

Corporate Solutions Short Form Application



1 Plan Details

Employer Name

Policy Number (if known)

2 Life to be assured

Title

 Last name First name(s)

Previous name (if changed)

Mailing address

 Street Suburb Town/City Postcode

Home address (if different)

Contact details

Home phone
() ()

Business phone
() ()

Mobile
() ()

 Email

Date of birth (dd/mm/yyyy)

 / /

Male

Female

X

In the last 12 months, have you smoked tobacco or any other substance and/or used smoking alternatives (e.g. e-cigarettes, vaping, nicotine gum or patches)?

Yes

No

If Yes, please give details of each substance including date started (or stopped) and quantity per day:

Employee applicant

Yes

No

Occupation
(please include duties)

If YES to any of the following you are not eligible for cover using this application form. You may elect to apply for cover by completing a **Corporate Solutions Personal Statement**

a. At the date of signing this application:

1. Are you off work due to injury or illness?

YES

NO

2. Do you have any limitation or restriction due to injury or illness and are not working your normal hours on the day cover is to commence?

YES

NO

3. Through injury or illness, are you prevented from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours per week), even though your actual employment may be on a full-time, part-time or contract basis?

YES

NO

Spouse applicant

Yes

No

If Yes, please advise your spouse's (the Employees) name

3 Benefits being applied for

Note: Accelerated benefits cannot exceed the amount of Life cover selected

Sum Assured (cover amount)	Benefit Expiry age (years)	Details
Life \$ <input type="text"/>	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	n/a
Total Permanent Disablement Accelerated \$ <input type="text"/>	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	<input type="checkbox"/> Any occupation or <input type="checkbox"/> Own occupation
Income Protection \$ <input type="text"/> p.a.	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	<input type="checkbox"/> Own occupation or <input type="checkbox"/> 2 Step occupation Benefit Payment Period (years) <input type="text"/> Waiting period (weeks) <input type="text"/>
Critical Illness \$ <input type="text"/>	<input type="checkbox"/> 65 <input type="checkbox"/> 70 Other <input type="checkbox"/>	<input type="checkbox"/> Accelerated or <input type="checkbox"/> Standalone

4 Personal Statement

If YES to any of the following you are not eligible for cover using this application form. You may elect to apply for cover by completing a **Corporate Solutions Personal Statement**.

- Have you been diagnosed with a terminal condition that reduces your life expectancy to less than 12 months? YES NO
- As at the date of this application have you been off work for more than 10 consecutive working days in the last 2 years for the same medical condition? YES NO
- Has any insurance you currently have, or have applied for (e.g. Life, Income Protection), ever been declined, deferred or modified including any loadings or exclusions? YES NO
- Have you ever had any sign or symptoms of, or been tested or treated for, or diagnosed with any of the following?
 - Cancer YES NO
 - Heart Disease YES NO
 - Stroke YES NO
 - Chronic liver disease including hepatitis B and/or C YES NO
 - Diabetes YES NO
 - Chronic kidney disorders (e.g. glomerulonephritis) YES NO
 - Any disease of the central nervous system including multiple sclerosis? YES NO
- If applying for TPD cover do you have, or have you previously had, a mental illness or back or neck complaint requiring time off work in the last 5 years? YES NO

Please note:

- an exclusion for suicide and self-harm will apply for 13 months from the member's cover commencement date; and
- There is no interim accident cover available during the application period for this cover.

5 Declaration and consent

Please read your duty of disclosure and declaration carefully, then complete the disclosure check boxes and sign the bottom of page 3 to show your acceptance of these terms. Failure to make the following declaration truthfully may invalidate any insurance issued in relation to your Application.

Important Notice: Your duty of disclosure

When you apply for insurance with AIA New Zealand Limited ("AIA"), and whenever you apply to vary or reinstate it, you have a duty to disclose 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, AIA may avoid any insurance issued in relation to your Application from the beginning, which means any claim will not be paid.

I acknowledge that in issuing insurance related to this Personal Statement form, that AIA is relying on all disclosures made by the Policy Owner, or by or on behalf of me ("life to be assured") on any application relating to the related Corporate Solutions Plan ("Plan"), this includes any application for a policy or policies issued by ("related company or companies") Sovereign Assurance Company Limited ("Sovereign") or AIA International Limited, New Zealand Branch ("AIA Intl"), and that all such disclosures were true and correct to the best of my knowledge at the time they were made.

Please note, AIA may request a copy of your entire medical file from your General Practitioner and other medical providers.

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

Life assured:

I understand the importance of full disclosure of all information required in this Personal Statement form, and have read the "Disclosure" section below.

 Yes

I consent to AIA obtaining my medical records from my doctor and other medical providers and have read the "My personal information" section below.

 Yes

I authorize AIA to disclose all personal information relating to this Personal Statement form to the Plan's financial adviser, pursuant to clause (q) under the "My personal information" section below.

 Yes

The below named life assured declares and agrees as follows:

Disclosure:

- I have read the notice explaining my duty of disclosure and all the statements contained in this Personal Statement form are true and complete to the best of my knowledge.
- Should I undergo any alteration in mental or physical health or have a change of occupation between the date of this Personal Statement form and the issue of the insurance, I agree to notify AIA immediately as this information is relevant to any decision AIA may make about issuing the insurance.
- I understand that statements made in this Personal Statement form, 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, form the entire basis of the AIA insurance contract.
- I understand that irrespective of whether I have been insured with AIA before, that AIA will rely on the accuracy and completeness of my answers given in this Personal Statement form and I must not assume AIA has any prior knowledge of my history.

Underwriting

- I will be bound by the standard conditions applicable to the proposed insurance upon AIA's acceptance of my Application. I understand that my Application requires underwriting, and that special terms (including special conditions, premium loadings, exclusions or maximums) may be applied. I understand that any special terms will apply from the risk commencement date of my insurance.
- I understand that if additional information is required to process my Application, I may be telephoned by an Underwriter. The information that I provide to the Underwriter will form part of my Application.
- I understand that if I do not consent to AIA collecting personal information on this Personal Statement form and from the sources listed in clause (r) AIA may not be able to undertake a full underwriting assessment which may result in AIA declining to offer cover or offering cover on less favourable terms than I may otherwise be offered.

- I understand the insurance proposed in my Application shall not commence until my Application has been accepted by AIA.

My Personal Information

- I understand that any personal information that I provide in this Personal Statement form will be collected, used, stored and disclosed in accordance with AIA's privacy statement, available at www.aia.co.nz/privacy
- I acknowledge and consent that except in relation to "health information" (as that term is defined in the Health Information Privacy Code 2020) personal information provided in this Personal Statement form to AIA, or obtained by AIA from the sources listed in clause (r) may be used, held, stored and/or disclosed by AIA and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their Plan Advisers and reinsurers:
 - > to assess and process my Application and any other application for insurance I make to AIA;
 - > for the purposes of assessing any claim(s), including assessing if I have met my duty of disclosure under this Personal Statement form;
 - > to design new, or enhance existing, products and services provided by AIA, including research/direct marketing firms engaged by AIA or its related companies to seek my views on products or services offered by AIA or its related companies (whether or not I choose to proceed with my Application);
 - > to communicate with me, including to send me administrative communications about any policy I may have with AIA;
 - > to third parties for the purposes of such parties providing AIA with technology services;
 - > for statistical or actuarial research undertaken by AIA;
 - > unless I tell AIA otherwise or opt out, to tell me about other products and services that are offered by AIA, or by reputable organisations with whom AIA contracts; or to send me other information or promotional material that we

- think may be of interest to you;
- > to assist AIA to work with other reputable organisations with whom AIA contracts, whether in New Zealand or overseas, that offer products or services (including loyalty programmes) connected with any of the services that AIA provides. Such assistance may include undertaking data matching exercises both internally within AIA and with such organisations in order to identify products and services that I might be interested in;
 - > for internal business and administrative purposes;
 - > where disclosure is required by law; and
 - > as otherwise specified in this declaration.
- k. I acknowledge and consent that health information provided in this Personal Statement form to AIA, or obtained by AIA from the sources listed in clause (r) may be used, held, stored and/or disclosed by AIA and/or any related companies (whether incorporated in New Zealand or elsewhere), their subsidiaries, their officers, their Plan Advisers and reinsurers:
- > to assess and process my Application and any other application for insurance I make to AIA;
 - > for the purposes of assessing any claim(s), including assessing if I have met my duty of disclosure under this Personal Statement form;
 - > where disclosure is required by law; and
 - > in accordance with clauses (l), (m) and (n) below.
- l. All personal information (including health information) may be collected, held and/or stored by AIA and may be made available to AIA related companies, local and overseas (and in this regard I consent to the transfer of my information outside New Zealand) and to any agent, contractor or third party who provides technology, administrative or other services to AIA or any member of the AIA Group.
- m. I understand that AIA is a member of the Health Funds Association of New Zealand (HFANZ). I agree that AIA is authorised to collect, use, store and disclose personal information and health information about me for the purposes of the HFANZ Integrity Registry. I authorise disclosure of personal and health information to HFANZ or its agents, and HFANZ Members, for that purpose.
- n. I authorise AIA to obtain my full medical history where this Personal Statement form contains:
- > ongoing medical conditions
 - > partial or incomplete medical history
 - > multiple medical conditions
 - > a referral to a medical provider
- o. I understand that all of my personal information (including health information) will be stored by AIA at 74 Taharoto Road, Takapuna, Auckland, New Zealand, and may also be held by AIA's data storage providers, including cloud-based data storage providers (in New Zealand or elsewhere). I understand that AIA will take reasonable steps to keep such information secure.
- p. I understand that access to and correction of my personal information (including health information) may be requested by me.
- q. I authorise AIA to disclose all personal information (including health information) relating to my Application to the Plan's financial adviser for the purposes of providing me with advice

regarding the underwriting of my Application by AIA. This authority is limited to my Application and is only valid for the period of the assessment and until an outcome is reached. I acknowledge that the personal information which may be disclosed includes, but is not limited to, health information, vocational, occupational and financial information relevant to the assessment of my Application.

- r. I consent and give authority to AIA 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 AIA 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 my current or former employers;
 - > insurers or reinsurers (whether public or private); and
 - > any government department, agency, organisation or enterprise.
- s. I understand that the supply of the information gathered from the above sources is voluntary and that AIA 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.
- t. I understand that in collecting information that is relevant to my Application AIA may also receive/collect information that is not relevant to the assessment of my Application or the assessment and administration of my claim and AIA will not use this non-relevant information for any purpose other than as permitted under the Privacy Act.

Correspondence by Email:

- u. Where I have provided my email address in this Personal Statement, I consent to AIA corresponding with me by email for the purposes set out in clause (j) above.
- v. Such correspondence can be sent to the email address(es) detailed in this Personal Statement or subsequent email addresses I provide to AIA.
- w. I am responsible for the security of the information sent to and held in my email account and the access that others have to this account e.g. the access other family members/colleagues may have to my emails.

Insurance Policy:

- x. I have checked the information that the Plan's financial adviser has entered on this Personal Statement form.
- y. At the date of my Application, no statement affecting my Application has been made to any representative of AIA that has not been recorded in this Personal Statement form.
- z. I am aware that a copy of the Plan's Policy Document can be requested from the Policy Owner and the financial statements of AIA are available to me on request from AIA's Head Office.

Full names of Life to be Assured	
Signature of Life to be Assured	X
	Date (dd/mm/yyyy) / /

AIA New Zealand Limited

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