

Employee Insurance Personal Statement

1. Plan details

Plan name Plan number

Person to be insured

This Personal Statement is to be completed by the person to be insured. It helps us to decide the terms and conditions of your insurance.

It is your responsibility to ensure that you answer all the questions fully and truthfully and disclose any matter that could be relevant.

Please note the following:

- When completing this form, it is important that you provide all details relevant to the questions asked, even if you have already discussed these with your adviser.
- If any details you have provided in this Personal Statement are incomplete, or change prior to receiving your policy document, you must advise us in writing.
- If you do not understand any of the questions, please ask your adviser to explain them to you.

Full name Date of birth Gender
 Home address Home phone
 Postcode Work phone
 Email address

2. Your occupation

a. What is your occupation?
 Industry

b. Do you have a second occupation? Yes No
If 'yes', please give full details.
 Industry

c. Please list your duties for each occupation, the hours per week spent on each duty, and the percentage of manual work involved in each duty.

Duties	Hours per week	% Manual work

d. Are you sometimes required to perform any hazardous activities (e.g. work at heights or underground, or with dangerous chemicals or materials)? Yes No
If 'yes', please give full details.

3. Personal details

- a. Height cm
- b. Weight kg
- c. Please provide the name, address and phone number of your usual doctor, or the doctor holding your records (if different).

- d. Within the last 12 months have you used e-cigarettes/vaporisers (with or without nicotine), used or smoked any product containing tobacco, or used nicotine replacement therapy? Yes No
If 'yes', please provide details of what you use/used, daily quantity and date of cessation – if applicable.

- e. How many standard drinks of alcohol do you consume on average per week?
Standard drink = 1 nip spirits, 1 glass of wine, 1 glass of liqueur or port/sherry, 10oz/285ml of beer

- f. Have you ever used or injected yourself with any illegal or illicit drugs, or received any medical advice, counselling, or treatment relating to the use of alcohol, drugs or gambling? Yes No
If you answered 'yes' please complete the following table.

Name of Drug	Date first used	Frequency e.g. daily, weekly, monthly	Date last used

Alcohol, Drug or Gambling	Type of Treatment	Frequency of Treatment e.g. daily, weekly, monthly	Period of Treatment (From – To)	Provider (Name & Address)

4. Travel

- a. In the next 12 months, do you have definite plans to travel, work or reside overseas? Yes No
If 'yes', please provide details below.

Countries to be visited	Purpose of the trip	Length of visit	Frequency

- b. If Yes, will you adhere to the published advice of the New Zealand Government at the time of your travel? This includes not travelling to any locations the New Zealand Government advises against. Yes No
If 'no', please provide details below.

5. Pursuits

- a. Do you currently participate in, or plan to take part in, any organised **sport**? (for example, rugby, football, boxing, wrestling, professional sports, ocean racing, martial arts, etc)? Yes No
If 'yes', please provide details in the table below.

Sport	Frequency	Professional/amateur	Location

- b. Do you currently, or do you plan to participate in any **hazardous activity**, such as parachuting, hang gliding, motor sports, powerboat racing, diving, rock climbing, caving, mountaineering, bungee jumping, aviation other than as a fare-paying passenger (e.g. Air NZ)? Yes No
*If 'yes' please complete the Pursuits Questionnaire on **page 6** of this application form.*

6. Medical conditions

Please tick 'Yes' or 'No' if you have **ever** had any symptoms, investigations, treatment or received a diagnosis for any of the following:

- a. High blood pressure, high cholesterol, heart attack, heart murmur, angina, chest pain, cardiac investigations or any other heart or blood vessel disorder? Yes No
- b. **Asthma, bronchitis**, emphysema, tuberculosis, sleep apnoea, or **any other lung or respiratory disorder**? Yes No
- c. Stroke, epilepsy or seizures, recurrent headaches or migraines, dizzy spells, fainting attacks, paralysis, Multiple Sclerosis or any disorder of the nervous system? Yes No
- d. Recurrent indigestion, hernia, ulcer, passing of blood from bowel, vomiting of blood? Yes No
- e. Any disorder of the gall bladder, liver (including hepatitis), intestines, stomach or pancreas? Yes No
- f. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? Yes No
- g. Diabetes or abnormal blood sugar or thyroid disorder or any other glandular disorder? Yes No
- h. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? Yes No
- i. Prostate disorder, sexually transmitted infection, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? Yes No
- j. Cancer, tumour, cyst, lump, abnormal breast exam or cervical smear or growth of any kind? Yes No
- k. Psoriasis, eczema or any other disorder of the skin or any allergic or chemical sensitivity reaction? Yes No
- l. **Back pain, neck pain, strain or sciatica**? Yes No
- m. **Arthritis, gout, osteoporosis, fibromyalgia, tendonitis, tenosynovitis, Repetitive Strain Injury (RSI) or any other inflammatory disorder, regional pain syndrome or chronic fatigue**? Yes No
- n. **Any other injury or disorder of the spine, the neck or any other joints, muscles, ligaments, cartilage or limbs**? Yes No
- o. **Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental or nervous disorder**? Yes No
- p. Any other sickness, injury, physical impairment, procedure or syndrome not previously mentioned? Yes No
- q. Do you take any medication on a regular basis (other than contraceptive pills)? Yes No
- r. Have you ever had, been advised to have, or are you considering having a genetic test? Yes No
- s. Other than already stated, in the last 3 years have you consulted any other doctor or health professional (e.g. chiropractor, physiotherapist, osteopath, clinic) for any reason other than a common cold/flu? Yes No
- t. Are you considering or in the last 3 years have you been advised to consult a doctor or health professional, seeking medical examination, advice, treatment, tests or an operation? This includes appointments you have not yet attended or did not attend. Yes No
- u. Other than for a condition already stated, in the last 3 years have you been hospitalised? Yes No

If you answered YES to any conditions in bold, please complete the corresponding questionnaire/s on the pages, 7, 8, and 9.

If you answered YES to any conditions that are NOT in bold please provide details in the table below.

No.	Name of condition	Date diagnosed	Date last symptoms	Treatment/ Investigations	Degree of recovery in %	Time off work	Doctors details

7. HIV & AIDS

- a. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS), diagnosed with the Human Immunodeficiency Virus (HIV) or carrying antibodies to HIV? Yes No
- b. Have you sought or do you intend to seek medical consultation treatment or investigation for any AIDS or HIV related conditions? Yes No

8. Family history

Have any of your parents and/or siblings ever been diagnosed with any of the following conditions:

- a. Breast, ovarian, prostate, colon or any other cancer, familial adenomatous polyposis, diabetes, heart disease, stroke, haemochromatosis? Yes No
- b. Muscular dystrophy, Parkinson's, Alzheimer's or Dementia, Multiple Sclerosis (MS), Huntington's disease, Polycystic Kidney Disease, Motor Neurone Disease and/or any other hereditary disease or disorder? Yes No

If 'yes' to any of the above please provide details below.

Family member (relationship to you)	Condition/sickness (please specify cancer or heart disease & specify type of diabetes etc.)	Age at onset (approx.)

9. Insurance history

- a. Do you have with us or any other company, and/or are you currently applying for, any type of life, sickness, accident, trauma, lump sum disablement or disability insurance (including mortgage and redundancy cover)? Yes No
If 'yes', please provide details below.

Name of company	Type of insurance	Insured benefit	Date commenced
		\$	
		\$	

- b. Has any application for insurance been refused, deferred, or accepted with modified terms? (For example, with an increased premium or exclusion). *If 'yes', please provide details below.* Yes No

- c. Have you ever been paid a benefit, or are you expecting a benefit to be paid for an illness or injury? (e.g. insurance policy, ACC, social security (including unemployment benefits), sickness benefits, third party, etc) Yes No
If 'yes', please provide details below.

Date from	Date to	Type of payment	Condition or cause	Amount
				\$
				\$
				\$

Privacy Act acknowledgement, Personal Declaration and Medical Authorisation

I understand that:

- a. This personal statement will form part of the contract for an insurance policy;
- b. I am required to advise Asteron Life of any change regarding the circumstances of my health, occupation, income and pastimes up until my application has been accepted and I have received acceptance terms;
- c. I understand that if I fail to provide any information that is material to this application, or if any information provided by me is substantially incorrect and material, then Asteron Life may be unable to accept this application; and any policy issued may be cancelled from inception or any one or more of the benefits may be cancelled from inception or reduced; and premiums forfeited; and benefits paid may have to be refunded;
- d. In respect of income protection, permanent disablement, living and critical care insurance, I will only be insured for pre-existing conditions if I have told Asteron Life about them in writing and insurance for those pre-existing conditions has been accepted by Asteron Life in writing;
- e. Any benefit payable under this policy may be reduced subject to the terms and conditions of this contract;
- f. The answers provided in this personal statement are either in my own handwriting or have been checked and approved by me as being accurate.

I declare that:

- a. All the answers provided in this personal statement (including any Pursuits, Respiratory Disorder, Mental Health or Musculoskeletal Questionnaire) are complete and correct. In addition, I have advised Asteron Life of any and all additional information that may affect its decision to accept the risk and terms of insurance applied for, whether requested in this personal statement or not.
- b. I acknowledge that it is my responsibility to ensure I have provided all information that may affect Asteron Life's decision to accept the risk and the terms of insurance applied for, whether the information is specifically requested in the personal statement or not.

I authorise that:

My current, previous and any subsequent doctor and/or health professional to give full details of my personal medical history to Asteron Life for the purposes of assessing my eligibility for insurance, or for assessing any claim in relation to this insurance. A photocopy of this authorisation shall be read as the original.

Privacy statement

For the purpose of the Privacy Act, we confirm that we collect and use your personal information and may disclose your personal information to third parties for the purpose of administering your policy or in order to comply with legal requirements. Your details are stored securely within Asteron Life and may also be securely stored electronically on servers located in New Zealand or overseas, by third parties on our behalf. You can contact us at any time to request access to and correction of your personal information. The collection of this information is required under the terms of your policy.

For further information about how we deal with your personal information, please refer to Asteron Life's Privacy Policy. It is available online at www.asteronlife.co.nz by phoning 0800 737 101, or by writing to Asteron Life Limited, PO Box 894, Wellington 6140.

I have read and understood the Asteron Life Privacy Statement in its entirety.

Please tick this box

Declaration and authorisation

Signature of the person to be insured

Date

Respiratory disorder questionnaire

Please complete this section if you answered YES to respiratory disorders question on page 3.

1. What is the name of your condition?
2. Date condition first diagnosed?
How often do you experience symptoms?
e.g. wheezing, breathlessness, chest tightness
3. When did you last experience symptoms?
4. Are you woken during the night with symptoms? Yes No
If 'yes', how often and date of last occurrence?
Frequency
5. Have you ever been off work due to this condition? Yes No
If 'yes', please advise when and for how long.
6. What is your current treatment?
(include type of medication and dosage)
Medication
Dosage and frequency
7. Have you ever required use of oral steroids or a nebuliser? Yes No
If 'yes', please advise when and for how long.
8. Please advise how many inhalers you use in a year?
9. Have you ever been in hospital or received emergency treatment for this condition? Yes No
If 'yes', please advise when, for how long and where.
10. Do you ever measure your peak flow or FEV (Forced Expiratory Volume)? Yes No
If 'yes', please advise your highest and lowest readings in the past six months.
Lowest Highest
11. Have you ever consulted a specialist for this condition? Yes No
If 'yes', please advise name and address of doctor and date of last consultation.
Specialist's name
Address / Phone
Date of last consultation
12. Please advise details of your most recent visit to any other doctor for this condition.
Include date, name and address of doctor consulted.
Doctor's name
Address / Phone
Date of last consultation

Mental health questionnaire

Please complete this section if you answered YES to Mental Health disorder question on page 3.

1. Nature of condition and underlying cause?

2. Describe your symptoms

3. Date symptoms commenced

a. Are you still experiencing symptoms? Yes No

b. If 'no' when did you last experience symptoms?

4. Have you taken regular or occasional medication for this condition? Yes No

If 'yes', please provide details.

Medication

Dosage and frequency

5. Are you still taking this medication? Yes No

If 'no', please advise date you last used the medication.

6. Have you had any other treatment (e.g. counselling, hospitalisation, ECT)?

If 'yes', please advise type, dates, hospital and name and address of treating doctor.

Treatment

Doctor's name

Address

Phone Date

7. Have you ever been off work or your normal daily activities restricted in any way due to this condition? Yes No

If 'yes', please advise when and for how long.

8. Have you any ongoing effects or restriction in your activities of any kind? Yes No

If 'yes', please provide details.

9. Have you ever consulted a psychiatrist, psychologist, counsellor or any other therapist? Yes No

If 'yes', please advise dates, name and address of all persons consulted.

Doctor's name

Address

Phone Date

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

If 'yes', please provide details.

11. Does your usual doctor have details of this condition? Yes No

If 'no', please provide name and address of doctor who has full details.

Doctor's name

Address / Phone

Musculoskeletal questionnaire

Please complete this section if you answered YES to Musculoskeletal injury/disorder question on page 3.

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

- a. cervical spine (neck)
- b. knee joint L R
- c. lumbar spine (low back)
- d. hip joint L R
- e. thoracic spine (mid back)
- f. other (specify below)

2. When did you first suffer from any of the above problems?

Area	Date of first symptoms

3. Please state the cause

Area	Cause

4. Describe the symptoms/exact nature of the problems/diagnosis (if available).

Area	Symptoms

5. What was the severity of the pain?

Area	Mild	Moderate	Severe

6. Have you had any recurrences in any of these areas? Yes No

Area	Number of occurrences	Date of last symptoms

7. Are you free of all symptoms? (e.g. no pain or stiffness) Yes No

a. If 'yes', for how long?

b. If 'no', what is the current severity of pain?

Area	Mild	Moderate	Severe

8. How much time have you lost from work as a result of one or more of the above areas?

9. Please describe the treatment(s) received.

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

Area	Details

11. If treatment has ceased, please give date of last treatment.

Area	Date of last treatment

12. Please give the dates, names and address of doctors or other health providers or advisers consulted for these problems.