Important Information

Completing this application form:

The purpose of this application form is to prompt you to provide information which we may consider relevant to the assessment of your application for insurance.

We understand that the questions we ask in this form may be sensitive and completing the form may take time, but it is very important that you give us all the information that may affect your application for insurance.

This means, you should

- Always tell the truth.
- Answer questions as fully as you can, including as much detail relating to your current and past circumstances as possible.
- Tell us, even if you are in doubt, or uncertain of the relevance of any information, it may be important to us.
- Say if you don't know the answer to any question.
- Ask if there is anything you're not sure of. Don't be afraid to ask your Adviser or Sovereign for help.

It is important that you understand your duty to provide truthful, complete and correct information about yourself, including your health and medical history. If we find out at a later time that you have not disclosed all material information, we may amend the terms of your policy or your policy may be voided altogether.

If you answer 'Yes' to any of the questions in this application form you will also need to complete the General Health Questionnaire in SECTION 6. This will help us to make a more accurate and timely assessment of your application.

What happens next:

Once you have completed this application form it will be sent to Sovereign and an Underwriter will assess the information you have provided. We may require further information from you or your GP to complete our assessment. Typically the more information you provide on the application form the faster we are able to process your application, so please provide as much detailed information in the General Health Questionnaire as you can.

After the assessment has been made:

You will be advised in writing of the outcome of your application, whether it has been accepted and if any special terms have been applied.

SOVEREIGN

You can enter and save data directly into this form, or you can print out and complete by hand.

1 Plan details

Name of plan: Ports Retirement Plan

Employer name:

2 Member/applicant details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

First name and surname:

Date of birth: / / Place of birth:

Male ☐ Female ☐

Occupation:

Industry:

Address

Street: City:

Suburb: Postcode:

Telephone Home: Business:

Mobile:

Email:

Depending on your answers to the questions below, we may need to contact you for more information.

If we require further information to process your application quickly, how can we best contact you? ☐ Telephone ☐ Email ☐ Via Adviser

If we require that you undergo medical tests, would you use our HealthScreen® service? ☐ Yes ☐ No

HealthScreen® is a free service developed to provide you with an efficient, convenient and professional means of gathering medical information required for processing your application for insurance.

3 Your insurance details

a. Has any insurance you have applied for ever been declined, deferred or offered modified terms (including loadings or exclusions)? ☐ Yes ☐ No

If Yes, please give details.

b. Have you claimed a benefit under a private insurance policy or a government benefits scheme (such as ACC or sickness benefit) due to sickness, injury or treatment for injury? ☐ Yes ☐ No

If Yes, please give name of condition and provide additional details in the General Health Questionnaire in SECTION 6.

4 Personal Statement

Should you need more space to provide answers to any of the questions in this form, please use the NOTES in SECTION 6 and write 'refer to notes' next to original question.

a. **What is your height and weight?** cm/feet/inches kg/stone/lb

b. **In the last 12 months have you smoked tobacco or any other substance and/or used smoking alternatives (as listed)?** ☐ Yes ☐ No

If Yes, how many years have you smoked or used smoking alternatives for? years

If Yes, please identify the type and quantity smoked below, eg cigarettes, tobacco, cigars, e-cigarettes

☐ **Cigarettes**	☐ **Tobacco**	☐ **E-cigarettes**
per day	per day	per day
☐ **Cigars**	☐ **Vaping**	☐ **Nicotine gum or patches**
per day	per day	per day

c. **Do you drink alcohol?** ☐ Yes ☐ No If YES, please give details below

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

d. **Have you ever received or are you considering seeking medical advice, counselling, or treatment for the use of alcohol, drugs or gambling?** ☐ Yes ☐ No If YES, please give details below

e. **Do you use, or have you ever used any recreational drugs and/or drugs that have not been prescribed to you, (excluding supermarket and/or pharmacy sold medications)?** ☐ Yes ☐ No

If Yes, please advise details including when commenced usage, type(s), frequency, method of delivery, date last used (If you prefer we can send a separate questionnaire for you to send to insurer directly).

Commenced	Type	Frequency	How delivered	Last used
/ /				/ /
/ /				/ /

Personal Statement continued

f. Please indicate your New Zealand residency status

☐ Citizen/ permanent resident ☐ Work permit (please enclose a copy) ☐ Long term business visa ☐ Other

How long have you resided in New Zealand? ______ Years

g. Do you intend to live, work or travel overseas for longer than 3 months within the next 12 months?

☐ Yes ☐ No If Yes, please tick purpose and give details below

☐ Live ☐ Work ☐ Travel

Country	Start date	Duration
	/ /	

h. In the last three years have you participated in, or do you currently or are you intending to participate in, any high risk or hazardous pastime or pursuit?

If yes please tick relevant box/es and complete details below

☐ Yes ☐ No

☐ Aviation ☐ Parachuting ☐ Hang gliding ☐ Motor sport (car/bike)

☐ Diving ☐ Motorboat racing ☐ Mountaineering ☐ Abseiling/Rock climbing

☐ Martial arts ☐ Other (please specify below)

Pastime/pursuit	No. of years participated and detail of experience	Frequency of participation per annum	Maximum height, depth, speed, record attempts	Geographic location	Equipment details

Additional info ______

i. Family history

Has any parent, sister or brother (blood relative) before the age of 60, received treatment for, or been diagnosed with, one of the following conditions: diabetes, stroke, mental illness, dementia, kidney disease, heart disease, high blood pressure, cancer (specify type), huntington's chorea, polycystic kidney, multiple sclerosis, or any hereditary or familial disease or disorder?

☐ Yes ☐ No If Yes, please give details

Relationship to you	Condition	Age at diagnosis	Age now	Current state of health

j. Doctor's and/or Health Professionals details

Tell us the name and contact details of any health professional you have consulted in the last 5 years.

Current doctor ______ Medical practice or clinic ______

Street and town/city ______ Years attended ______

Holds medical records ☐ Yes ☐ No

Other Health professional ______ Medical practice or clinic ______

Street and town/city ______ Years attended ______

Holds medical records ☐ Yes ☐ No

Personal Statement continued

Other Health professional [ ] Medical practice or clinic [ ]

Street and town/city [ ] Years attended [ ]

Holds medical records [ ] Yes [ ] No

k. Please tell us if you have ever had any signs or symptoms of, or if you have ever been tested for, treated for, or diagnosed with, any of the following:

Please complete the General Health Questionnaire in SECTION 6 if you tick yes to any of the following. If you have had a medical condition that is not listed below, please tick the 'Other' box and give details in the General Health Questionnaire.

1. Brain, neurological or nervous system disorder [ ] Yes [ ] No If YES, please select from list below

   - [ ] Epilepsy
   - [ ] Seizures
   - [ ] Multiple Sclerosis
   - [ ] Stroke
   - [ ] TIA
   - [ ] Fainting/ Blackouts
   - [ ] Recurrent headaches
   - [ ] Motor Neurone
   - [ ] Dizzy spells
   - [ ] Other (Please specify) [ ]

2. Stress, mental health or nervous disorder [ ] Yes [ ] No If YES, please select from list below

   - [ ] Depression
   - [ ] Schizophrenia
   - [ ] Anxiety
   - [ ] Panic attack
   - [ ] Fatigue
   - [ ] Suicidal ideation
   - [ ] Stress
   - [ ] Post Traumatic Stress Disorder
   - [ ] Insomnia
   - [ ] Other (Please specify) [ ]

3. Ear, nose, eye, throat or speech disorder [ ] Yes [ ] No If YES, please select from list below

   - [ ] Deafness/ Hearing disorder
   - [ ] Tinnitus
   - [ ] Allergy
   - [ ] Eye or vision disorder (except wearing prescription glasses)
   - [ ] Other (Please specify) [ ]

4. Heart, blood vessel or other blood circulation disorder [ ] Yes [ ] No If YES, please select from list below

   - [ ] Chest pain
   - [ ] Heart attack
   - [ ] Aneurysm
   - [ ] Palpitations
   - [ ] Angina
   - [ ] High blood pressure
   - [ ] Rheumatic fever
   - [ ] High cholesterol
   - [ ] Heart murmur
   - [ ] Varicose veins
   - [ ] Deep vein thrombosis / blood clot
   - [ ] Other (Please specify) [ ]

5. Lung or other breathing/ respiratory disorder [ ] Yes [ ] No If YES, please select from list below

   - [ ] Asthma
   - [ ] Emphysema
   - [ ] Bronchitis
   - [ ] Chronic lung condition
   - [ ] Tuberculosis
   - [ ] Sleep apnoea
   - [ ] Pleurisy
   - [ ] Other (Please specify) [ ]

6. Endocrine system, or glands disorder [ ] Yes [ ] No If YES, please select from list below

   - [ ] Diabetes
   - [ ] Abnormal blood sugar
   - [ ] Thyroid disease or disorder
   - [ ] Pituitary adenoma
   - [ ] Graves disease
   - [ ] Addison's disease
   - [ ] Other (Please specify) [ ]

Personal Statement continued

7. Liver, gallbladder, stomach, bowel or other digestive gastrointestinal disorder

☐ Yes ☐ No If YES, please select from list below

☐ Hernia ☐ Irritable bowel syndrome ☐ Crohn's disease ☐ Barrett's Oesophagus

☐ Ulcer ☐ Hepatitis ☐ Bleeding from bowel ☐ Polyps

☐ Ulcerative colitis ☐ Other (Please specify)

8. Skin, blood or bleeding disorders

☐ Yes ☐ No If YES, please select from list below

☐ Psoraisis ☐ Eczema/ dermatitis ☐ Anaemia ☐ Clotting disorder

☐ Heamochromatosis ☐ Leukaemia ☐ Haemophilia

☐ Other (Please specify)

9. Kidney, bladder or other urinary or reproductive system disorder

☐ Yes ☐ No If YES, please select from list below

☐ Renal colic ☐ Kidney stone ☐ Repeated bladder infections ☐ Sexually transmitted infection (STI)

☐ Endometriosis ☐ Polycystic kidney disease ☐ Prostate enlargement

☐ Other (Please specify)

10. Cancer, tumour (malignant or benign), growth of any kind, whether present or removed

☐ Yes ☐ No If YES, please select from list below

☐ Lymphoma ☐ Breast lump ☐ Abnormal cervical smear ☐ Basal cell carcinoma

☐ Melanoma ☐ Squamous cell carcinoma ☐ Abnormal mole ☐ Cancer

☐ Tumour Other (Please specify)

11. Musculoskeletal disease or disorder, pain, strain or injury to muscle, bone, joint or limb

☐ Yes ☐ No If YES, please select from list below

☐ Spine ☐ Neck ☐ Back muscles ☐ Sciatica

☐ RSI/OOs or any regional pain ☐ Tendinitis ☐ Osteoporosis ☐ Arthritis

☐ Any joint (Please specify) Other (Please specify)

12. Any other illness or condition not already stated

☐ Yes ☐ No If YES, please select from list below

☐ Rheumatoid arthritis ☐ Fibromyalgia ☐ Gout ☐ Obesity

☐ Chronic fatigue ☐ Lupus ☐ HIV/AIDS

☐ Other (Please specify)

If YES, please give the name of the condition/s and details in the General Health Questionnaire in SECTION 6

l. In the last five years, have you had any medical examinations by a doctor or specialist, specialist tests, blood tests (including but not limited to liver function, cholesterol and blood sugar tests) or X-rays?

☐ Yes ☐ No If YES, please give details in the **General Health Questionnaire** in SECTION 6

m. **Have you had surgery or been in hospital before?**

☐ Yes ☐ No If YES, please give details in the **General Health Questionnaire** in SECTION 6

Personal Statement continued

n. Are you experiencing any health problems or are you receiving or considering seeking medical advice, counselling, specialist tests, blood tests (including but not limited to liver function, cholesterol and blood sugar tests),treatment or an operation from a health professional or awaiting any screening or tests results?

☐ Yes ☐ No If YES, please give details in the **General Health Questionnaire** in SECTION 6

5 Only answer the following two questions if you are applying for income protection insurance and you earn more than $240,000

Does your net investment income (including income from family trusts and associated business entities) exceed 10% of your gross weekly/salary from your employer who is providing the insurance? ☐ Yes ☐ No

Does your net asset base exceed $400,000 (including assets in family trusts and associated business entities but exclude family home and personal effects such as furniture etc.) ☐ Yes ☐ No

If you answer yes to either of these questions please complete an Occupation and Income details questionnaire subsided risk form available from your Adviser and submit with this Personal Statement.

6 General Health Questionnaire

To be completed if you have answered Yes to questions in this application which requires further details. Use NOTES section below if you need extra space.

		Condition 1	Condition 2
a.	Name of condition		
b.	Date of first symptoms	/ /	/ /
c.	Date of last symptoms	/ /	/ /
d.	Date of last Doctor or Health professional consultation for this condition	/ /	/ /
e.	Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
f.	Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
g.	Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
h.	Have you ever had any recurrence of this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
i.	Please give full details if you have answered YES to questions (e), (f), (g) or (h) above		

General Health Questionnaire continued

		Condition 3	Condition 4
a.	Name of condition		
b.	Date of first symptoms	/ /	/ /
c.	Date of last symptoms	/ /	/ /
d.	Date of last Doctor or Health professional consultation for this condition	/ /	/ /
e.	Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
f.	Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
g.	Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
h.	Have you ever had any recurrence of this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
i.	Please give full details if you have answered YES to questions (e), (f), (g) or (h) above		

		Condition 5	Condition 6
a.	Name of condition		
b.	Date of first symptoms	/ /	/ /
c.	Date of last symptoms	/ /	/ /
d.	Date of last Doctor or Health professional consultation for this condition	/ /	/ /
e.	Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
f.	Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
g.	Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
h.	Have you ever had any recurrence of this condition?	☐ Yes ☐ No If YES, please give full details at (i)	☐ Yes ☐ No If YES, please give full details at (i)
i.	Please give full details if you have answered YES to questions (e), (f), (g) or (h) above		

Notes Use this section as extra space for your answers. Please make sure you have written 'refer to notes' next to original question.

7 Declaration and consent

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

Important notice: your duty of disclosure and personal information

When you apply for this insurance, and whenever you apply to vary or reinstate it, you have a duty to disclose to Sovereign Assurance Company Limited ("Sovereign") all information you know (or could reasonably be expected to know) that would influence the judgment of a prudent underwriter in deciding whether or not to insure you, and if so, on what terms and at what cost. If you fail to comply with your duty of disclosure, Sovereign may avoid this insurance from the beginning, which means no claim/s will be paid.

Please note, Sovereign may request a copy of all or part of your medical file from your General Practitioner and other medical providers if we consider it necessary to properly assess your application or claim.

If in doubt - disclose. We treat all information confidentially.

Life assured:

I understand the importance of full disclosure of all information required in this application for Insurance and have read the "Disclosure" section below. ☐ Yes

I consent to Sovereign obtaining my medical records, financial information or other personal information from my doctor and other medical providers and other agencies and have read the "My personal information" section below. ☐ Yes

I authorise Sovereign to disclose **all** personal information relating to this application for Insurance to my Adviser, for the period of the assessment of this application for Insurance, pursuant to clause (k) under the "My personal information" section below. ☐ Yes

The below named life assured declare and agree as follows:

Disclosure:

a. I have read the notice explaining my duty of disclosure and all the statements contained in this application for insurance ('Application') are true and complete to the best of my knowledge.

b. Should I undergo any alteration in mental or physical health or have a change of occupation between the date of this Application and the issue of the insurance, I agree to notify Sovereign immediately as this information is relevant to any decision Sovereign may make to accept this Application.

c. I understand that statements made in this Application and any other application relating to the Plan, including statements made by me to any medical examiner or made by any medical examiner on my behalf, forms the entire basis of the insurance contract with Sovereign.

d. I understand that irrespective of whether I have been insured with Sovereign before, that Sovereign will rely on the accuracy and completeness of my answers given in this Application and I must not assume Sovereign has any prior knowledge of my history.

Underwriting:

e. I will be bound by the standard conditions applicable to the proposed insurance upon Sovereign's acceptance of this Application. I understand that if my Application requires underwriting, then special terms (including special conditions, premium loadings, exclusions or maximums) may be applied to my policy. I understand that any special terms will apply from the risk commencement date of my insurance.

f. I understand if additional information is required to process my Application, I may be telephoned by a Telephone Underwriter. The information that I provide to the Telephone Underwriter will form part of my Application.

g. I understand that if I do not consent to Sovereign collecting personal information on this Application and from the sources listed in paragraph (l), Sovereign may not be able to undertake a full underwriting assessment which may result in Sovereign declining to offer cover or offering cover on less favourable terms than I may otherwise be offered.

h. I understand that financial information may be required as part of the underwriting process, and that if requested, any such information will form part of my Application.

Premiums:

i. I understand the insurance proposed in this Application shall not commence until this Application has been accepted by Sovereign and the initial premium has been received by Sovereign.

My personal information:

j. I consent to the use of the personal information provided in this Application or obtained from any source indicated in paragraph (l) by Sovereign and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application, for the processing of this Application and administration of my insurance cover and any claims including assessing if I have met my duty of disclosure under this Application or any prior applications, for promotion of insurance

Declaration and consent continued.

and financial services to me and for market research purposes (whether or not I choose to proceed with this Application). I consent to my name, phone number and address being given to research/direct marketing firms engaged by Sovereign or its related companies to seek my views on products or services offered by Sovereign or its related companies. I understand that my personal information will be stored at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). I understand that Sovereign will take reasonable steps to keep such information secure. I understand that Sovereign may be required to disclose my personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. I understand access to and correction of my personal information may be requested by me.

k. I authorise Sovereign to disclose all personal information relating to this Application to my Adviser. The information is to be provided for the purposes of my Adviser providing me with advice regarding the underwriting of this Application by Sovereign. This authority is limited to this Application, and is only valid for the period of the assessment of this Application until an outcome on this Application is reached. I acknowledge that the personal information which may be disclosed includes, but is not limited to, medical, vocational, occupational and financial information relevant to the assessment of this Application.

l. I consent and give authority to Sovereign and/or any of its related companies to seek from, and for all and any of the following, their officers and employees, to disclose to Sovereign and/or any of its related companies, their advisers, reinsurers, and to any legal tribunal before which any question concerning the insurance may arise, any medical, financial or other personal information affecting such insurance which they may hold in respect of me:
   - any doctor or other registered medical practitioner or specialist, counsellor, psychologist, therapist, dentist, clinic, hospital or medical laboratory;
   - the Accident Compensation Corporation;
   - any bank, financial institution, accountant or financial adviser;
   - any of your current or former employers;
   - insurers or reinsurers (whether public or private); and
   - any government department, agency, organisation or enterprise.

m. I understand that the supply of the information gathered from the above sources is voluntary and that Sovereign and/or any of its related companies may or may not seek information from the above agencies – whether they seek information is dependent on what information is required to make a decision on my insurance.

n. I understand that in collecting information that is relevant to this Application Sovereign may also receive/collect information that is not relevant to the assessment of this Application for Insurance, or the assessment and administration of my claim and Sovereign will not use this non-relevant information for any purpose other than as permitted under the Privacy Act 1993.

Correspondence by Email:

o. Where I have provided my email address(es) in Section 2, I consent to Sovereign corresponding with me by email regarding this application and any changes or additions in respect of this application listed in Section 2.

p. Such correspondence can be sent to the email address(es) detailed in Section 2 or subsequent email addresses I provide to Sovereign.

q. I am responsible for advising Sovereign if my email address(es) change.

r. I am responsible for the security of the information sent to and held in my email account(s) and the access that others have to this account/these accounts e.g. the access other family members/colleagues may have to my emails.

Insurance policy:

s. The above answers have been entered by me in this Application and have been checked by me and no statement affecting this insurance has been made to any representative of Sovereign that is not recorded in this Application.

t. I am aware that a copy of the Plan's Policy Document is available from the Employer and the financial statements of Sovereign are available to me on request from Sovereign's Head Office.

General:

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

Full name of Life to be Assured	
Signature of Life to be Assured	
Date	/ /

Sovereign House, 74 Taharoto Road, Takapuna, Auckland 0622

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Freephone: 0800 500 103
Freefax: 0800 329 768

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