



Application for reinstatement

To be completed by the Life Assured

Please state full particulars in reply to each question, using an additional sheet if necessary.
Please use a separate form for each Life Assured.

1. Life Assured

Title: <input type="text"/>	First names: <input type="text"/>	Surname: <input type="text"/>
Street address: Street: <input type="text"/> Suburb: <input type="text"/> Town / city: <input type="text"/> Postcode: <input type="text"/>		Postal address: (if different from physical address) Street: <input type="text"/> Suburb: <input type="text"/> Town / city: <input type="text"/> Postcode: <input type="text"/>
Home phone: () <input type="text"/>	Business phone: () <input type="text"/>	Mobile phone: () <input type="text"/>
Occupation: <input type="text"/>		Email: <input type="text"/>
Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Place of birth: <input type="text"/>	Nationality: <input type="text"/>
Previous name (if changed) <input type="text"/>		Gender: (Please tick) <input type="checkbox"/> M <input type="checkbox"/> F

2. Policy Owner(s) (Please note the Policy Owner(s) must be the same as at the time of the policy lapse)

If different from Life Assured.

Policy Owner 1

Title: <input type="text"/>	First names: <input type="text"/>	Surname: <input type="text"/>
Street address: Street: <input type="text"/> Suburb: <input type="text"/> Town / city: <input type="text"/> Postcode: <input type="text"/>		Postal address: (if different from physical address) Street: <input type="text"/> Suburb: <input type="text"/> Town / city: <input type="text"/> Postcode: <input type="text"/>
Home phone: () <input type="text"/>	Business phone: () <input type="text"/>	Mobile phone: () <input type="text"/>
Occupation: <input type="text"/>		Email: <input type="text"/>
Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Place of birth: <input type="text"/>	Nationality: <input type="text"/>
Previous name (if changed) <input type="text"/>		Gender: (Please tick) <input type="checkbox"/> M <input type="checkbox"/> F

Policy Owner 2

Title: <input type="text"/>	First names: <input type="text"/>	Surname: <input type="text"/>
Street address: Street: <input type="text"/> Suburb: <input type="text"/> Town / city: <input type="text"/> Postcode: <input type="text"/>		Postal address: (if different from physical address) Street: <input type="text"/> Suburb: <input type="text"/> Town / city: <input type="text"/> Postcode: <input type="text"/>
Home phone: () <input type="text"/>	Business phone: () <input type="text"/>	Mobile phone: () <input type="text"/>
Occupation: <input type="text"/>		Email: <input type="text"/>
Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Place of birth: <input type="text"/>	Nationality: <input type="text"/>
Previous name (if changed) <input type="text"/>		Gender: (Please tick) <input type="checkbox"/> M <input type="checkbox"/> F

3. General details

1. Have you ever been declined, deferred, or accepted at special terms under a life, accident, medical or other health-related insurance by any other insurance company?
If yes, give details.

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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2. Are you intending to travel or reside overseas?
If yes, give details.

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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3. Do you engage in motor sports, climbing, scuba diving, hang gliding and aviation other than as a fare paying passenger on a regularly scheduled airline of travel overseas other than for vacation or holiday or participate in any other hazardous activities or hobbies.
If yes, give details.

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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4. Health and medical history

1. What is your height? inches/cms What is your weight? stone/kg

2. What is the name and address of your current doctor?

3. How long have you been a patient of your current doctor?

4. Are you in good health and do you normally enjoy good health?
If no, give details.

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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5. Since applying for the above policy have you had any of the following?

a. Any heart conditions e.g. rheumatic fever, chest pain, coronary artery disease, angina

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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b. High blood pressure and/or high cholesterol

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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c. Brain or neurological conditions e.g. stroke, paralysis, epilepsy, headaches

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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d. Cancer, tumour, cyst, mole or growth of any kind

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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e. Skin disorders

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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f. Liver disorders e.g. hepatitis

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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g. Kidney, bladder or prostate disorders e.g. colic, stones, prostatitis

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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h. Lung disease e.g. asthma

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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i. Impaired speech, hearing or vision (e.g. wearing glasses), ear or nose or throat disorders, or teeth or gum problems

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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j. Gastric ulcers or any stomach or bowel disorders e.g. indigestion, crohns disease, ulcerative colitis

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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k. Diabetes or thyroid disorders

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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l. Blood disorders e.g. anaemia, haemophilia, leukaemia

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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m. Disorders of spine, joints, muscles e.g. arthritis, back pain, gout

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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n. Mental or nervous disorders e.g. depression, stress, fatigue, anxiety

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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o. Haemorrhoids, varicose veins, hernias

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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p. Any disorder of the reproductive system or sexually transmitted disease

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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q. Do you have any symptoms or conditions for which you intend to visit a doctor in the future

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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r. Congenital conditions, illnesses or injuries not listed above

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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s. Are you taking any drugs or medications on a regular basis, prescribed or otherwise

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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t. Tests, examinations, x-rays, surgery or hospitalisation

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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To be answered by females only -

- u. Disease or disorder of the gynaecological tract, including the cervix, uterus, fallopian tube(s), ovary, vulva, vagina, abnormal smear test(s), fibroids, irregular or heavy menstrual bleeding or mid cycle pain, breast lumps, thickenings, cancer or abnormal mammogram(s) and ultrasound(s)?

☐ Y ☐ N

- v. Are you pregnant? If yes, due date

☐ Y ☐ N

If yes to any of the conditions above, please give full details.

Date	Nature of illness/test	Duration	Time off work	Treatment received	Name of doctor/hospital

6. Has there been any change in your family history since your previous statement?

☐ Y ☐ N

If yes, provide further details.

5. Aids declaration

The following declaration should be made by the Life Assured if able to do so. Inability to make the declaration will not necessarily mean that insurance is not available. However, in that case, an HIV antibody test may be required.

I declare that the following statements are TRUE:

- I have not been infected by the virus which is believed to cause AIDS (the Human Immunodeficiency Virus), I am not carrying antibodies to that virus.
- In connection with AIDS or AIDS related conditions, I have not sought, and I am not intending to seek a medical consultation, treatment or investigation.
- To my knowledge, all my sexual partners since 1980 would be able to make the same declaration in relation to statements 1 and 2 above.

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

If you have answered NO to any of the above statements, please provide details.

6. Occupation

Questions 1-2 must be completed for ALL benefits.

1. Current occupations: Principal Industry
 Secondary Industry

2. Describe fully your normal duties and state any hazardous or manual aspects.

State percentage of work that is manual. %

Complete questions 3-11 only if you are applying for reinstatement of Total and Permanent Disability, Income Protection, Vital Income Protection, Mortgage Income Protection, New to Business, Business Continuation, Business Overheads, Locum Cover, Key Person Benefit or Waiver of Premium.

- Hours worked per week?
- How long have you been in your current occupation? years/months
- Annual income? \$
- Is your occupation: ☐ Full time ☐ Part time ☐ Seasonal
- Do you work from home? ☐ Y ☐ N % of time %

8. Who is your current employer?

9. What qualifications and training do you hold for your present occupation?

10. What was your previous occupation?

11. Are you about to change your occupation or duties? ☐ Y ☐ N
If yes, give details.

7. Business continuation cover

1. Are you a key person in the business? ☐ Y ☐ N
If yes, please state why your position is key to the business and its revenue.

2. Total No. of employees Full time Part time No. of non-income producing employees
Total number of key persons

3. Amount of revenue generated by the key person applying for this insurance? \$

4. Trading revenue (less cost of goods sold) generated by the business? \$

5. Net profit of the business (before tax) for the current year? \$

6. Will your company continue to operate and generate income in the event of your disability? ☐ Y ☐ N

If yes, for how long? Years Months

If yes, please quantify the potential loss of personal income to you.

8. Disclosure information to AIA New Zealand

Definition: AIA New Zealand shall mean AIA International Limited, trading as AIA New Zealand, and/or any related companies and/or agents (including company officers acting in the scope of their authority) and AIA New Zealand's Insurance Advisers or reinsurers.

You are not insured:

- until this application has been accepted by AIA New Zealand; and
- you have paid in full any premium arrears.

AIA New Zealand may decline this application, or may accept this application subject to certain conditions and exclusions.

Your duty of disclosure: When you apply for insurance with AIA New Zealand, you have a legal duty of disclosure to AIA New Zealand.

This means that:

1. All the statements you make to AIA New Zealand (both written and oral) including the answers in this application, must be true and correct.
2. You must disclose everything that you know, or could reasonably be expected to know, that is relevant to AIA New Zealand's decision whether:
 - to accept your application for insurance; and
 - if AIA New Zealand accepts your application, then on what terms AIA New Zealand will accept it and how much it will cost.
3. This duty of disclosure continues from the time you complete this application until either:
 - the commencement date of this policy or the date AIA New Zealand accepts your application for insurance, whichever is the later; or
 - AIA New Zealand declines your application for insurance.
4. You also have the same duty of disclosure to AIA New Zealand at the time you extend, vary or reinstate your insurance.

Important

If you do not comply with your duty of disclosure, and AIA New Zealand would not have accepted your application for insurance on the same terms or at the same premium if you had made full disclosure, then legally AIA New Zealand may:

- decline any claim that you make; and/or
- retain all premiums paid and recover any benefits paid; and/or
- alter the terms of any benefits under the policy; and/or
- remove any benefits under the policy; and/or
- void your insurance from inception.

IF YOU ARE NOT SURE WHETHER YOU NEED TO DISCLOSE A PARTICULAR FACT, PLEASE ASK AIA NEW ZEALAND OR YOUR INSURANCE ADVISER.

NOTE - U.S. Citizens: By purchasing this policy and signing below, I/we represent that I/we are not a U.S. person for the purpose of U.S. federal income tax and I/we are not acting on behalf of a U.S. person.

9. Declaration to AIA New Zealand

It is important for you to read and understand this declaration before signing the application, as there are terms and conditions that you may not be aware of and that will form part of your insurance if AIA New Zealand accepts your application.

1. I/We declare that the statements made in this application are true and complete and that I/we have disclosed all information material to this insurance for myself/ourselves and on behalf of family members.
2. I/We agree that this application and any other written statements made in connection with the proposed insurance shall form the basis of the contract between myself/ourselves and AIA New Zealand.
3. I/We understand that AIA New Zealand reserves the right to recover any medical costs incurred in assessing this application should I/we decide to cancel this application.
4. I/We further declare that if the answers to the questions in this application are not in my/our writing, that they have been correctly written down at my/our dictation and read and approved by me/us.
5. I/We acknowledge that the illustration attached to this application forms part of the application and sets out the insurance benefits I/we are applying for.
6. I/We acknowledge that if I/we undergo any alteration in my/our mental or physical health or have a change of occupation between the date of this application and the commencement date of this policy, or the date AIA New Zealand accepts this application for insurance, whichever is later, I/we agree to notify AIA New Zealand immediately.
7. I/We acknowledge that I/we are signing on behalf of any children under the age of 16 and declare that I/we have disclosed all health information, including any pre-existing conditions, for such children as well as myself/ourselves.
8. I/We authorise AIA New Zealand to debit my/our nominated credit card account with the premiums payable pursuant to the insurance. AIA New Zealand may debit the credit card account with an insurance premium even where there may be insufficient clear funds in the credit card account, but AIA New Zealand should not be obliged to do so. If there are insufficient funds but AIA New Zealand debits the credit card account, AIA New Zealand may also debit the credit card account with any applicable fees and charges. If the insurance premium cannot be recovered from me/us, then AIA New Zealand may reverse the insurance premium payment resulting in the premiums being treated as not having been paid and AIA New Zealand may be entitled to cancel the insurance in accordance with the insurance terms relating to non-payment of premiums.
9. I/We acknowledge that personal information collected or held by AIA New Zealand (whether contained in this application or otherwise obtained) is provided and may be held, used, and disclosed by AIA New Zealand to:
 - process this application; and
 - any other application for insurance I/we make to AIA New Zealand; and
 - for the purpose of assessing any claim I/we may make should this or any other application be accepted by AIA New Zealand; and
 - for the purposes of any legal proceedings before a Court, or review or arbitration before a statutory or independent body.
10. I / We acknowledge that for the purposes set out in clause 9, personal information may be made available to our subsidiary and affiliated companies, local and overseas (and in this regard you consent to the transfer of your information outside New Zealand) and to any agent, contractor or third party who provides administrative or other services to AIA New Zealand or any member of the AIA Group.
11. I/We authorise AIA New Zealand to obtain my full medical history where the application form contains:
 - on-going medical conditions
 - multiple medical conditions
 - partial or incomplete medical history
 - a referral to a medical provider
12. I/We acknowledge that if I/we fail to provide any information requested in this application, AIA New Zealand may be unable to process the application for insurance.
13. I/We understand that access to my/our personal information is available to me/us under the Privacy Act 1993 by writing to AIA New Zealand.
14. I/We authorise AIA New Zealand to obtain personal information held about me/us relevant to my/our application, my/our insurance, or any claim that I/we may make. This declaration shall constitute sufficient authority to the party that AIA New Zealand requests the information from and extends to personal information held about me/us by any government department, incorporated body or person, including (but not limited to) information held by:
 - Accident Compensation Corporation
 - employers
 - accountants and other financial advisers
 - government departments and bodies
 - banks and insurers
 - medical laboratories
 - counsellors, psychologists and therapists
 - private and public hospitals
 - dentists
 - registered medical practitioners and specialist
15. I/We agree that a photocopy of this authority shall be treated as an original.
16. If this application is to replace existing cover with another insurer, I/we have read, understood and signed an Advice on Replacement Business form.
17. I/We have been advised that specimen policy wordings are available from my/our Insurance Adviser and that AIA New Zealand's financial statements are available from AIA New Zealand's head office.

If you are applying for Superior 3 Health Cover please read this carefully before signing.

If any claim arises from, or which is traceable to, or medically related to any pre-existing condition(s) within the first three years from the commencement date of the contract, AIA New Zealand will not pay the resulting claim. A pre-existing condition is any illness, injury or medical condition you or the Life Assured(s) were aware of; or of which the direct indication you or the Life Assured(s) had that something was wrong; or for which you or the Life Assured(s) sought medical treatment or medical advice on or before the commencement date of the contract. This exclusion will apply to any person(s) added to this policy for the first three years from the date of their addition as a Life Assured under this contract. AIA New Zealand will not at any time pay a claim for any exclusion noted in the policy schedule.

I/We declare that I/we have read and understood the above declaration and agree to be bound by these terms and conditions.

To be signed below by every person to be covered by this insurance and all Policy Owners.

(To be signed by the parent/legal guardian if the Life Assured is a child under 16 years.)

Full name of Life Assured

Signature of Life Assured

Date

Full name of Policy Owner (1)

(if different from Life Assured)

Signature of Policy Owner (1)

Date

Full name of Policy Owner (2)

(if different from Life Assured)

Signature of Policy Owner (2)

Date

AIA New Zealand

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AIA International Limited, trading as AIA New Zealand

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