AMP Workplace Protection

Personal Statement

Workplace Protection Team

Phone: 0800 267 425
Email: workplace@amp.co.nz
Website: amp.co.nz
Post: PO Box 1692, Wellington 6140, New Zealand

To be completed by the life to be insured

Please read the notices relating to "Duty of Disclosure" and "Privacy Act 1993" before completing the following questions.

AMP Plan number:

Member number:

Personal Details

Title:
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

☐ Male ☐ Female

First name(s) (please print):

Surname:

Private address:

Contact phone number: ( )

Mobile number: ( )

Date of birth: D D M M Y Y Y Y

Email address:

Occupation:

In which industry do you work?

Employer name:

Residence and Travel Details

Are you a permanent resident of New Zealand or Australia? ☐ Yes ☐ No

If **no,** please confirm the date you arrived in New Zealand and provide details including the type of Visa you hold: D D M M Y Y Y Y

Including annual holidays, are you likely to live, travel or work overseas? ☐ Yes ☐ No

If **yes,** provide details including, where, purpose and for how long:

Your Cover Details

☐ Death only
Amount of cover: $

☐ Death and TPD
Amount of cover: $

☐ Income Continuance
Amount of cover: $

☐ Trauma
Amount of cover: $

Current Annual Salary: $

Your Pursuits

1. Do you engage in or intend to engage in any of the following:

a. Aviation (other than as a fare paying passenger on a scheduled commercial flight or charter service) ☐ Yes ☐ No

b. Motor racing (including car, bike and boat) ☐ Yes ☐ No

c. Mountaineering/rock climbing ☐ Yes ☐ No

d. Underwater diving ☐ Yes ☐ No

e. Any other hazardous activity, pursuits or sport not previously disclosed (including but not limited to parachuting/skydiving, paragliding, ocean racing, martial arts, horse riding or any other motor sports) ☐ Yes ☐ No

f. Do you wish to be covered for the sports and pastime activities you have disclosed in this Application? ☐ Yes ☐ No

NOTE: This is subject to approval by AMP Underwriting.

If you answered yes to any of the pursuits in bold above you will be required to complete the Sports and Pastimes section of the Health, Sports and Pastimes Questionnaire. This will be provided to you by Mercer Marsh Benefits on receipt of this personal statement.

If you answered **yes** to any of the pursuits **not in bold** provide details below. Please attach an extra page if you need more room to fill out details in the table below.

Activity or sport	Location	Other details (including remuneration received)	Number of events/hours per year	Amateur/professional

Your Health

2. What is your height? cm/feet/inches _____ **What is your weight?** kg/lbs _____

3. Do you smoke or have you ever been a smoker? ☐ Yes ☐ No

If **yes,** on average, how many do you or did you smoke daily? _____

If you have stopped smoking. When did you stop? D D M M Y Y Y Y

4. Do you or have you ever used recreational drugs or non prescription drugs? If yes, give details. ☐ Yes ☐ No

_____

5. How many standard drinks containing alcohol do you consume on average per week? _____ standard glasses per week (standard drink = 1 nip spirits, 100ml of wine, 10 oz/285ml beer)

6. At any time in your life have you ever suffered from, received advice for, or had any symptoms of the following: (even if you have not seen a doctor)

a. Heart complaint, rheumatic fever, high blood pressure, raised cholesterol or circulation disorder? ☐ Yes ☐ No

b. Disorder related to kidney, bladder, prostate, bowel, stomach or liver (including Hepatitis B&C)? ☐ Yes ☐ No

c. Disorder of the brain, nervous system, stroke or epilepsy? ☐ Yes ☐ No

d. Diabetes or thyroid disorder? ☐ Yes ☐ No

e. Asthma, lung condition, breathing or respiratory disorder or sleep apnoea? ☐ Yes ☐ No

f. Depression, anxiety, nervous condition, stress or post traumatic stress disorder, mental illness? ☐ Yes ☐ No

g. Chronic fatigue, fibromyalgia, fibrositis, myalgia, **chronic pain syndrome, OOS (Occupational Overuse Syndrome) /RSI (Repetitive Strain Injury)?** ☐ Yes ☐ No

h. Cancer, leukaemia, melanoma, tumour of any kind, or any blood disorder? ☐ Yes ☐ No

i. Back/neck disorder, arthritis, joint or muscle disorder? ☐ Yes ☐ No

j. Disorder of the eyes, ears or skin? ☐ Yes ☐ No

k. 1. Have you ever sought or been advised to, or are you intending to seek, a medical consultation, treatment or investigation in connection with AIDS or AIDS related conditions or to determine the presence of HIV? ☐ Yes ☐ No

2. Have you been infected by the virus which is believed to cause AIDS (the Human Immunodeficiency Virus HIV) or carrying the antibodies to HIV? ☐ Yes ☐ No

3. To the best of your knowledge, have you had any sexual partners who have AIDS or are HIV positive? ☐ Yes ☐ No

Your Health - continued

If you answered yes to any of the conditions in bold above, complete the relevant questions within the Health section of the Health, Sports and Pastimes Questionnaire. This will be provided to you by Mercer Marsh Benefits on receipt of this personal statement.

If you answered **yes** to any of the conditions **not in bold** provide details below.
Please attach an extra page if you need more room to fill out details in the table below.

Question number: ☐ **Date symtom(s) started:** D D M M Y Y Y Y **Date symtom(s) ceased:** D D M M Y Y Y Y

Details (including condition, treatment, results and length of time off work):

Name and address of doctor, hospital or health professional consulted:

Question number: ☐ **Date symtom(s) started:** D D M M Y Y Y Y **Date symtom(s) ceased:** D D M M Y Y Y Y

Details (including condition, treatment, results and length of time off work):

Name and address of doctor, hospital or health professional consulted:

7. Do you contemplate seeking any medical advice, investigation or treatment including surgery in the near future? ☐ Yes ☐ No

If **yes,** please provide details:

8. In the past 5 years have you:

a. had any blood or urine tests, counselling of any kind, review of a previously diagnosed condition or any diagnostic test of any nature e.g. genetic test, x-ray, medical test, mammogram, abnormal smear test? ☐ Yes ☐ No

b. had any other illness, injury, inherited disorder, operation or disability? (other than colds or influenza) ☐ Yes ☐ No

c. used or are you currently using any medication (taken by mouth, injections, inhaled spray, cream, ointment) for any symptoms, sickness, injury or medical condition? ☐ Yes ☐ No

If you answered yes to questions 9a, b or c, please provide name of doctor, date of consultation if known and condition.

a.

b.

c.

9. Have any of your parents, brothers or sisters suffered from: heart disease, stroke, high blood pressure, diabetes, breast cancer, bowel cancer, other cancer, polycystic kidney disease, Huntington's chorea, inherited blood disease, inherited brain disease, kidney failure, muscular dystrophy or any other inherited disease? ☐ Yes ☐ No

If **yes,** provide details in the table below

Family member Example: (mother/father, etc)	**Conditions/illness** (if cancer or heart disease, please specify condition and type)	**Age at onset** (approximate)	**Age at death** (approximate)

Your Health - continued

10. FEMALES ONLY - Are you currently pregnant? ☐ Yes ☐ No

If **yes,**

a. What is the expected date of birth?

D	D	M	M	Y	Y	Y	Y

b. Have there been any complications with this or a previous pregnancy? ☐ Yes ☐ No

If **yes,** please provide details:

Other Insurance

11. Has any company refused, deferred or applied loadings or exclusions to a proposal on your death or disability insurance? ☐ Yes ☐ No

12. Have you ever made or are you planning to make a claim, or are you currently receiving benefits, or are you entitled to receive benefits for any type of trauma, sickness, accident, unemployment, war service pension, workers compensation, e.g. ACC? ☐ Yes ☐ No

If **yes,** provide details

Doctor Information

Please provide details of your usual doctor/health clinic. If you do not have a usual doctor then the last doctor/health clinic you visited.

Name: | Phone Number: | Address:

Please read - Important information, declaration and agreement

Duty of Disclosure

Until there is insurance cover in place resulting from this Application, you have a continuing legal duty to disclose to the Insurer everything that is material to the risk to be insured under this Workplace contract. This means you must tell the Insurer everything that would influence the judgement of a prudent insurer in deciding the premiums or whether to accept this application, and if so, on what terms. You must advise the Insurer of any changes that occur up until cover commences.
Any incorrect or misleading information or omission by you may affect your cover and/or entitlement to benefits.

Privacy Act 1993 ("The Act")

Any personal information collected will be held by AMP and used to evaluate and process this application (including completion of any necessary medical tests) and to administer the policy issued by AMP and your cover under the policy and consider any claims (and may be provided to third parties for these purposes, where relevant).
The information may also be used by AMP or third parties to provide you with information about other products or serviced offered by AMP.
You have the right to ask for, see and, if incorrect, request correction of the information AMP holds about you, by contacting 0800 106 652.

References to "AMP" includes, where relevant, the AMP group of companies, their subsidaires (including The National Mutual Life Association of Australasia Limited), associated companies and agents including companies authorised by AMP to collect and/or store information on AMP's behalf.

Financial Strength Rating

The National Mutual Life Association of Australasia Limited is the insurer offering insurance under Workplace Protection and has an AA- financial strength rating given by Standard & Poor's Australia Pty Ltd, an approved rating agency. Financial Strength Ratings may change from time to time.
Contact AMP or your Financial Adviser to confirm AMP insurers current ratings or go to the rating agency website at www.standardandpoors.com.

A summary of the Standard & Poor's Financial Strength Rating Scale is as follows.

Secure Range				Vulnerable Range				
AAA Extremely strong financial security characteristics	**AA** Very strong financial security characteristics	**A** Strong financial security characteristics	**BBB** Good financial security characteristics	**BB** Marginal financial security characteristics	**B** Weak financial security characteristics	**CCC** Very weak financial security characteristics	**CC** Extremely weak financial security characteristics	**R** Regulatory action has been taken

The ratings from 'AA' to 'CCC' may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories.

Application and Declaration

PART A - APPLICATION TO THE NATIONAL MUTUAL LIFE ASSOCIATION OF AUSTRALASIA LIMITED

1. I request that AMP provides me with the insurance to which this Application relates on AMP's standard Workplace terms and conditions.

PART B - DECLARATIONS

1. I confirm the truth, accuracy and completeness of all statements given in support of this Application (whether in this Application form, given orally or in any other document in connection with this Application) which shall form the basis of any insurance cover resulting from this Application.
2. I have read and understand the section in this Application form headed 'Duty of Disclosure' and confirm that I have disclosed everything that is material to the risk to be insured.
3. I have read and understand the section in this Application form headed 'Privacy Act 1993'. I authorise AMP to disclose any personal information about me that it holds to any person where that disclosure is necessary for one or more of the purposes for which the personal information was collected.
4. I authorise any person (including any Medical Practitioner or other health care professional) to release to AMP any medical and other personal information about me now or in the future held by that person and requested by AMP in connection with this Application or any cover issued by AMP as a result of this Application or any claim, and I agree that a photocopy of this authority shall be sufficient evidence of my consent to such release.

I, PRINT FULL NAME OF LIFE TO BE INSURED

Date of birth D D M M Y Y Y Y

Signature of Life to be Insured

SIGN HERE

Dated D D M M Y Y Y Y

TOWN/CITY WHERE THIS WAS SIGNED