Risk cover.

Application form.

November 2023

Est. in NZ 1973

91% of new claims accepted 1/7/22 – 30/6/23

NZ based customer service

Over $1.5B paid out in claims since 1973

Rated A- (Excellent) for financial strength*

Here for the good of NZ

*Fidelity Life has an A- (Excellent) financial strength rating from A.M. Best. The rating scale that this rating forms part of is available for inspection at our offices. For more information please visit Fidelity Life's financial strength page.

Please read these instructions before completing the application.

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

- Please do not write on this page or inside the perforated section of the spine, as the front page and spine are detached and discarded for processing purposes when received by Fidelity Life.
- Any notes should be included on the "Additional information" page (refer to pages 18 and 19).
- If completing by hand, use a black pen where possible and print in BLOCK CAPITALS within the spaces provided, e.g.

C	H	R	I	S		J	O	N	E	S

- Do not leave empty boxes at the start of lines containing words, but leave a space between words.
- Always attach an illustration.
- Remember to complete all questions in the required sections. Any alterations made must be initialled by the life to be insured and policy owner where applicable.

Ensure the following sections are completed.

For all applications.

- Please complete sections 1 to 15

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

Section 16

- Income protection/Business expenses/Key person/ Rural key person
- Total and permanent disability
- Waiver of premium

Section 17

- Key person

Section 18

- Business expenses

Please provide any additional details relating to this application in the Additional information found after the question sections.

1. Adviser to complete.

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

See attached quote.

Commencement date for direct debits only.

– monthly 1st to 28th

– fortnightly 1st to 31st

Day of week Month Year

Joint Life Applications – where the policy comprises more than one life,

do you wish the policy to be issued on acceptance of any one life? ..... Yes ○ No ○

is this application to amend an existing policy? ..... Yes ○ No ○

- If 'Yes', please give policy number and complete Alteration request form (on page 25)

Is this application dependent on completion of any other arrangement? ..... Yes ○ No ○

- If 'Yes' please give details in the Additional information section on pages 18 and 19.

Adviser declaration.

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

Name of Adviser

Adviser signature

Date (DD/MM/YYYY)

2. Credit card payment.

If you have requested to pay on a recurring basis by credit card your financial adviser will send you a registration link to a secure website where you can register your credit card to automatically pay for your premiums.
(Please ensure that your email address is included on page 4 of this application form).

Please note:

1. It is important that you register your credit card within 7 days of receiving this email. Should you need any assistance with this link, please contact the Fidelity Life customer care team.
2. Credit card payments will be accepted for all monthly, quarterly, half-yearly and annual premiums.
3. If you have any questions about the credit card payment system, please call new business on telephone 0800 88 22 88 option 2 and then option 1.

3. Duty of disclosure. Please read **before** completing application.

What you need to tell us.

1. **Always tell the truth**. You must tell us everything that may affect our decision to insure you. Insurance is based on the principle of utmost good faith. Put simply you have a positive duty to provide truthful, complete and correct information about yourself, including your health and medical history. Your duty of disclosure extends to the date the contract of insurance commences. For example, you are required to tell us if you are diagnosed with a medical condition after the date of your application, but before we agree terms of cover we may offer. If we offer to cover you, you will be insured on the basis of the information you have provided.
2. **Answer questions as fully as you can**. Applying for insurance involves responding to a number of questions. Your answers need to include as much detail relating to your current and past circumstances as possible. While this may take time, it is important to ensure that we have all the information we need when we make the decision to insure you and on what terms.
3. **If in doubt, tell us**. Be aware the law does not distinguish between innocent or deliberate non-disclosure. If you are uncertain of the relevance of any information, please include it on your form because, even if you aren't sure, it may be important to us. If someone else is completing the form on your behalf, it is important that you check that the information is correct and nothing has been left out.
4. **If you don't know something, say so**. If you say that you don't know what the answer is and we think we need more information about your answer to a question so we can offer you insurance, we will need to obtain the information from somewhere else. By signing the declaration and consent, you give us your consent to get this information.
5. **Know what you're signing**. By signing the declaration on your form, you are saying that you have answered all the questions completely and to the best of your knowledge, as well as providing any other information that may influence our decision about your policy. If you are uncertain about any of your answers, ask your adviser or us before signing the declaration. By completing and signing the declaration you are agreeing to be bound to Fidelity Life's terms.
6. **How non-disclosure affects claims**. When you make a claim we may look further into your personal history. If we discover that you did not provide us material information we may avoid your policy and no claim will be payable or at our discretion amend the terms of your insurance policy. It does not matter if the new information is about a condition unrelated to your claim. If we avoid your policy from its inception, this means that you would not be able to make a claim as no policy would exist. In addition, all premiums paid may be forfeited.
7. **Help us to help you when you need to claim**. Depending on what you tell us on your claim form, we might need more information to make a decision about your claim. We may get this information by calling you, asking you to fill out another form or asking you to have a medical test. Sometimes we will need to get information from other people who may include your doctor, your employer, ACC or other government departments. By signing the consent form you give us the consent to do this.
8. **Know what are consenting to**. We can only request information that we need to assess your application for insurance or for payment of a claim. At all times, you have the right to access the information we hold about you and, if it is wrong, to ask us to correct it.
9. **Don't be afraid to ask**. If there is anything you're not sure of, don't be afraid to ask. Contact your adviser, or phone Fidelity Life on 0800 88 22 88.

4. Medscreen.

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

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

5. Telephone underwriting.

To speed up the acceptance of this application, if we need further information we will contact you directly (e.g. via email or telephone) unless you indicate otherwise.

◯ No - please do not contact me ◯ Yes - when is the best time? ◯ a.m / ◯ p.m

6. Life to be insured.

Title Mr ○ Mrs ○ Ms ○ Miss ○ Dr ○ Other ○

Surname

First name(s)

Residential address

Mailing address, if different from above

Gender* Male ○ Female ○ Date of birth (DD/MM/YYYY)

Previous surname (if applicable)

Phone number Email

Occupation Industry

Average Gross Annual Earnings (net of expenses) $

Is the life to be insured a policy owner? ○ Yes ○ No

*Fidelity Life recognises that gender is diverse. This question refers to assigned sex at birth which is used for underwriting purposes. If you have any questions, or require further information please discuss with your Adviser.

7. Policy owner(s).

Policy owner (1)

Title Mr ○ Mrs ○ Ms ○ Miss ○ Dr ○ Other ○

Surname (or registered company name)

First name(s)

Residential address

Mailing address, if different from above

Relationship to life to be insured Male ○ Female ○ Date of birth (DD/MM/YYYY)

Phone number Email

Policy owner (2)

Title Mr ○ Mrs ○ Ms ○ Miss ○ Dr ○ Other ○

Surname (or registered company name)

First name(s)

Residential address

Mailing address, if different from above

Relationship to life to be insured Male ○ Female ○ Date of birth (DD/MM/YYYY)

Phone number Email

We'll always communicate with you via email. If you prefer your policy documents sent by post, let us know.

Select email address to be used – Life to be insured if policy owner ○ Policy owner (1) ○ Policy owner (2) ○

8. Other insurance arrangements.

a. Are you currently applying to any other company? ..... ○ Yes ○ No

b. Do you have any life or trauma/critical illness or disability insurance? ..... ○ Yes ○ No

If 'yes' to questions a. or b. please give details.

Life (#)	Company	Year issued	Type	Sum insured	Status (applied for / in force / cancelled)

c. Is this application replacing an existing policy, or a policy discontinued within the last 6 months, with Fidelity Life or any other company? ..... Yes ○ No ○

9. Residence and travel.

Residency Status (please tick one)

a. ☐ Citizen or Permanent Resident of New Zealand

☐ Applied for Permanent Residency

☐ Work Visa/valid for more than 12 months

☐ Other (please provide details)

b. Do you intend to travel to (other than on holidays) or live in another country? If 'Yes', please give details ..... Yes ○ No ○

Country	City/Province	Purpose	Duration

10. Hazardous pursuits and activities.

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

Do you participate or intend to participate in any of the following: ..... Yes ○ No ○

- Aviation (other than as a fare-paying passenger)
- Hang-gliding/kiting
- Motor sport – any form, including off-road activities or power boat racing
- Scuba diving
- Mountaineering, rock climbing, abseiling or caving
- Parachuting
- Any other hazardous sports/pastimes/activities (e.g. martial arts, competitive horse riding, hunting, etc.)

11. Medical records.

Doctor's details

a. Please give details of your usual doctor below

Name

Medical practice City

b. How long have you been with your usual doctor? Years Months

c. Are your medical records held under the same doctor's name as shown in Section 11.a. above? ..... Yes ○ No ○

If 'No', please give details of the doctor who holds your records (i.e. if different from above)

12. Your personal information.

a. What is your height? ____ cm or ____ ft ____ ins What is your weight? ____ kg or ____ lbs

b. Has your weight changed by more than 5kgs in the last year? Yes ○ No ○ If 'Yes', it **increased** by ____ kg/lbs or **decreased** by ____ kg/lbs

Please provide reason for weight change ____

c. Do you currently, or have you in the last 12 months smoked tobacco, or used nicotine replacement (incl. vaping with nicotine)?..... Yes ○ No ○

If 'Yes', what? ____ How many per day? ____

d. If you haven't smoked in the last 12 months, have you ever smoked?..... Yes ○ No ○

If 'Yes', date last smoked (DD/MM/YYYY) ____

e. Have you used marijuana, heroin, cocaine, narcotics, barbiturates, recreational or psychoactive drugs, or any other non-prescription drugs other than in accordance with manufacturers instructions? If 'Yes', please give details below Yes ○ No ○

____

f. Do you drink alcohol (including kava)? Yes ○ No ○ If 'Yes', number of standard drinks* per ____ day ____ week ____ month

Type of alcohol/kava consumed? ____

*a standard drink = 1 nip of spirits or 1 glass of wine or 1 glass of beer.

g. Have you ever been advised by a medical practitioner to reduce or stop your alcohol consumption or have you ever had a consultation or been treated for addiction to, or abuse of, alcohol and/or drugs? If 'Yes', please give details ..... Yes ○ No ○

____

h. Are you currently under investigation for, or have you ever been charged with or convicted of, a criminal offence?..... Yes ○ No ○
If 'Yes', please give details below

____

i. Have you ever been declared bankrupt, or are you pending bankruptcy? If 'Yes', please give details below ..... Yes ○ No ○

____

13. Your health history.

Are you currently, or have you ever

- experienced symptoms or been diagnosed with
- sought medical advice or treatment
- had or been advised to have investigation/s or test/s
- taken regular medication
- had a medical procedure or operation

from any Health professionals including chiropractors, physiotherapists, naturopaths, osteopaths, counsellors, or alternative health practitioners for any of the following:

a. Asthma, bronchitis, emphysema, sleep apnoea, COVID-19 or any other respiratory disorder ..... (Complete Section 20) Yes ○ No ○

b. High blood pressure or raised cholesterol ..... (Complete Section 25) Yes ○ No ○

c. Chest pain, heart murmur, heart attack, angina, palpitations, coronary artery disease, rheumatic fever or any other heart condition ..... Yes ○ No ○

d. Gastric or duodenal ulcer, reflux or frequent indigestion ..... Yes ○ No ○

e. Stomach or bowel disorder, ulcers, colitis, ongoing abdominal pain, or any other disease/disorder of the gastro-intestinal tract, pancreas or gall bladder ..... Yes ○ No ○

f. Depression, breakdown, stress or anxiety disorder, panic attack, sleeplessness, post traumatic stress disorder, eating disorder, or any other mental or nervous disorder ..... (Complete Section 24) Yes ○ No ○

g. Diabetes or Impaired Glucose Tolerance (Pre-diabetes) ..... (Complete Section 21) Yes ○ No ○

h. Liver disease or disorder e.g. hepatitis abnormal liver function tests or cirrhosis ..... Yes ○ No ○

i. Sexually transmitted illness or virus ..... Yes ○ No ○

j. Thyroid disorder or any other glandular disorder ..... Yes ○ No ○

k. Back or neck problems, spinal conditions, sciatica or whiplash ..... (Complete Section 23) Yes ○ No ○

l. Arthritic disorders such as rheumatism, osteoarthritis, rheumatoid arthritis or gout ..... (Complete Section 23) Yes ○ No ○

m. Strains or sprains, Occupational Overuse Syndrome/RSI, broken bones or fractures or general injuries (including head injuries) ..... (Complete Section 23) Yes ○ No ○

n. Recurrent or chronic allergy or skin disease ..... Yes ○ No ○

o. Cancer or tumour including skin lesions, moles, cysts or growths of any kind ..... (Complete Section 22) Yes ○ No ○

p. Disease of the kidneys, bladder or other reproductive or genito-urinary system, prostate or gynaecological disorders ..... Yes ○ No ○

q. Anaemia, haemophilia, leukaemia, haemochromatosis or any other type of blood disorder(s) ..... Yes ○ No ○

r. Any brain or neurological disorder e.g. epilepsy, multiple sclerosis, paralysis or stroke, dizzy spells, migraines, head injury or transient ischaemic attack ..... Yes ○ No ○

(If you have answered 'Yes' to any of these questions then either complete the Section indicated OR give full details in the space provided below)

Question	Condition	Date first started	Date of last symptoms	Full details of investigation/treatment	Degree of recovery (e.g 100%)	Full name of doctor or hospital

14. Additional health information.

The following questions relate to any medical conditions or disorders you have not already disclosed in this application.

a. Have you had any other illness, injury, condition, medical treatment, surgery or medication not already mentioned..... Yes ○ No ○

b. In the past five years have you ever had more than five consecutive days off work/school due to illness or injury?..... Yes ○ No ○

c. Have you ever had any disability, health or trauma/critical illness claim, including ACC loss of earnings claims? ..... Yes ○ No ○

d. Do you have impaired speech, hearing or vision? ..... Yes ○ No ○

e. Have you ever received, or are you expecting to receive any medical treatment, advice or blood tests connected with HIV, AIDS or any AIDS related condition?..... Yes ○ No ○

f. Have you been advised to have any medical investigation or test that you haven't undergone, or are you awaiting results of any medical investigation or test?..... Yes ○ No ○

Females only.

Please answer the following questions concerning your medical history

g. Have you ever had an abnormal pap smear or mammogram? ..... Yes ○ No ○

h. Have you ever had, or do you have, a breast lump (even if you have not seen a doctor about it?) ..... Yes ○ No ○

i. Are you currently pregnant? ..... Yes ○ No ○

If yes, please give estimated date of delivery ..... Date (DD/MM/YYYY)

j. If currently pregnant have you had any complications with this or past pregnancies?..... Yes ○ No ○

If 'Yes', to any of questions a. to j. please give details

Question	Reason	Date first started	Duration	Time off work	Full details of treatment including degree of recovery	Full name of doctor or hospital or health professional

15. Your family history.

Has any blood-related immediate family member (father, mother, brother, sister) had or been diagnosed with:..... Yes ○ No ○

- Cancer (breast, cervical, ovarian, colon or other)
- Diabetes
- Epilepsy
- Familial Polyposis
- Haemochromatosis
- Heart disease
- High blood pressure
- High Cholesterol
- Huntington's disease
- Kidney disease
- Mental Health (incl. depression)
- Motor neurone disease
- Multiple sclerosis
- Muscular dystrophy
- Stroke
- Any hereditary condition

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

16. Your occupation.

For Income protection/Business expenses/Key person*/Monthly mortgage repayment, complete questions 16a. to 16w.**

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

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

4 If the total monthly benefit is over $15,000, a Confidential financial questionnaire is required.

a. *Supporting financial evidence isn't required for Key person cover for farmers or Key person cover for new to business.

b. **For MMR, if the monthly benefit is over $5,000, confirmation of whether any rent is received will be required. If it is based on income, evidence of mortgage will also be required.'

For Total and permanent disability cover and Waiver of premium cover, complete questions 16a. to 16s.

For Rural key person cover, please complete question 16a to 16x.

a. What is your principal income-earning occupation?

b. Do you hold a professional or trade qualification relevant to your occupation? ..... Yes ○ No ○ If yes please provide details

c. Are you self-employed? ..... Yes ○ No ○
or a shareholder-employee? ..... Yes ○ No ○ ..... If a shareholder-employee, % of shares owned %

d. What is the name of your employer,
or registered company name if self-employed?

e. What is the nature of the business?

f. How long have you been with this employer or in your current self-employment? years months
(if self-employed less than twelve months, please contact Underwriting Dept)

g. What is the start date of the business? (DD/MM/YYYY)

h. If you have been in your current occupation for less than five years, give details of your occupation(s) during the past five years (attach separate sheet if necessary)

From (MM/YYYY)	To (MM/YYYY)	Occupation	Employer

i. Describe your exact duties, the tasks involved (including details as applicable of heights, depth and locations at which you work, and chemicals, gases or any toxic substances used) and provide the percentage of time spent on each duty and the percentage of time that each duty requires manual or physical work, including driving.

Exact duties	% of time on each duty	% that requires manual or physical work, including driving

j. Are you aware of any pending redundancy or liquidation at your place of permanent employment or have you been advised that you may be made redundant? ..... Yes ○ No ○
If yes please provide details.

k. Is your income derived from

Salaried employment
- Full-time ○
- Part-time ○
- Seasonal ○

Self-employment
- Sole proprietor ○
- Partnership ○
- Other ○ If other, please specify below (e.g. Trust, Directors fees)

If partnership
- Number of partners
- Profit Share entitlement %

l. If you are self-employed, or a shareholder/shareholder employee with 20% or more shares, what is the total number of employees? Full-time Part-time

m. If you are self-employed, in the last 12 months, has your business had a change to your operations including hours worked, volumes and capacities, services offered, turnover or net income? ..... Yes ○ No ○

If yes, please give full details.

n. If you are an employee, in the last 12 months have you had a change to your occupational duties, hours worked or income (salary or wage)? ..... Yes ○ No ○

If yes, please give full details.

o. How many hours per week do you spend at your principal occupation?

p. How much of your income would continue if you were disabled? How long would it continue for? What would be the source of income? E.g. sick leave entitlements outside of the Holidays Act (2003), outstanding accounts, retainers, superannuation benefits, ongoing profits or entitlements.

q. Do you work at home? ..... Yes ○ No ○

If 'Yes', please give full details of work activities performed away from home and average weekly hours of such activities

r. Do you have a second occupation or financial interest in any other business entity? ..... Yes ○ No ○

If 'Yes', please give full details

Occupation	Duties	Hours/week	Income per annum

s. Do you intend to change your occupation or duties in the next two years? ..... Yes ○ No ○

If 'Yes', please give full details

t. Annual income details (from personal exertion in principal occupation only)

(i) **Employed**

Annual Salary or Wages (before tax)	$
Plus Fringe Benefits (e.g. car)	$
	$
	$
	$
Plus bonus/commission	$
Total insurable income	**$**

Please specify

(see Note 3. at beginning of this section)

(ii) **Self employed or a Shareholder employee**

a. Total gross income of the business	$
b. Less total expenses	$
c. Net profit	$
d. Your share of net profit	$
e. Plus your shareholder salary/wages	$
Total insurable income (d + e)	**$**

u. Is your income split for tax purposes with your spouse or partner? ..... Yes ◎ No ◎
If 'Yes', please advise the percentage split and the hours and nature of work they do in the business

16. Your occupation (continued).

v. Do you have net assets in excess of $5 million or investment income greater than $100,000 per year? ..... Yes ◎ No ◎
If 'Yes', please complete a Confidential Financial Questionnaire

w. Have you previously made any claim under ACC, sickness or accident policies or any other disability policies for a period of more than two weeks? ..... Yes ◎ No ◎
If 'Yes', please give details

x. If you are applying for a Rural key person cover only benefit and you are a sharemilker, what type of sharemilker are you?

Own herd/50:50		Lower order	
Contract		Other (please state%)	%

17. Key person.

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

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

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

18. Business expenses.

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

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

19. Hazardous occupation or pursuits.

	Pursuit 1	Pursuit 2
a. Name of occupation or pursuit		
b. How long have you participated in this activity?		
c. Are you a member of a club or association?	Yes ◎ No ◎	Yes ◎ No ◎
If yes, please give details.		
d. Are you a certified instructor?	Yes ◎ No ◎	Yes ◎ No ◎
e. What formal qualifications or licence do you have for this activity?		
f. Please advise the number of hours you engaged in this activity in the last 12 months?		
g. How often do you intend to participate in the future?		
h. Have you ever competed in this activity?	Yes ◎ No ◎	Yes ◎ No ◎
If yes, please give details (e.g. Pro/Amateur/Comp Amateur)		
i. Do you intend to participate alone or in a group?		
j. Where do you participate in this activity (geographically)?		
k. Is the use of an aircraft involved?	Yes ◎ No ◎	Yes ◎ No ◎
If yes, please give details.		
(i) Number of hours flown Total ____ This Year ____ Last Year ____ Expected next year ____		
(ii) Have you had any previous flying accident(s) and/or charges relating to violating Civil Aviation Regulations? Yes ◎ No ◎		
If yes, please give details.		
l. What safety precautions are taken?		
m. Do you have any plans to become a professional or change current licence/qualification?	Yes ◎ No ◎	Yes ◎ No ◎
n. Please give details of maximum heights, speeds and depths		
o. Please give full details including the engine size and model for any cars, motorbikes, boats, planes or other equipment used		
p. Have you ever required medical attention following participation in this pursuit/occupation?	Yes ◎ No ◎	Yes ◎ No ◎
If yes, please give details.		

20. Respiratory.

a. Diagnosis/condition

b. When did you first develop the conditions/symptoms?

c. When did you last experience symptoms?

d. How frequently did those symptoms occur in the last two years?

e. What is your present treatment (please give names of inhalers and/or tablets and dosage)?

f. How many inhalers do you use in a year?.....

g. Have you ever been admitted to a hospital for treatment? ..... Yes ○ No ○

If 'Yes', please give details

h. Have you had treatment with cortisone or prednisone in the last two years?..... Yes ○ No ○

If 'Yes', please give details

i. How much time have you lost from work in the last two years due to the respiratory condition?

j. Have you ever had any investigations into your respiratory condition? (e.g. Peak flow, Spirometry etc) ..... Yes ○ No ○

If yes please provide details (dates, results etc)

21. Diabetes/IGT/pre-diabetes.

If you answer 'Yes' to any questions, please provide details.

a. When were you first diagnosed with diabetes?

b. What type of diabetes do you have? (e.g: Type 1 or 2 / IGT/Pre-diabetes)

c. Do you use insulin? If not, what treatment do you require for your diabetes? ..... Yes ○ No ○

d. Have you ever had any albumin or protein in your urine or any kidney problems?..... Yes ○ No ○

e. Have you ever suffered from eye problems or had an abnormal eye examination as a result of your diabetes?..... Yes ○ No ○

f. Have you ever had numbness or tingling in your feet or legs, or any other complications? ..... Yes ○ No ○

g. Have you had a blood test done in the last six months for your condition? ..... Yes ○ No ○

h. Do you have your HbA1c reading? If yes, what was your reading? ..... Yes ○ No ○

i. Have you had a diabetic (Hyperglycemic) or insulin (Hypoglycemic) coma in the past three years?..... Yes ○ No ○

j. How many days have you taken off work/school because of this condition in the last twelve months?

22. Cancer, tumour or skin growth questionnaire.

a. Please state the nature of the cancer or lesion including location and date(s) diagnosed

b. If the cancer or lesion has been treated, please give details of treatment and diagnosis

c. Was the cancer or lesion benign, pre-malignant or malignant?

d. Have any follow up checks or treatment been required? ..... Yes ○ No ○

e. If 'Yes', please provide dates, further details, results (if known) and the name and full address of attending doctor / specialist

23. Musculoskeletal questionnaire.

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

a. When did you first suffer from any of the above problems? Date (DD/MM/YYYY)

b. Please state – i) the cause
ii) the symptoms/exact nature of the problems

c. Please indicate the area or joint involved and specify which side (if applicable)

cervical spine (neck) ○ knee joint L ○ R ○ Other, please specify L ○ R ○
lumbar spine (low back) ○ hip joint L ○ R ○
thoracic spine (mid back) ○

d. What was the severity of the pain? Mild ○ Moderate ○ Severe ○

e. How many recurrences have you had of the problems? When? Duration of episode(s)

f. Please advise date of last symptoms (e.g. pain or stiffness) Date (DD/MM/YYYY)

If not symptom-free, what is the current severity of pain?

g. How much time have you lost from work as a result of the above problems?

h. Please describe the treatment(s) received

i. If you are still undergoing treatment, please give details

j. If treatment has ceased, please give date Date (DD/MM/YYYY)

k. Please advise diagnosis (e.g. slipped disc, arthritis, etc.)

Continued over page.

23. Musculoskeletal questionnaire (continued).

l. Have you ever had any associated depression? ..... Yes ○ No ○

m. Please give the dates, names and address of doctor(s) or other health provider(s) or adviser(s) consulted for these problems

24. Mental health questionnaire.

a. Please indicate which of these apply to you:

Depression ○ Stress ○ Anxiety disorder ○ Panic attack ○ Phobia ○ Compulsive disorder ○ Chronic fatigue ○ Eating disorder ○

Other (please specify)

b. Date of onset or dates if you have suffered more than one episode

c. Did this issue arise as a result of particular circumstances? ..... Yes ○ No ○

If 'Yes', please outline those circumstances

d. Have you ever had any suicidal thoughts or attempts of suicide or self-harm? ..... Yes ○ No ○

If 'Yes', please give details

e. Please provide the name of any doctor(s) or health provider you have consulted regarding your symptoms.

f. Please give details of any drugs or treatment prescribed, date(s) and duration(s).

g. Are you still on treatment for this issue? ..... Yes ○ No ○

If 'Yes', please give details. If 'No' please give date of cessation of treatment

h. How much time have you had off work for this issue?

i. Date(s) of last symptoms (if applicable) Date (DD/MM/YYYY)

j. Number of GP visits in the last 12 months

25. High blood pressure and/or high cholesterol questionnaire.

	High blood pressure	High cholesterol
a. Date of diagnosis (DD/MM/YYYY)		
b. Do you know your most recent Blood Pressure (BP) reading and/or serum cholesterol test reading? If Yes please provide result and date test taken (DD/MM/YYYY)	Yes ○ No ○	Yes ○ No ○
c. Do you take medication for your BP/Cholesterol?	Yes ○ No ○	Yes ○ No ○
d. Has your medication been altered in the last 12 months?	Yes ○ No ○	Yes ○ No ○
e. Has your doctor advised that your BP and/or cholesterol has been normal for the last 12 months?	Yes ○ No ○	Yes ○ No ○

26. General health questionnaire.

a. Please describe your particular health condition.

b. When did this condition first occur?

c. Please describe the location on the body and the severity and nature of symptoms, eg. left leg.

d. When were the most recent symptoms?

e. Have you had time off work as a result? ..... Yes ◎ No ◎

If 'Yes', when and for how long?

f. Have you ever been hospitalised or attended a clinic as a result of this condition? ..... Yes ◎ No ◎

If 'Yes', when and for how long?

g. Please advise full details of treatment, medication, tests, investigations and advice you have had for this condition, eg. x-rays, ECGs, physio, etc.

Please name any drugs and dosage.

h. Which doctors or health professional(s) did you consult and on what dates?

i. On what date did you last receive treatment/medication for this condition? Date (DD/MM/YYYY)

j. Has further treatment been recommended? ..... Yes ◎ No ◎

If 'Yes', please give details

k. Have you fully recovered from this condition? ..... Yes ◎ No ◎

If 'Yes', please advise date Date (DD/MM/YYYY)

If 'No', please give details below of ongoing issues

Additional information.

Question Number	Applicant's/Child's name	

Additional information.

Question Number	Applicant's/Child's name	

Declaration.

Your Duty of disclosure for the life to be insured and policy owner(s).

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

Privacy Act 2020 and The Health Information Privacy Code 2020.

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

Declaration and authority by life to be insured and policy owner(s).

- I/We have read the notice explaining my/our duty of disclosure and have had an opportunity to discuss it with my/our adviser. I/ We understand the contents in the Duty of disclosure and wish to proceed with my/our application with that understanding. I/We have completed the sections in this application required to be completed. If I/we have not done this, I/we declare that I/we have read the completed application and the information given (including any personal statement) is true, accurate and complete.
  I/we have not withheld or misstated any material fact.
- No statement affecting this insurance has been made to any representative of Fidelity Life that is not recorded in this application.
- I/We acknowledge that the information I/we have provided and the information provided by anyone else on my/our behalf in this application will form the basis of the contract of insurance between me/us and Fidelity Life.
- I/We understand if additional information is required to process my/our application for insurance, I/we may be telephoned by an underwriter. The information that I/we provide to the underwriter will form part of my/our application for insurance.
- I/We will immediately notify Fidelity Life of any circumstances affecting the risk that may occur after signing this application and before the contract of insurance commences.
- I/We understand that the contract of insurance with Fidelity Life will not commence until this application has been accepted by Fidelity Life, acceptance terms have been agreed to by the policy owner(s) and received by Fidelity Life and until payment of the premium is received, or receipt of a valid direct debit to operate within 30 days.
- If I/we have provided my/our email address in this application, or if I/we provide it at some stage in the future, I/we consent to receive emails from Fidelity Life in respect of Fidelity Life and any further services.
- I/We have read and understand the sections in this application headed Privacy Act 2020 and The Health Information Privacy Code 2020, and Statement of Consent by Life to be Insured. I/we authorise Fidelity Life to disclose any personal information that it holds about me, to any person where the disclosure is necessary for one or more purposes for which the personal information was collected.

Statement of consent by life to be insured.

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

Acceptance of Fidelity Life's Policy terms.

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

14-day free look.

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

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

A-
Excellent

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

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

Signature of life to be insured (1)

Date (DD/MM/YYYY)

Signature of life to be insured (2)

Date (DD/MM/YYYY)

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

Date (DD/MM/YYYY)

Signature of policy owner(s)
(If company-owned, authorised signatory must sign and indicate they are signing on behalf of the Company and their position in the Company.)

1.

Date (DD/MM/YYYY)

2.

Date (DD/MM/YYYY)

3.

Date (DD/MM/YYYY)

Please complete and return:

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

STB

Office use only

Policy number(s)

Contact phone number

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

Direct debit authority.

Direct debit authority.

Name on my account to be debited (acceptor):

Name of my bank:

My bank account number:

Bank | Branch | Account | Suffix

Initiator's authorisation code

0 6 0 4 9 0 2

Approved

490 | 04/20

From the acceptor to my bank:

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

I agree that this authority is subject to:

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

Please include the following information on my bank statement:

Authorised signature(s):

Date (DD/MM/YYYY)

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.

November 2023

Alteration request.

Policy number

Insured person(s).

Last name | First name | Date of birth (DD/MM/YYYY)

Email address | Phone number

Last name | First name | Date of birth (DD/MM/YYYY)

Email address | Phone number

Policy owner(s).

Last name | First name | Date of birth (DD/MM/YYYY)

Email address | Phone number

Last name | First name | Date of birth (DD/MM/YYYY)

Email address | Phone number

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

○ Increase/addition* ○ Decrease ○ Other

*Requests for increases in cover or new covers may be subject to underwriting criteria and if accepted may be issued on different terms

Cover	Change from	To

Alteration request.

With effect from (DD/MM/YYYY) | New total premium $

Payable ○ Monthly ○ Half yearly ○ Annual ○ Other

Paying by direct debit ○ Existing ○ New (attached)

Declaration.

I understand and agree that:

- this form, together with the application will be the basis of the contract for the altered insurance.
- any endorsement, and/or special terms and conditions on the current covers will also apply to any change in those covers unless advised otherwise by Fidelity Life.

Insured person (please print)	Insured person signature	Date (DD/MM/YYYY)

Policy owner (please print)	Policy owner signature	Date (DD/MM/YYYY)

Policy owner (please print)	Policy owner signature	Date (DD/MM/YYYY)

Policy owner (please print)	Policy owner signature	Date (DD/MM/YYYY)

Privacy.

This form collects personal information that will be used to update your policy. The way we collect, use, disclose and store your personal information is set out in our privacy statement, available at fidelitylife.co.nz.

Please return your completed form and any accompanying documents to:

@ admin.services@fidelitylife.co.nz ✉ Freepost 1893, PO Box 37275, Parnell, Auckland 1151.

If you have any queries please contact us on 0800 88 22 88.

November 2023

Certificate of Free temporary cover.

Free temporary cover starts.

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

Free temporary cover ends.

The Free temporary cover ends on the earliest of the following happening:

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

When there is no Free temporary cover.

There is no Free temporary cover if:

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

Trauma conditions covered.

Blindness, Coma, Deafness, Severe burns, Major head trauma, Paralysis and Total and permanent loss of use of two limbs, as defined in Fidelity Life's Trauma Cover wording.

The amount of Free temporary cover.

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

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

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

Exclusions.

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

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

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

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

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

November 2023

fidelity life

Why choose Fidelity Life?

Since 1973, we've helped people live with more certainty, knowing that tomorrow's taken care of. Important to us, is our ability to stay relevant to you throughout your life. We'll be here as you change and grow, to celebrate your successes and support you when life doesn't quite go to plan.

Est. in NZ 1973

Protecting your New Zealand way of life.

It's our promise to you. We love our place in the world and exist to look after New Zealanders like you.

91% of new claims accepted 1/7/22 – 30/6/23

Here when you need us.

Life doesn't always go to plan. Rest assured we want to pay your claim.

NZ based customer service

Like you, we're local.

Our friendly New Zealand based customer care team are here for you come rain or shine.

Over $1.5B paid out in claims since 1973

You're in safe hands.

Chances are we've helped a New Zealander near you. You can rely on us to be here for you when it matters most.

Rated A- (Excellent) for financial strength*

Our financial strength rating.

Issued by A.M. Best, our A- (Excellent) financial strength rating indicates our ability to pay claims.

Here for the good of NZ

Doing right by New Zealanders.

Every day we work to protect our environment, make a real difference to people, act responsibly and operate with transparency.

*Fidelity Life has an A- (Excellent) financial strength rating from A.M. Best. The rating scale that this rating forms part of is available for inspection at our offices. For more information please visit Fidelity Life's financial strength page.

Piha
Tāmaki Makaurau
Aotearoa New Zealand

0800 88 22 88
customerservice@fidelitylife.co.nz
fidelitylife.co.nz

November 2023