Group Continuation Option Application



Application for - Continuation Option

This form is to be used in co	niunction with the Group	n Insurance policy	document terms and conditions.

Please complete all sec	ctions.																				
Name of former employer																					
Date you left that employer	Day	Moi	nth	Year																	
Name of new employer																					
Date employment started	Day	Mor	nth	Year																	
1. Life to be Insured																					
Title	Mr O	M	rs O	Mi	$_{\rm ss}$	M	\circ	Othe	r:												
Surname																					
First name(s)																					
Residential address																					
																Po	ostcode				
Mailing address																					
(if different from above)																Pe	ostcode				
Previous surname (if applicable)																					
Have you smoked any form of tobac	Male O cco or any o			Date o		_		Mont Yes		Year No O											
Telephone		1 1		1	1				1	1		ı	ı	ı	ı	ı	ı	ı	ı	ı	ı
Email																					
2. Policy Owner (if not the	ne Life te	o be l	nsur	ed al	ove	e)															
Title	Mr O	M	rs O	Mi	ss	M	is O	Othe	r:												
Surname																					
First name(s)										<u> </u>	 <u> </u>						<u> </u>				
Residential address											<u> </u>							<u> </u>			
																Pe	ostcode				
Mailing address																					
			- 1													Po	ostcode				
(if different from above)															_						
(if different from above) Previous surname (if applicable)																					
	Male O	Female	<u> </u>	Date	of birth	Mob	Day	Mont	h	Year											
Previous surname (if applicable)		Female	<u> </u>	Date	of birth	_		Mont	h	Year											
		Female	eO	Date o	of birth	_		Mont	h	Year											

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3. Residence				
a) Are you a citizen or permanent resi	dent of New Zealand?	Yes O	No O	If 'No', please give details
b) Do you intend to travel to (other the Destination	an on holidays) or live in any other co	ountry? Yes O	No O	If 'Yes', please give details Duration
4. Personal information				
a) Are you ceasing employment due to	o sickness or injury?	Yes O	No O	
b) Have you been diagnosed with any	illness or disease			
that is expected to cause death with		Yes O	No O	
If 'Yes' to either question a) or b), plea	se provide details below			
E Occumention/Imagence do				
5. Occupation/Income de To be completed by the Life to be Insu		on ou Total 9 Doumano	nt Disablament han afit	
a) What is your new occupation title				5.
a) what is your new occupation tide	and in which industry will you wor	rk iii your principai occ	upations	
-				
b) How many hours per week and wee	eks per year will you spend working	in your principal occupa	ation? Hours per week	Weeks per year
	J J	J · · · · · · · · · · · · · · · · · · ·	Trouis per week	weste per year
c) Please provide your new annual ir	ncome details (from personal exerti-	on in your principal oc	cupation only)	
(i) Employed				
Annual Salary or Wages (before ta	ax) \$			
Plus Fringe Benefits (e.g. car)	\$	Please specify		
	\$			
	\$	_		
	\$			
Plus bonus/commission	\$			
Total insurable income	\$			
(ii) Self employed or a Shareho	older employee			
a. Total gross income of the busin	· _			
b. Less total expenses	\$			
c. Net profit	\$			
d. Your share of net profit	\$			
e. Plus your shareholder salary/wa				
Total insurable income (d + e)	s s			
Total insurable income (u + e)				
d) In your principal occupation, what	percentage of time do you spend per	forming the following to	mes of duties:	
, , ,	1	Describe specific duti		
		Describe specific duti	es periorineu.	
– Sedentary / administrative	%			
– Supervise manual work	%			
– Manual work				
- Other — (including hazardous dut				
e.g. handling dangerous substance	es, working at heights) % TOTAL DUTIES	100 %		
\ ·				
e) Do you have a second occupation or		ss Yes O	No O	
entity? If 'Yes', please give full details,	including specific duties, below			

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Privacy Act 1993 and Health Information Privacy Code 1994

This application collects personal information about you. You have the right of access to, and correction of, the information that relates to you.

The personal information and any additional information obtained (including medical and financial information) will be used by Fidelity Life Assurance Company Limited ("Fidelity Life"), its subsidiaries, its officers, its advisers, reinsurers and other companies for processing on Fidelity Life's behalf and to calculate, administer and promote insurance services to you. This information may also be used for statistical purposes provided you are not identified.

Your personal information is securely held by Fidelity Life Assurance Company at 81 Carlton Gore Road, Newmarket, Auckland, or at a secure location to be determined by us and through cloud-based services who store information on our behalf in New Zealand or Australia. This information may be disclosed outside of Fidelity Life where the disclosure is necessary for one or more purposes for which the personal information was collected, to your adviser (or one assigned to your business), where required by law, to the main contact for the policy owner, and with your consent.

DUTY OF DISCLOSURE

Before you enter a contract of insurance you have a duty to disclose to Fidelity Life every matter that is relevant to Fidelity Life's decision whether to accept the risk of insurance and if so on what terms. You have the same duty to disclose those matters to Fidelity Life that occur after signing this application and before your contract of insurance commences. You also have the same duty to disclose those matters to

Fidelity Life before you apply to increase or re-instate your insurance. If you fail to comply with your duty of disclosure, **Fidelity Life may cancel your policy from inception**, or at its discretion, alter the amounts and terms of the insurance or decline to consider any claim(s). If Fidelity Life cancels your policy from inception, all premiums paid may be forfeited.

DECLARATION AND ACKNOWLEDGEMENT

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

- I understand that Fidelity Life has not provided me with personalised financial advice in regard to this application and that if advice is required I will speak to my adviser.
- ▶ I understand that the contract of insurance with Fidelity Life will not commence until this application has been accepted by Fidelity Life, acceptance terms have been agreed to by the policy owner(s) and received by Fidelity Life and until payment of the premium is received, or receipt of a valid direct debit to operate within 30 days.
- lacksquare I shall be bound by the terms and conditions in the policy to be issued by Fidelity Life.
- If I have provided my email address in this application, or if I provide it at some stage in the future, I consent to receive emails from Fidelity Life in respect of Fidelity Life and any further services.
- I have read and understand the sections in this application headed Privacy Act 1993 and Health Information Privacy Code 1994.

A- Excellent

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

(Fair)
C+ (Marginal)
-

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

Life to be insured

Name

Signature

Policy Owner

Name

Signature







Please complete and return:

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

STB	Policy number(s)			Contact phone nu	mber
				()	
Office use only					
I would like to pay:	Fortnightly	○ Monthly	O Quarterly	O Half-yearly	O Annually

Direct Debit Authority

			0 6 0	4 9 0 2
lame of my bank:				
My bank account numb	er:		Арр	proved
			490	08/15
Bank Branch	Account	Suffix		
-	-	of direct debits from Fidelity	l ife Assurance Com	nany Limited
l authorise you to debit r with the authorisation o	my account with the amounts o	•	•	-
I authorise you to debit r with the authorisation or I agree that this authori The bank's terms a	my account with the amounts o	n accordance with this autho	•	
with the authorisation of I agree that this authori The bank's terms a The specific terms	my account with the amounts or ode specified on this authority in ty is subject to: and conditions that relate to my	n accordance with this author	•	

SPECIFIC CONDITIONS RELATING TO NOTICES AND DISPUTES

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

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

For customer-initiated payments the initiator may only send a direct debit if you have:

- · Asked the initiator to send it, and
- · Agreed the amount of the direct debit, and

The initiator is required to give you a written notice of the amount and date of each direct debit no less than the date of the debit.

- 2. I may ask my bank to reverse a direct debit up to 120 calendar days after the debit if:
 - I don't receive a written notice of the amount and date of each direct debit from the initiator, or
 - · I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.
- 3. If the bank dishonours a direct debit but the initiator sends the direct debit again once within 5 business days of the dishonour, the initiator is not required to give you a second notice of the amount and date of the direct debit.