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Supplementary Child's application
MajorCare

Parents' details

(PLEASE USE BLOCK LETTERS)

Mr/Mrs/Miss/Ms

Last name | First names

Daytime phone ( ) | Email | Date of birth / /

Mr/Mrs/Miss/Ms

Last name | First names

Daytime phone ( ) | Email | Date of birth / /

Home address

Mailing address (if different)

Existing Sovereign policy numbers (if applicable)

Child to be assured

(Please complete a separate supplementary application for each Child to be Assured) (PLEASE USE BLOCK LETTERS)

Last name | First names

Date of birth / / | Place of birth | ☐ Male ☐ Female

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Answers to all questions should be given on the basis they relate to the Child to be Assured.

1 Personal statement

We understand that the medical questions that we ask in this section may be sensitive, but it is very important that you give us all the information that may affect your application for insurance. If you prefer, you can complete this form in private and post it directly to Sovereign Assurance Company Limited, Private Bag Sovereign, Auckland Mail Centre 1020.

(a) Do you have or are you currently applying for any other policies with Sovereign or any other company?

☐ Yes ☐ No If YES, please give details below

Company	Type of Insurance	Applied for	In Force	To be replaced *
Sovereign	MajorCare	☐	☐	☐
Other	Medical	☐	☐	☐

* If YES, complete the Advice on Replacement Business form on the associated Parents' application form.

(b) Has any insurance you have or applied for (e.g. life, income protection) ever been declined, deferred or modified?

☐ Yes ☐ No If YES, please give full details

(c) Have you ever claimed benefits (e.g. from ACC or an insurer) due to sickness or injury?

☐ Yes ☐ No If YES, please give name of condition below and complete the applicable questionnaire in section 6.

Name of Condition

(d) Do you have permanent residency status in New Zealand?

☐ Yes ☐ No If NO, please give full details

(e) What is your height and weight?

cms/feet/inches

kgs/stones/lbs

(f) Doctor's details

Please give the details of any medical professional or clinic you have consulted in the last 5 years. (Indicate the name of the medical professional or clinic holding your records with an *).

Name of medical professional or clinic	Years attended	Mailing Address

Personal statement (continued)

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(g) i) Has a parent, sister or brother suffered from diabetes, stroke, mental illness, dementia, kidney disease, heart disease, high blood pressure, cancer (specify type), before the age of 60?

And/or

ii) Is there a history of Huntingtons chorea, polycystic kidney, or any hereditary or family disease or disorder?

☐ Yes ☐ No If YES, please give details below

Details of condition suffered and current state of health	Relationship to you	Age when condition diagnosed (if known)	Current age	Age at death

☐ Yes ☐ No If YES, please give details below

Details of condition suffered and current state of health	Relationship to you	Age when condition diagnosed (if known)	Current age	Age at death

(h) Are you currently experiencing any health problems or are you receiving or considering seeking any advice, counselling, tests, treatment or operation from a health professional?

☐ Yes ☐ No If YES, please give details in the General Health Questionnaire in section 3 on page 5.

(i) Are you receiving, or have you ever consulted or received counselling or treatment from a health professional for any of the following?

If YES, please give details in the General Health Questionnaire in section 3 on page 5.

Any breathing problems including asthma, lung, chest, respiratory diseases or bronchitis	☐ Yes	☐ No
Liver disease or disorder e.g. hepatitis	☐ Yes	☐ No
Kidney disease, kidney stones or kidney infections	☐ Yes	☐ No
Any brain or neurological disease including epilepsy, motor neurone disease, multiple sclerosis, paralysis, stroke or seizures	☐ Yes	☐ No
Mental or nervous disorder e.g. anxiety, depression, stress, fatigue or phobia	☐ Yes	☐ No
Arthritis, rheumatism, OOS, or disorder, disease or injury to muscles, bones or joints, including hips, shoulders, back, neck, knees, wrists	☐ Yes	☐ No
Any disease or disorder of the gastro-intestinal tract or bowel, including chronic constipation, irritable bowel, crohns, haemorrhoids, ulcers, colitis or indigestion	☐ Yes	☐ No
Heart murmur or irregular heartbeat, chest pain, high blood pressure, heart disorder, rheumatic fever, high cholesterol	☐ Yes	☐ No
Diabetes, gout, thyroid disorder, or any other glandular condition	☐ Yes	☐ No
Bladder, urinary, prostate condition or endometriosis	☐ Yes	☐ No
Cancer, tumour, cyst, abnormal cervical smear, breast lump; moles, skin disorder or any other lesion	☐ Yes	☐ No
Varicose veins (even minor) or blood disorder	☐ Yes	☐ No
Disease or disorder of the eyes, ears, nose or throat including sinusitis or rhinitis, recurrent sore throats, tonsillitis or ear infections	☐ Yes	☐ No
Any disease of the teeth or gums including oral surgery	☐ Yes	☐ No
Any other illness, injury or condition not already stated	☐ Yes	☐ No

(j) Have you had any medical exam, tests or x-rays in the last five years?

☐ Yes ☐ No If YES, please give details in the General Health Questionnaire in section 3 on page 5.

(k) Have you had surgery or been hospitalised before?

☐ Yes ☐ No If YES, please give details in the General Health Questionnaire in section 3 on page 5.

(l) Have you received any counselling or treatment from a health professional or had any symptoms for any of the following?

If YES, please give details in the General Health Questionnaire in section 3 on page 5.

Any birth damage or defects?	☐ Yes	☐ No
Any recurrent infections of chest, skin or other?	☐ Yes	☐ No
Any lumps, bumps or tumours on skin or any other part of body?	☐ Yes	☐ No
Any ear nose or throat diseases or disorders in particular any recurrent ear infections requiring specialists treatment (grommets) or recurrent throat infections (including Tonsillitis)?	☐ Yes	☐ No
Any problems with the teeth or gums?	☐ Yes	☐ No

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2 Adult Dependant Section (To be completed by all adult dependants between 16 and 21 years old at time of application)

(a) Occupation (if currently working)

Industry

(b) Do you intend to live or work overseas?

☐ Yes ☐ No If YES, please give details below

Country | Start Date | Duration

(c) Do you smoke?

☐ Yes ☐ No If YES, please give details below

Cigarettes (quantity per day) | Cigars (quantity per day) | Tobacco (quantity per day) grams | Other (please specify)

(d) Have you ever smoked?

☐ Yes ☐ No If YES, have you smoked in the last year? ☐ Yes ☐ No

(e) Do you drink alcohol?

☐ Yes ☐ No If YES, please give details below

Beer (average units per week) (300ml = 1 unit) | Wine (average units per week) (100ml = 1 unit) | Spirits (average units per week) (30ml = 1 unit)

(f) Have you ever used any drug not prescribed by a Doctor, or received medical advice, counselling or treatment for the use of alcohol, drugs or gambling?

☐ Yes ☐ No If YES, please give full details

TO BE COMPLETED BY MALES ONLY

(g) Have you had any symptoms, received any counselling or treatment from a health professional for any of the following?

If YES, please give details in the General Health Questionnaire in section 3 on page 5.

Sexually transmitted diseases?	☐ Yes	☐ No
Problems passing urine?	☐ Yes	☐ No
Prostate problems?	☐ Yes	☐ No
Blood in urine?	☐ Yes	☐ No
Lumps or infections in the testicles?	☐ Yes	☐ No

TO BE COMPLETED BY FEMALES ONLY

(h) Have you had any symptoms, received any counselling or treatment from a health professional for any of the following?

If YES, please give details in the General Health Questionnaire in section 3 on page 5.

Any breast infections, cyst, lumps, tumours or cancer?	☐ Yes	☐ No
Any breast enlargement causing shoulder and/or backaches and pains?	☐ Yes	☐ No
Any pelvic infections, Pelvic Inflammatory Disease, vaginal discharges other than thrush (candida)?	☐ Yes	☐ No
Any sexually transmitted diseases including warts, herpes, and chlamydia?	☐ Yes	☐ No
Any heavy menstrual bleeding, irregular bleeding or clots?	☐ Yes	☐ No
Any treatment for painful menstruation other than aspirin or paracetamol?	☐ Yes	☐ No
Any ovarian or hormonal problems?	☐ Yes	☐ No
Any complications of pregnancy?	☐ Yes	☐ No
Any termination of pregnancy or miscarriages?	☐ Yes	☐ No
Any atypical or abnormal smears?	☐ Yes	☐ No
Been told that your womb or uterus is enlarged except when pregnant?	☐ Yes	☐ No
Any leakage of urine on coughing or sneezing or when your bladder is full?	☐ Yes	☐ No

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3 General Health Questionnaire

	Condition 1	Condition 2
(a) Name of Condition		
(b) Date of first symptoms	/ /	/ /
(c) Date of last symptoms	/ /	/ /
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(e) Have there been any subsequent problems, impairments or after effects of this condition?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(f) Are you currently receiving treatment or follow up or been advised that treatment or follow up is required?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(g) Have you ever had any recurrences of this condition?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g)		

	Condition 3	Condition 4
(a) Name of Condition		
(b) Date of first symptoms	/ /	/ /
(c) Date of last symptoms	/ /	/ /
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(e) Have there been any subsequent problems, impairments or after effects of this condition?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(f) Are you currently receiving treatment or follow up or been advised that treatment or follow up is required?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(g) Have you ever had any recurrences of this condition?	☐ Yes ☐ No If YES, please give full details below at (h)	☐ Yes ☐ No If YES, please give full details below at (h)
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g)		

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4 Declaration and consent

Your Duty of Disclosure – Important Notice

Before you enter into this contract of Insurance ("Insurance") you have a duty to disclose to Sovereign Assurance Company Limited ("Sovereign") every matter that is material to its decision whether to accept the risk of the Insurance and if so on what terms. You have the same duty to disclose those matters to Sovereign before you apply to vary or reinstate the Insurance. If you fail to comply with your duty of disclosure to us and we would not have issued the Insurance on the same terms if disclosure had been made we may cancel and avoid the Insurance from inception.

The below named Child to be Assured and Policy Owner(s) declare and agree that:

(a) The above answers have/have not been entered by me/us in this Application ("Application") but they have been checked by me/us and no statement affecting this Insurance has been made to any representative of Sovereign that is not recorded in this Application.

(b) I acknowledge that the Illustration attached to Section 4 of my parents' Application forms part of the Application and sets out the Insurance benefits I am applying for.

(c) I/We have read the notice explaining my/our duty of disclosure and all the statements contained in this Application are true and complete to the best of my/our knowledge.

(d) Should the Life to be Assured, undergo any alteration in mental or physical health or have a change of occupation between the date of this Application and the issue of the Insurance, I/we agree to notify Sovereign immediately as this information is relevant to any decision Sovereign may make to accept this Application.

(e) I/We understand that statements made in this Application including any statements made by me/us to any medical examiner or made by any medical examiner on my/our behalf forms the entire basis of the Insurance contract between me/us and Sovereign.

(f) I/We understand the Insurance proposed in this Application SHALL NOT COMMENCE until this Application has been accepted by Sovereign and the initial premium or a completed Direct Debit Authority or premium payment direction (such as a Credit Card) has been received by Sovereign.

(g) I/We authorise Sovereign to debit the nominated credit card account with the premiums payable pursuant to the Insurance premium. Sovereign may debit the credit card account with an Insurance premium even where there may be insufficient clear funds in the credit card account, but Sovereign shall not be obliged to do so. If there are insufficient funds but Sovereign debits the credit card account, Sovereign may also debit the credit card account with any applicable fees and charges. If the Insurance premium cannot be recovered from me/us, then Sovereign may reverse the Insurance premium payment resulting in the premiums being treated as not having been paid and Sovereign may be entitled to cancel the Insurance in accordance with the Insurance terms relating to non-payment of premiums.

(h) I/We will be bound by the standard conditions applicable to the proposed insurance upon Sovereign's acceptance of this Application.

(i) I/We have been advised that a Specimen Policy Document and the financial statements of Sovereign are available to me/us on request from Sovereign's Head office.

(j) I/We consent to the use of the personal information provided in this Application by Sovereign and/or any related companies, their subsidiaries, their officers, their advisers and reinsurers so that they can assess this Application for Insurance, for the processing of this Application and administration of the Insurance and any claims, and for promotion of insurance and investment services to me/us. I/We understand that the personal information collected will be held at Sovereign's Head Office, 33-45 Hurstmere Road, Takapuna. I/We understand access to and correction of my/our personal information may be requested by me/us.

(k) I/We acknowledge that I/we are signing on behalf of any children and declare that I/we have disclosed all health information, including any pre-existing conditions, for such children and ourselves.

(l) I/We have read Sovereign's Telephone Underwriting information sheet and understand if additional information is required to process my/our Application for insurance, I/We may be telephoned by a Telephone Underwriter. The information that I/We provide to the Telephone Underwriter will form part of my/our Application for insurance.

(m) I/We consent and give authority to Sovereign 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 Sovereign 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/us:

- Registered Medical Practitioners and specialists
- Dentists
- Employers (whether current or not)
- Insurers (whether public or private)
- Hospitals (whether public or private)
- Medical laboratories
- Accountants and other financial advisers
- Counsellors, psychologists and therapists
- Accident Compensation Corporation
- Government departments, agencies, organisations and enterprises
- Banks and other financial institutions

I/We agree that a photocopy of this authority will be valid as an original. I/we agree that this authority applies to those signatures listed below.

(n) I understand that neither ASB Bank Limited or its subsidiaries, the Commonwealth Bank of Australia, nor any other company in the Commonwealth Bank of Australia Group, nor any of their directors, nor any other person, guarantees Sovereign Assurance Company Limited or its subsidiaries, nor any of the products issued by Sovereign Assurance Company Limited or its subsidiaries.

Failure to make this declaration truthfully may invalidate your Insurance.

Please print full name of Child to be Assured

Signature of Child to be Assured
(If over the age of 16)

Date / /

Signature(s) of Policy Owner(s)
(Parent or legal guardian)

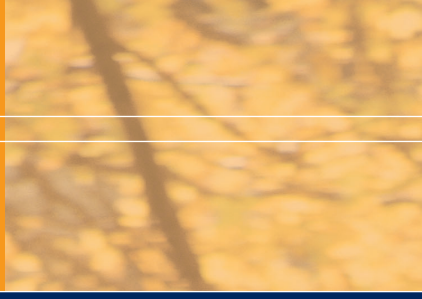
Date / /

Date / /

Date / /

Date / /

5 Additional information



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Your accredited Sovereign adviser

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