yes', please tell us below what percent of your normal working day is spent on each of these activities, and describe your typical working day.

Administration ____ % Manual work ____ % Driving ____ %

Typical working day:

8. Is your employer, or business if you're self-employed, based in New Zealand? Yes ☐ No ☐

If 'no', please provide details below.

9. Do you hold any tertiary qualification or trade licensing certification relevant to your job? Yes ☐ No ☐

If 'yes', please provide details below.

10. On average, how many hours per week do you work in your primary job?

Less than 20 ☐ 20-29 ☐ 30-55 ☐ 56-60 ☐ 61-70 ☐ More than 70 ☐

11. Do you have any reason to believe that your current job, duties, working hours or employment status might change in the next 12 months? Yes ☐ No ☐

Examples include potential redundancies, restructuring, reduction in hours, changing from employed to self-employed, selling your business, taking an extended period of leave (i.e. more than 3 months absence).

If 'yes', please provide details below.

12. Do you have any other paid occupation?

Yes ☐ No ☐ *If 'yes', please complete the following table and question.*

Occupation	Income you receive (per annum)	Hours per week	Description of duties
	$		
	$		
	$		

Are you intending to protect the income earned from these other occupations with this application? Yes ☐ No ☐

18. Financial

1. **What is your annual earned income?** $

   Please note that we may ask you for more information about your income later in this application, as part of the underwriting assessment, or due to the total amount of cover you have applied for.

2. **Do you have a mortgage on your primary residence?**

   Yes ☐ No ☐

Please complete the remainder of this section if you are applying for any of the following: Income Protection Cover, Workability Cover, Mortgage and Living Cover, Business Disability Cover, Farmers Disability Cover, Business Expenses cover. Otherwise go to Section 22.

3. **Will *any* of your income continue for more than 3 months if you are unable to work due to an injury or illness?** Yes ☐ No ☐

   This question relates to **all** income sources including both earned and unearned (passive) income. For example, sick pay, director fees, dividends or a percent of net profits, rental income, investments.

   If 'yes', please complete the following table.

Source of income	Duration you would receive this	Amount you would receive (per annum)

If you're only applying for Mortgage and Living Cover based on mortgage – go to Section 19

If you're an employed person, with no ownership interest in the company – go to Section 19

If you are self-employed, employed by your own company, or a contractor – complete the remainder of this financial section. (This includes all applications for Farmers Disability Cover)

Self-Employed person or contractor

(Includes those employed by own company or trust and customers applying for Farmers Disability Cover)

4. **Name of business**

5. ***In the last 7 years* have you, or any entities owned or controlled by you, been made bankrupt, or been placed in receivership, involuntary liquidation or under management?** Yes ☐ No ☐

   If 'yes', Date of event (e.g. when declared bankrupt) Date discharged

6. **What percentage of your work is freelance/contract?** Freelance % Contract %

7. **Will you be providing a Financial Statement as part of this application for insurance?** Yes ☐ No ☐

   Please speak to your adviser about evidence requirements.

   If 'yes', please go to Section 19

8. **Including yourself, how many shareholders/owners are in the business?**

9. **What percent of the business do you own?** %

10. **Are there any other businesses or related entities, service, or management companies other than the main operating entity?** Yes ☐ No ☐

    If 'yes', please provide details, including name and relationship to main operating entity.

11. **Is your income split for tax purposes with your spouse or partner?**

    Yes ☐ No ☐ *If 'yes', please provide the following details.*

    What is the percentage split? %

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

    What is the nature of work done by your spouse/partner?

12. Please provide the following business income figures for the last 2 financial years.

Please note this is not required if you will be supplying full accounts and individual tax returns for the last 2 years.

Year ending 31st March	Turnover/Revenue	Expenses	Net income before tax	Your total net earned income*
	$	$	$	$
	$	$	$	$
	$	$	$	$

** Note: 'Your total net earned income' is the income earned by your own personal exertion before tax, which will cease if you are unable to work.*

13 *In the last 12 months*, has your business experienced a reduction in turnover of 20% or more? Yes ☐ No ☐

If 'yes', please provide the YTD (year to date) figures in the table above.

Reason for the reduction in turnover:

19. Mortgage and Living Cover, based on monthly mortgage

(Only complete if applying for Mortgage and Living Cover based on your monthly mortgage)

1. Is the mortgage for your own residential property and will be owner occupied? Yes ☐ No ☐

2. Has the mortgage for this dwelling that you live in been drawn down (activated)? Yes ☐ No ☐

If you've answered "no" to either of the above questions, please provide details below.

Please note that financial evidence will be requested to support this cover. Please speak to your adviser about evidence requirements.

20. Business Disability Cover

(Only complete if applying for Business Disability Cover)

1. What is the nature of the business?

2. How long has the business been in operation?

3. Other than the person to be insured, how many people does the business employ? Full time | Part time

4. What is the role of the key person in the business?

5. What is the key person's total remuneration package? $

6. Why is the person to be insured considered key to the business?

7. On what basis has the sum insured been calculated?

Please tick all that apply.

Percentage of Profit ☐ What percent of gross profit is generated by the key person? %

Multiple of Salary ☐

Other (e.g. Cost of replacement) ☐

If 'Multiple of Salary' or 'Other' please provide details below, including how calculated.

8. Please provide full details of the effect the loss of the key person would have on the business, and over what timeframe.

For example, the duration the business would continue in the event of their disablement before income starts to decline.

9. If the person to be insured is a sole trader or contractor, are they contractually responsible for replacing themselves in the event of disablement?

Yes ☐ No ☐ Not applicable ☐

10. Are there currently any other Key Person or Business Disability Cover insurance policies in place, or being applied for, on other people in the company? Yes ☐ No ☐

If 'yes', please provide details below, for example names, and the type and amounts of cover.

11. Is there anything else you wish to add that you consider might help us with our assessment? Yes ☐ No ☐

For example, any other information about how Business Disability Cover will meet the needs of the business.
You can also attach a copy of the completed Statement of Advice as an alternative.

21. Business Expenses Cover

Please complete the Business Expenses worksheet, available from your adviser.

22. Payment details (Must be completed)

Please let us know how you would like to pay for the policy. We'll then validate your Temporary Cover Certificate.

What payment options would you like?

a. Payment Frequency Yearly ☐ Half-yearly ☐ Quarterly ☐ Monthly ☐ Fortnightly ☐

b. Payment Method Direct debit ☐ Credit card ☐

c. If paying fortnightly, what day of the week (Monday-Friday) would you like to pay?

d. What date would you like your first payment to be?

If your policy is not issued before the date you've given, your first payment will be one month/fortnight after that date. Depending on how close the first payment date provided is to the date we issue your policy, your first payment might happen before you receive your policy documentation in the mail.

If you have chosen to pay by Direct Debit or Credit Card, please complete the relevant authority below.

Credit Card Authority

I/we authorise Asteron Life to charge my credit card for all premiums due on this policy until further notice.

Internal use client number

Please tick one Visa ☐ MasterCard ☐

Cardholder's name First payment ☐ All payments ☐

Card number Expiry date

Cardholder's signature Sign here

Direct Debit Authority

Internal use Policy number

Payer's details (Please use BLOCK LETTERS)

Title Family name Given name(s)

Authority to accept Direct Debits

Authorisation code

0 1 0 0 4 0 9

Name of account holder

Name of my bank

Approved

0040

10 2017

BANK BRANCH ACCOUNT NUMBER SUFFIX

From the acceptor (you) to your bank:

I authorise you to debit my account with the amounts of direct debits from Asteron Life 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.

Authorised signature Sign here

Date

Specific direct debit conditions relating to notices and disputes

Asteron Life is required to give 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. The notice is to include:

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

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 confirmation of the amount and date of each direct debit from Asteron Life, or
- I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.

If I'm not reasonably satisfied that the authority authorised my bank to debit my account with the amount of the direct debit, I may ask my bank to reverse a direct debit up to 9 months after the date Asteron Life sent the first direct debit under the authority.

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

If Asteron Life proposes to change an amount or date of a direct debit specified in the confirmation, they are required to give notice:

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

I understand I can contact Asteron Life at any time and cancel or change this payment authority.

You will be sent confirmation of your payment details as part of your policy documentation within 5 working days of your policy being issued.

23. Declarations (Must be completed)

Consent

I/we, the person to be insured, authorise Asteron Life to obtain at any time from any employer, doctor, hospital, health agency, insurance office, Government department or agency, or any other person or entity, any and all information Asteron Life may require. I/we understand that Asteron Life can only obtain information about me or any child to be insured for the purpose of assessing or re-assessing an application for cover; an application to alter or reinstate cover; a claim; reviewing observance of obligations including disclosure; or administering the policy. A photocopy of this authorisation shall be read as the original and any relevant person or entity is directed by me to release to Asteron Life any personal information they hold concerning me or any child to be insured. I/we understand that a third party may also be used to process this information for Asteron Life.

Acknowledgement, Authorisations and Declaration

Please read carefully before signing.

Parts 2 and 3 of this section apply to the Person to be Insured only.

1. I/we the proposed **policy owner(s)**:
   a. have read and understood the Asteron Life Privacy Statement on page 2, "Your duty of disclosure" on page 3, as well as this Acknowledgement, Authorisations and Declaration, and Consent sections.
   b. agree that this application, declaration and any personal statements will form part of the proposed insurance contract between me/us and Asteron Life.
   c. understand that if I/we do not provide any information that is material to this application, or if any information provided by me/us is substantially incorrect and material, then Asteron Life may not be able to accept this application; and any policy issued may be avoided from inception.
   Any claims already paid may have to be paid back.
   d. confirm that the information provided by me/us in this application is either in my/our own handwriting or has been checked and approved by me/us as being accurate and complete.
   e. confirm that where any person(s) to be insured is less than sixteen (16) years of age, confirm that I/we are authorised, to act on their behalf.
   f. have agreed that a photocopy of this authority shall be treated as an original.
2. I/we, **the person(s) to be insured**, understand that:
   a. this application will form part of the basis of the proposed contract for insurance.
   b. I/we am required to advise Asteron Life of any change that is material to this application up until the contract of insurance is formed. The duty of disclosure also applies if in future there is a request to extend or alter the policy, or application to reinstate the policy after it has lapsed.
   c. if I/we do not provide any information that is material to this application, or if any information provided by me/us is substantially incorrect and material, then Asteron Life may not be able to accept this application; and any policy issued may be avoided from inception. Any claims already paid may have to be paid back.
   d. I/we will only be insured for pre-existing conditions if I/we have told Asteron Life about them in writing and insurance for those pre-existing conditions has been accepted by Asteron Life in writing.
   e. the information provided in this application is either in my/our own handwriting or has been checked and approved by me as being accurate and complete.
3. I/we, **the person(s) to be insured**, declare that:
   a. All the answers provided in this application are complete and correct.
   b. In addition, I/we confirm that I have advised Asteron Life of all additional information that may affect its decision to provide insurance cover on the terms and conditions applied for.
   c. I/we acknowledge it is my responsibility to ensure I/we have provided all information that may affect Asteron Life's decision to provide insurance cover, whether the information is specifically requested in the application or not.

	Full name	Signature	Date	
Person to be Insured				Sign here
Child to be Insured 1 (age 16 years or over)				Sign here
Child to be Insured 2 (age 16 years or over)				Sign here
Policy Owner 1				Sign here
Policy Owner 2				Sign here
Policy Owner 3				Sign here

The person to be insured MUST SIGN on the 'Person to be Insured' line. If the Person to be Insured is also a Policy Owner, that person need only sign once in the box marked 'Person to be Insured'.

End of Part 2

TEMPORARY COVER CERTIFICATE

Thank you for choosing Asteron Life

Temporary cover

While we assess your application the Person to be insured has temporary cover from Asteron Life Limited.

Temporary cover will last a maximum of 60 days from the date on which the application was signed on page 28.

Please take the time to read the full terms and conditions of the temporary cover below, as this includes details of when we will pay under this cover, how much we will pay, and when the temporary cover ends.

Please keep this certificate and information in a safe place until your policy document arrives.

Grant Willis

Executive General Manager – Life
Asteron Life Limited

Terms and conditions for temporary cover

1. When Temporary Cover applies

Temporary Cover provides protection for those cover type(s) applied for in the application while being assessed by Asteron Life Limited. In addition to those in this certificate, the standard terms, conditions, definitions and exclusions for the cover(s) applied for in the application will apply to this temporary cover.

We will pay the Temporary Cover benefit if the person to be insured dies, or becomes disabled from any of the following conditions: coma, paralysis, blindness, deafness, loss of speech, loss of limbs, major head trauma or burns.

The maximum we will pay under this temporary cover, and any other temporary cover that you hold with us, in respect of any one event is the lesser of the sum applied for in the application or the following cover type limits:

Cover type	Maximum payable
Life	$500,000
Trauma	$500,000
Total and Permanent Disablement (TPD)	$500,000
Income Protection, Workability, and Mortgage and Living	$2,500 per month
Business Disability, Business Expenses, Farmers Disability	$2,500 per month
We Pay Your Premiums	$100 per month

Where you suffer injury or illness giving rise to a claim under this temporary cover, this may be taken into account in our assessment of your application and whether to provide you with cover and on what terms.

If you make a claim, you will need to provide us with any documents that we may ask for, at your own expense.

2. When we will not pay a Temporary Cover benefit

There is no cover if any of the following apply:

- for life cover, the Person to be Insured is under 16 years old or over 65 years old;
- for all other cover types, the Person to be Insured is under 16 years old or over 60 years old;
- you do not comply with your duty of disclosure when you complete your application;
- any information on either the application or personal statement (including telephone interview) is incorrect or incomplete;
- the application is not accompanied by the first premium or an authorised direct debit authority or credit card authority;
- the Person to be Insured has in the past:
  a. had an insurance application refused or deferred by any life insurance company
  b. been offered cover with additional terms and/or reduced benefit(s) by any life insurance company
  c. had an insurance policy avoided due to non-disclosure, or cancelled;
- an application for similar benefit(s) has been accepted and a policy issued by another company since this application was completed;
- death, disablement or other claim event occurs as a direct or indirect result of any of the following:
  a. an intentional self-inflicted act of the Person to be Insured, whether sane or insane;
  b. participation in a criminal activity by the Person to be Insured;
  c. as a result of any condition for which symptoms exist or existed that would cause a reasonable and prudent person to seek diagnosis, care or treatment from a registered doctor or other healthcare professional in the 30 days following the date of application;
  d. as a result of any condition for which medical advice or treatment was recommended by, or received from, a registered doctor or other healthcare professional before the application date;
  e. the Person to be Insured driving a motor vehicle with a blood alcohol level in excess of the legal limit;
  f. the Person to be Insured participating in racing (except on foot) or any sport or pastime for which he or she has received any type of reward in the previous two years;
  g. the Person to be Insured engaging in a work or a lifestyle activity that involves explosives, weapons, heights above 20metres, depths below 30metres or speeds above 130km per hour other than as a fare-paying passenger on a commercial airline;
  h. the Person to be Insured being incapable of normal personal care as a result of taking drugs, alcohol or any intoxicating substance;
  i. the Person to be Insured taking part in any of the pursuits, activities or occupations which would be excluded from the cover applied for; or
  j. the Person to be Insured working, residing in (including temporarily), travelling to or travelling from destinations which are deemed to be high or extreme risk. This can be determined by visiting www.safetravel.govt.nz.

3. When Temporary Cover ends

Temporary Cover ends on the earliest of:

- the policy commencement date;
- the date we receive a request to cancel the application;
- the date we advise you, or the Person to be Insured, that the application has been refused; or
- 60 days have passed since this temporary cover started.

PART 3: Adviser details

This section needs to be completed by the Adviser.

Advisers: If you have any questions, please phone the Adviser Support team on 0800 808 106 or email them at contactus@asteronlife.co.nz.

1. Servicing adviser's report

Adviser number | Adviser's name

Adviser's daytime phone no. | Email

Who completed this application form (i.e. whose handwriting)?

I confirm that the illustration(s) attached to this application accurately reflects the Person(s) to be Insured and the details and requirements of the Policy Owner(s) and has been verified by the Policy Owner(s) Yes ☐ No ☐

Signature of Adviser **Sign here**

Date

1. Please enter your preferred FlexiRate. If Nil commission is selected then Commission by Cover is not available. The FlexiRate applies to all covers within the policy.

	FlexiRate *If left blank Standard commission applies*			
	FlexiRate	Initial commission	Service commission	Nil comm
Personal Insurance	%	%	%	☐
Business Insurance	%	%	%	☐

2. Please tick the appropriate box below to select the policy level commission type. Policy level commission will apply to *Needlestick, Kids Cover and We Pay Your Premium benefits*. It will also apply to any cover(s) not listed at step 3 below.

	Policy Level Commission type		
	Upfront	Spread 20	Level 30
Personal Insurance	☐	☐	☐
Business Insurance	☐	☐	☐

3. Please fill out the table below if you want to select the commission type by specific covers within the policy (if different from the main commission type).

Policy Level Commission type					
Cover	Sum insured	Stepped/Level	Upfront	Spread 20	Level 30
			☐	☐	☐
			☐	☐	☐

Please note: Accelerated covers will be the same commission type as the main cover

4. **Commission split** *If left blank your default commission split will apply.*

	Adviser name	Adviser number	Initial commission	Service commission
			%	%
			%	%
			100%	100%

Asteron Life PO Box 894, Wellington 6140, Freepost 795
Ph: **0800 737 101** (Contact Centre hours: Mon–Fri 8.30am–5pm)
Email: **newbusiness@asteronlife.co.nz** Web: **asteronlife.co.nz**

Asteron Life