Click here to clear form

AMP

Client details/reference

Application and Personal Statement

The AMP group of companies operates in New Zealand through two life insurance companies, AMP Life Limited (Incorporated in New South Wales, Australia), ("AMP Life") offering Lifetrack and Businesstrack insurance and The National Mutual Life Association of Australasia Limited (Incorporated in Victoria, Australia) ("NMLA") offering Risk Protection Plan insurance.

Application for:

☐ Risk Protection Plan ☐ Lifetrack ☐ Businesstrack Business name:

Type of application

Please choose one of the following:

☐ **New policy**

☐ **Existing policy** *Please indicate below:*

☐ Increase ☐ Reinstatement ☐ Conversion/replacement business

☐ Addition ☐ Reassessment ☐ Alteration to cover

☐ Other (please specify):

Policy number

Linking a Risk Protection Plan policy

If you are applying for a Risk Protection Plan policy, is this to be linked to another Risk Protection Plan policy? ☐ Yes ☐ No

If 'Yes' to which policy number?

Full client name of linked policy

Date of birth D D M M Y Y Y Y

Once your application for insurance has been accepted, can we activate your policy before any linked policy is activated? ☐ Yes ☐ No

If this application is for Lifetrack or Businesstrack, and there is more than one proposed Person Insured, please provide details below of all Persons Insured to be included with this application. Please indicate the type of application to be completed (i.e. Application, Personal Statement, *easywrite* Application - more than one option can apply):

Full name(s) of other proposed Person Insured	Date of birth	Application	Personal Statement	*easywrite* Application
	D D M M Y Y Y Y	☐	☐	☐
	D D M M Y Y Y Y	☐	☐	☐
	D D M M Y Y Y Y	☐	☐	☐

Children's Trauma/Crisis Cover

Is Children's Trauma/Crisis Cover required? ☐ Yes ☐ No

If 'Yes', please select required cover option and provide details below. ☐ Inbuilt Risk Protection Plan Child's Trauma ☐ Optional Risk Protection Plan Children's Trauma Insurance ☐ Inbuilt Lifetrack Child's Trauma Cover ☐ Optional Lifetrack Children's Crisis Cover

Child Insured full name	Gender	Date of birth
	☐ Male ☐ Female	D D M M Y Y Y Y
	☐ Male ☐ Female	D D M M Y Y Y Y
	☐ Male ☐ Female	D D M M Y Y Y Y

Lifetrack Children's Crisis Cover - if the Child is under the age of 10, please complete questions on page 16. If the Child is over the age of 10 or you are applying for the Optional Risk Protection Plan Children's Trauma Insurance, please complete questions on page 17.

Life / Person Insured

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Last name

Given names

Preferred name

Date of birth D D M M Y Y Y Y

Gender ☐ Male ☐ Female

Which country were you born in?

Mailing address

Street address

Suburb

Town/City

Postcode

Country

Contact details

Home ( )

Work ( )

Mobile ( )

Email address

☐ Yes, I consent to receiving electronic messages regarding any products, services or promotions offered, managed or distributed by the AMP group of companies and agree that sending any such message need not include a functional unsubscribe facility in the message.

Policy Owner 1 - *Correspondence will be sent to the address of only Policy Owner 1.*

☐ **If the Life /Person Insured is Policy Owner 1, please tick here.**

If you are Policy Owner 1, please go directly to the Personal Statement section on page 4.

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Last name

Given names

Preferred name

Date of birth D D M M Y Y Y Y

Gender ☐ Male ☐ Female

Will this policy be owned by a business? ☐ Yes ☐ No

If 'Yes', please complete the details below:

Contact name

Business/Trading name

Policy Owner 1 – address details

Street address

Suburb | Town/City | Postcode

Mailing address (If different from above)

Street address

Suburb | Town/City | Postcode

Contact details

Home ( ) | Work ( ) | Mobile ( )

Email address

☐ Yes, I consent to receiving electronic messages regarding any products, services or promotions offered, managed or distributed by the AMP group of companies and agree that sending any such message need not include a functional unsubscribe facility in the message.

Policy Owner 2

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Last name | Given names

Preferred name | Date of birth (D D M M Y Y Y Y) | Gender ☐ Male ☐ Female

Policy Owner 3

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Last name | Given names

Preferred name | Date of birth (D D M M Y Y Y Y) | Gender ☐ Male ☐ Female

Personal Statement

Duty of Disclosure:

Until there is a contract of insurance resulting from this application, you have a continuing legal duty to tell us everything you know (or ought to know) material to the risk to be insured. You must tell us 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. For example, you must tell us about any present or past health condition as well as any symptom that might indicate a health condition. This duty applies from the time you complete this application until cover commences, which is when we accept your application, issue a policy to you and we have received payment of the first premium. You must advise AMP of any changes that occur up until cover commences. If you fail to do so, AMP may at its discretion decline a claim, avoid or void the policy from inception, decline to pay any benefits, or take other action as specified in the policy. When in doubt, please disclose.

Life / Person Insured details

Life/Person Insured last name

Life/Person Insured given names

What is your current occupation?

What is your current annual income?

$

Please give a brief description of your occupation duties:

Are you happy to be contacted by an AMP Underwriter or a nurse? ☐ Yes ☐ No

Best time during business hours to be contacted: AM

A. Residency and Travel section

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

Please provide details including type of visa you hold:

2. In the next 12 months, do you have any definite plans to travel or reside overseas, other than Australia? ☐ Yes ☐ No

If 'Yes', which countries will you travel to?

What is the purpose of travel?

When is the planned departure and duration?

Departure date D D M M Y Y Y Y

B. Details of other insurance

1. Do you already have Life, Lump Sum Disablement, Trauma, Income Insurance, Business Insurance or Group Salary Continuance Cover with AMP or any other company, or are you currently applying for Insurance with AMP or any other company? ☐ Yes ☐ No

If 'Yes', please provide details below (exclude this application):

Company	Type of insurance	Benefit amount	Reason for Cover	Applied for	Inforce	To be replaced*
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

2. Have you ever had an application on your life declined, deferred or approved with special conditions applied? ☐ Yes ☐ No

If 'Yes', please provide details below:

***If you are replacing a policy, please fill out the 'Advice on Replacement Business' form on page 29.**

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

C. Your health section

1. Have you smoked in the last 12 months (such as cigarettes, cigars, marijuana) or used nicotine replacements? ☐ Yes ☐ No

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

2. Do you drink alcohol? ☐ Yes ☐ No

If 'Yes', over the past 12 months, how many alcoholic drinks would you typically have? Per day _____ Or per week? _____

A "standard" drink means any of: 1 nip of spirits, 1 glass of wine, 1 sherry glass of port or sherry, a 1/2 pint of beer (300ml).

3. Have you ever received advice, counselling or treatment in relation to alcohol consumption? ☐ Yes ☐ No

If 'Yes', please provide details: _____

4. Do you use or have you ever used recreational drugs or any drugs not prescribed to you (other than for coughs, colds, flu or similar minor ailments)? ☐ Yes ☐ No

If 'Yes', please provide details: _____

5. What is your height? _____ metres **Or** _____ feet _____ inches

6. What is your weight? _____ kilograms **Or** _____ stone _____ pounds

7. Has your weight changed in the last 12 months? ☐ Yes ☐ No

If 'Yes', please provide details: _____

D. Family history

1. Has your mother, father, any brother or sister suffered from diabetes, cancer, hypertrophic cardiomyopathy, high blood pressure, heart disease, stroke, mental disorder or depression, haemophilia, Huntington's disease, polycystic kidney, multiple sclerosis, Alzheimers or any disease which may be inheritable? ☐ Yes ☐ No

If 'Yes', please fill out this table:

Family member	Condition/illness	Age at onset	Age at death
Example: Mother *(e.g. Mother, Father, etc.)*	Condition: Cancer Type: Lung *(if cancer or heart disease, please specify condition AND type)*	53 *(approximate)*	— *(approximate)*

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

E. Health details

1. Have you ever suffered from, had any symptoms or received advice for OR are you considering seeking advice including tests, treatments, or investigations for any of the following (even if you have not seen a doctor)?

If you have had any of the following conditions, please complete the General health table on page 8.
If you selected any conditions/disorders in **bold**, please complete the relevant health questionnaire.

a. Heart, blood vessel or other blood circulation disorder

☐ Chest pain ☐ Heart attack ☐ Aneurysm ☐ Palpitations ☐ Angina
☐ High blood pressure ☐ Rheumatic fever ☐ Raised cholesterol ☐ Heart murmur ☐ Other ☐ No

b. Blood disorders

☐ Anaemia ☐ Haemochromatosis ☐ Haemophilia ☐ Other ☐ No

c. Kidney, bladder or other urinary or reproductive system disorder

☐ Renal colic ☐ Prostate disorder ☐ Blood in urine ☐ Sexually transmitted illness
☐ Endometriosis ☐ Kidney stone ☐ Infection ☐ Other ☐ No

d. Liver, gall bladder, stomach, bowel or other digestive/gastrointestinal disorder

☐ Hiatus hernia ☐ Irritable bowel syndrome ☐ Crohn's disease ☐ Diverticulosis ☐ Reflux
☐ Hepatitis ☐ Ulcer ☐ Ulcerative colitis ☐ Other ☐ No

e. Brain, neurological or other nerve pathway disorder

☐ Epilepsy ☐ Seizures ☐ Multiple Sclerosis ☐ Blackout ☐ Stroke
☐ Recurrent headaches ☐ Dizzy spells ☐ Paralysis ☐ Fainting attacks ☐ Other ☐ No

f. Psychiatric or psychological disorder (including stress)

☐ **Depression** ☐ **Schizophrenia** ☐ **Anxiety** ☐ **Stress -** *worrying enough for you to talk to a doctor/ counsellor or other medical professional*
☐ **Suicide attempt** ☐ **Breakdown** ☐ **Panic attack** ☐ **Post Traumatic Stress Disorder (PTSD)** ☐ Other ☐ No

g. Cancer, tumour (malignant or benign), cyst, growth of any kind or breast lump even if you have not seen a doctor

☐ Lymphoma ☐ Abnormal pap smear ☐ Prostate cancer ☐ Enlarged gland ☐ Other lesion removed
☐ Bowel polyp ☐ Lump ☐ Breast cancer ☐ Mole removed ☐ Leukaemia
☐ Other ☐ No

h. Ear, nose, eye, speech or skin disorder

☐ Hearing disorder ☐ Psoriasis ☐ Tinnitus ☐ Eye or vision disorder *(excluding prescription glasses)*
☐ Allergic or chemical sensitivity reaction ☐ Eczema ☐ Dermatitis ☐ Other ☐ No

i. Lung or other breathing/respiratory disorder

☐ **Asthma** ☐ Emphysema ☐ Bronchitis ☐ Tuberculosis ☐ Sleep Apnoea
☐ Pleurisy ☐ Other ☐ No

j. Bone, joint, muscle, ligament, cartilage, limb or other musculoskeletal disorder, pain, strain or injury

☐ **Spine** ☐ **Neck** ☐ **Back muscles** ☐ **Sciatica** ☐ RSI/OOS *or any regional pain syndrome*
☐ Tendonitis ☐ Osteoporosis ☐ Arthritis ☐ **Any joint** ☐ Other ☐ No

k. Other condition

☐ Rheumatoid arthritis ☐ Thyroid disorder ☐ Fibromyalgia ☐ Gout ☐ Insulin resistance
☐ Abnormal blood sugar ☐ **Diabetes** ☐ Chronic fatigue ☐ Other ☐ No

2. <u>Other than</u> any condition or disorder indicated above or cold/flu or contraceptive medication, have you in the last five years taken regular medication, or had any medical procedure, consultation, investigation or test (including blood test)? ☐ Yes ☐ No

If 'Yes' to question (2), please provide details in the General health table on page 8.

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

F. AIDS Section

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

G. FEMALES ONLY - Pregnancy

1 . 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:

H. Doctor information

1. Name and address of your usual doctor/health clinic. If you do not have a usual doctor, then the last doctor/health clinic that you visited.

Name	Address	Phone number

2. If you have known your doctor for less than 2 years, please provide details of the previous doctor.

Name	Address	Phone number

3. Date of last consultation with any doctor: D D M M Y Y Y Y

4. Name of doctor/health clinic you visited (if same as above write 'as above'):

5. a) What the consultation was for:

b) What was the outcome/result of the consultation?

6. Were you referred for further tests, investigations or referred to a specialist? ☐ Yes ☐ No

If 'Yes', please provide details:

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

General health table

For any conditions or disorders you selected in the Health details section on page 6, please provide further details in the table below.

Example:

Question number: (12) **Date symptom(s) started:** 0 5 1 9 9 9 **Date symptom(s) ceased:** 1 2 1 9 9 9	
Details (include condition, treatment, results and length of time off work): Kidney stone. Lower abdominal pain, saw doctor,	
was prescribed painkillers, passed stone 4 days later. Two days off work. No reoccurrence since.	
Name and address of doctor, hospital or health professional consulted: Dr. A B Smith	
Denton Medical Centre, 104 High Street, Ashburton	

Question number: **Date symptom(s) started:** D D M M Y Y Y Y **Date symptom(s) ceased:** D D M M Y Y Y Y	
Details (include condition, treatment, results and length of time off work):	
Name and address of doctor, hospital or health professional consulted:	

Question number: **Date symptom(s) started:** D D M M Y Y Y Y **Date symptom(s) ceased:** D D M M Y Y Y Y	
Details (include condition, treatment, results and length of time off work):	
Name and address of doctor, hospital or health professional consulted:	

Question number: **Date symptom(s) started:** D D M M Y Y Y Y **Date symptom(s) ceased:** D D M M Y Y Y Y	
Details (include condition, treatment, results and length of time off work):	
Name and address of doctor, hospital or health professional consulted:	

Question number: **Date symptom(s) started:** D D M M Y Y Y Y **Date symptom(s) ceased:** D D M M Y Y Y Y	
Details (include condition, treatment, results and length of time off work):	
Name and address of doctor, hospital or health professional consulted:	

If more space is required, please use 'Additional notes' section on page 34.

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

I. Health questionnaires

For any conditions or disorders you selected in **bold** in the Health details on page 6, please complete the relevant health questionnaire.

Depression/Anxiety/Nervous condition

1. **What is the name of the condition(s)/disorder(s) (psychiatric or psychological disorders - including stress)?**

2. **When did you first have symptoms?** D D M M Y Y Y Y

3. **When did you last have symptoms?** D D M M Y Y Y Y

4. **Describe your symptoms fully:**

5. **What was the cause of your condition/disorder?**

6. **How long did you suffer from the condition/disorder?**

7. **Provide details and nature of treatment for this condition/disorder (e.g. were you treated with tranquillisers or other drugs, did you undergo counselling, therapy)?**

8. **Have you had any recurrence?** ☐ Yes ☐ No
   If 'Yes', provide full details:

9. **How long, if at all, have you been free of any signs or symptoms relating to the condition(s)/disorder(s)?**

10. **When did treatment cease?** D D M M Y Y Y Y
    If on going treatment - provide details (e.g. dosage and type of medication, counselling).

11. **Provide names and addresses of all doctors and health professionals consulted for these conditions/disorders including approximate dates of consultations.**

12. **Name of doctor or health professional last consulted for this condition/disorder and the date of the last consultation.** D D M M Y Y Y Y

13. **Have you lost any time from your employment due to this condition/disorder?** ☐ Yes ☐ No
    If 'Yes', provide details:

14. **Are you currently fit and well and able to do your work without stress or discomfort?** ☐ Yes ☐ No
    If 'No', provide details.

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

Health questionnaires continued

Asthma

15. When was your asthma diagnosed? D D M M Y Y Y Y

16. When did you first have symptoms? D D M M Y Y Y Y

17. When did you last have symptoms? D D M M Y Y Y Y

18. Approximately how many times per year do you get symptoms?

19. Do the attacks occur in a particular season or during exercise? ☐ Yes ☐ No
If 'Yes', provide details:

20. How much time have you lost from work (or education) in the past due to asthma?

21. Provide details of the treatment for your asthma, including dosage of drugs taken and frequency?
(i.e. aerosol spray, tablets or injections, amounts and number of times per day).

22. Provide details of the doctor who you consult for your asthma?

23. When did you last consult this doctor for asthma? D D M M Y Y Y Y

24. Have you ever been treated for your asthma with steroids (e.g. Prednisone)? ☐ Yes ☐ No
If 'Yes', provide details:

25. Have you ever been hospitalised for asthma? ☐ Yes ☐ No
If 'Yes', provide details including dates:

26. In the last 5 years, have you had a chest X-Ray or respiratory function test? ☐ Yes ☐ No
If 'Yes', provide details including dates:

Diabetes

27. Please tick the appropriate box: ☐ Diabetes – go to (28) ☐ Abnormal Blood Sugar level – go to (29)

28. Please confirm type of diabetes: ☐ Type 1 - Insulin Dependent ☐ Type 2 - Diet controlled and/or oral medication

29. When was your condition first diagnosed? D D M M Y Y Y Y

30. Please advise the date and result of your last blood test readings for the following:

HbA1c D D M M Y Y Y Y

Blood Glucose level D D M M Y Y Y Y

31. As a result of your condition have you ever had any of the following?

☐ High blood pressure ☐ High cholesterol ☐ Eye problems ☐ Kidney problems ☐ Heart problems
☐ Numbness or tingling in your hands or feet ☐ Diabetic or insulin coma

If 'Yes', please provide dates and further details:

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

Health questionnaires continued

Please complete. if you ticked 'Spine', 'Neck', 'Back muscles' or 'Sciatica' in the Health details section on page 6.

If you are applying for **Life Cover only**, just complete details in the General health table on page 8.

Back/Spinal Disorder

32. When did you first suffer from back/neck trouble? D D M M Y Y Y Y

33. What was the cause?

34. What was the exact nature of the back/neck trouble?

35. Please fully describe symptoms, severity and area of back/neck involved:

36. Please provide names and addresses of doctors consulted and dates:

37. What was the nature of the treatment?

38. Are you still undergoing treatment? ☐ Yes ☐ No
If 'No', when did the treatment stop? D D M M Y Y Y Y

39. Have you had any recurrence of back/neck trouble? ☐ Yes ☐ No
If 'Yes', please complete the following table:

Episode(s)	Date(s)	Severity
Back trouble	October 2012 – December 2012	Unable to walk

40. How long have you been completely free from back/neck symptoms?

41. How much time have you lost from education or work through your back/neck trouble?

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

Health questionnaires continued

Joint Disorder

Please complete if you ticked 'Any joint' in the Health details section on page 6.
If you are applying for **Life Cover only**, just complete details in the General health table on page 8.

42. State specific conditions/symptoms and diagnosis made?

43. When did you first suffer from this disorder? D D M M Y Y Y Y

44. When did you last suffer from this disorder? D D M M Y Y Y Y

45. State which joints (e.g. knee, ankle, elbow, wrist or shoulder) were affected and if it was the left, right or both.

46. Describe the symptoms fully.

47. What was the cause or nature of the disorder?

48. Have you had any treatment/surgery? ☐ Yes ☐ No
If 'Yes' what was the nature of the treatment? If surgery, provide details (e.g. plates or screws inserted/removed, arthroscopy, etc)

49. Have you had any recurrence of this disorder? ☐ Yes ☐ No
If 'Yes', please complete the following table:

Episode(s)	Date(s)	Severity
Back trouble	October 2012 – December 2012	Unable to walk

50. Provide the names and addresses of all doctors and health professionals consulted in relation to your joint disorder or pain and the approximate dates of consultation.

51. How long, if at all, have you been free of symptoms?

52. How much time have you lost from education or work due to this disorder?

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

J. Lifestyle and Sports section

1. In the last 5 years have you taken part, or do you have definite plans to take part, in any of the following activities or sport? ☐ Yes ☐ No

If 'Yes', then please indicate the activity from the following examples:

☐ Aviation ☐ Parachuting ☐ Hang-gliding ☐ Rugby/Football* (any code) ☐ Motor sport (including car, bike and boat)

☐ Underwater diving ☐ Mountaineering ☐ Caving ☐ Rock climbing ☐ Martial arts

☐ Equestrian activity

☐ Other (please specify):

If you have ticked any of the above activities or sports, please complete details below.

*If you play Rugby/Football (any code) you only need to complete the section below if you are applying for all regular payment disability benefits (including Income, Business Expenses, Business Protection and Rural Income Protection).

	Activity 1	**Activity 2**
a. Name of activity.		
b. How long have you participated in this activity?		
c. Are you a certified instructor?	☐ Yes ☐ No	☐ Yes ☐ No
d. In the last 12 months how many events, trips, climbs, jumps did you participate in?		
e. Please advise the number of hours you engaged in this activity in the last 12 months:		
f. Where do you participate in this activity geographically?		
g. If your activity is diving do you ever dive alone, or in caves, wrecks, pot holes or at night?		
h. Do you have any plans to become a professional in this pursuit?	☐ Yes ☐ No	☐ Yes ☐ No
i. Please disclose maximum heights, speeds, depths:		
j. Please give full details including the engine size, for boats or other vehicles/equipment used:		
k. Are you involved in any record attempts?	☐ Yes ☐ No	☐ Yes ☐ No

Note: If you need to list more than 2 activities, please use 'Additional notes' section on page 34.

Duty of Disclosure warning:

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K. Occupation section

Please complete this section for all disability benefits (including Income, Business Expenses, Business Protection, Total and Permanent Disablement and Rural Income Protection).

1. Please indicate how you are employed:

Employee

☐ Salary/Wage earner in a business in which you have less than 15% ownership (inclusive of all family interests)

Self employed

☐ a. Partner in partnership (e.g. law firm, accountancy firm)

☐ b. Commission only salesperson

☐ c. Independent Contractor

☐ d. Business in which you have greater than 15% ownership i.e. Sharemilker (inclusive of all family interests)

2. Please complete details of your occupation(s) over the last five years (including periods of unemployment)

From	To	Occupation	Self-employed (S) or Employee (E)		Name of Employer or Business	Country
	Present		☐ S	☐ E		
			☐ S	☐ E		
			☐ S	☐ E		

If you require more space for comments, please use 'Additional notes' page at the back of this form.

3. (a) How many hours do you work per week in your main/principal occupation? _____ hours

(b) How many weeks do you work per year (excluding holidays) in your main/principal occupation? _____ weeks

4. What are the main duties of your occupation?

Duties *(e.g. office work, sales, supervision, manual work, explosives handling etc)*	% of time	Location *(e.g. on-site, at home, driving, underground, offshore, underwater, at heights etc)*	% of time

5. Do you have any specific qualifications (e.g. Degree, trade certificate, etc) relating to your occupation? ☐ Yes ☐ No

If 'Yes', please give details:

6. Do you work from home? ☐ Yes ☐ No

If 'Yes', please provide details of actual work you perform at home, your work set up (e.g. separate office) and frequency and type of contact with clients.

7. Do you have definite plans to change your occupation, including change in hours, duties, employment status or take extended leave or sell your business? If 'Yes', please provide details: ☐ Yes ☐ No

8. Do you have a second occupation? (e.g. hobby farm, bar work). If 'Yes', please provide full details: ☐ Yes ☐ No

Nature of work

Duties performed

Number of hours worked per week in your second occupation

Annual income

9. Have you ever claimed on any type of trauma, disability or income cover insurance, or lump sum or income benefits from ACC (excluding doctors fees, perscriptions, etc)? ☐ Yes ☐ No

If 'Yes', please provide details:

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

L. Income section

Solvency

1. **Have you ever been made bankrupt or become insolvent (including receivership or liquidation) or been convicted of fraud or any offence including dishonesty or had any business made bankrupt, been liquidated or in receivership, or been placed under administration?** If 'Yes' please provide details: ☐ Yes ☐ No

Please complete this section if this application is for regular payment disability benefits (including Income, Business Expenses, Business Protection, Total and Permanent Disablement). **Please ensure the income figures you provide below accurately reflect your financial position for the periods indicated.**

Insurable income ($)	Last financial year ending D D M M Y Y Y Y	2 financial years ago ending D D M M Y Y Y Y	3 financial years ago ending D D M M Y Y Y Y
Salary/wages			
Fringe benefits			
Commission			
Bonuses			
Share of profit			
Other			
Total: Gross income from personal exertion	$ 0.00	$ 0.00	$ 0.00
Less: Business expenses			
Equals: Net income before tax	$ 0.00	$ 0.00	$ 0.00

(Financial evidence may be required to substantiate this income both at the time of underwriting and when making a claim).

2. **Do you receive any income (which is more than 20% of your annual earnings) which will continue if you are unable to work?** ☐ Yes ☐ No
   (Including all forms of income including investment, interest, profit share, rents etc or income from a business which will keep operating).
   If 'Yes', how much? $

3. **Do you have more than 3 months accumulated sick leave?** ☐ Yes ☐ No
   If 'Yes', how much?

M. Self employed income section

1. **What is the structure of your business?** ☐ Sole trader ☐ Partnership ☐ Company ☐ Trust
   Business name and address:

2. **(a) Number of income producing employees:** Full-time | Part-time
   (b) Number of non-income producing employees: Full-time | Part-time
   (c) Number of Directors and/or Shareholders: Directors | Shareholders
   (d) How long have you been self-employed? Years | Months
   (e) What share of the business do you own? %

3. **Is your income split for tax purposes with your spouse?** ☐ Yes ☐ No
   If 'Yes', please provide details below:

Amount:		**Percentage:**	%	**To whom paid:**	
Number of hours per week your spouse works in the business:					
Nature of work performed:					

4. **Do you have a trust or other identity that affects your taxable income?** ☐ Yes ☐ No
   If 'Yes', please provide details of the trust or entity and the effect on your taxable income:

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

N. Business expense details (For Lifetrack/Businesstrack Business Cover and RPP Business Expenses Protection only)

1. **What is your percentage share of the total business expenses?** %

2. **Please list below your share of the annual business expenses, in dollar values, which will continue while you are disabled.**
(include in 'other' any normal, necessary and regular expenses).

Salaries of non-income producing employees		$
Costs directly relating to salaries:		
Superannuation		$
ACC levies		$
Fringe benefit tax		$
Other (please specify):		$
Business premises:		
Rent or interest on business mortgage		$
Property rates or taxes		$
Other (please specify):		$
Financial:		
Leasing or hire purchase of equipment and motor vehicles		$
Interest on loans to finance this business		$
Accountant's and auditor's fees		$
Other (please specify):		$
General operation:		
Telephone and communications	$	
Electricity/gas/water		$
Cleaning and laundry	$	
Subscriptions to associations		$
Fire and general insurance premiums	$	
Other (please specify):		$
Total eligible expenses		$ 0.00
Average monthly eligible expenses		$ 0.00

O. Children's Crisis Cover: Lifetrack only Under Age 10 Personal Statement - *All other Children's applications, please complete questions on next page*

1. **Child's full name:**

What is the state of the Child's health?

Name and address of usual doctor/ health clinic:

2. **Has the Child had any abnormality from birth, or ever had an illness or injury?** ☐ Yes ☐ No
(Other than for minor matters such as a common cold or a broken arm or leg.) If 'Yes', please complete the details below.

Date symptom(s) started: D D M M Y Y Y Y Date of last symptom(s): D D M M Y Y Y Y

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

Details (include condition, treatment and results):

3. **Has any parent, brother or sister suffered from diabetes, heart disease, stroke, mental disorder or any hereditary disease?** ☐ Yes ☐ No

If 'Yes', please provide details:

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

P. Children's Trauma/Crisis Cover: Optional Risk Protection Plan and Lifetrack Over Age 10 Personal Statement

Personal details

Child's full name:

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

Residence and travel details

1. Is the Child a permanent resident or citizen of New Zealand or Australia? ☐ Yes ☐ No
If 'No', please provide details:

2. Including annual holidays, is the Child likely to live or travel overseas? ☐ Yes ☐ No
If 'Yes', provide details including where, when and for how long:

Other Insurer details

3. Does the Child have any form (either pending or in force) of Life or Trauma insurance with AMP or any other company? ☐ Yes ☐ No
If 'Yes', provide details:

Company	Type of insurance	Benefit amount	Date commenced	To be replaced
		$	D D M M Y Y Y Y	☐ Yes ☐ No
		$	D D M M Y Y Y Y	☐ Yes ☐ No

Child's health - *To be completed by the Parent or Guardian of the proposed Child Insured in all cases*

4. What is your Child's height? cm / feet / inches **What is your Child's weight?** kg / lbs

5. Provide contact details of your Child's current Doctor/Health Clinic:

Name

Phone ( )

Address

a. How long has the Child been his/her patient? Years Months

b. Date, reason and result of Child's last consultation: **Date of last consultation** D D M M Y Y Y Y

Reason	Result

6. Have you received or are you considering seeking or been advised to seek medical advice for the Child including tests, treatment for any other reason not already provided for in this section? ☐ Yes ☐ No
If 'Yes', provide details:

7. Has the Child ever suffered from AIDS, AIDS related conditions, infection with the HIV virus or a positive antibody test to HIV? ☐ Yes ☐ No

Duty of Disclosure warning:

You have a continuing legal duty to tell us everything you know (or ought to know) relevant to our decision to accept your application and on what terms (for example, any present or past health condition as well as any symptom that might indicate a health condition). You must advise AMP of any changes that occur up until cover commences. Any incorrect, misleading information or omission by you may affect your entitlement to benefits. When in doubt, please disclose. We treat all information confidentially.

Child's health - continued - *to be completed by the Parent or Guardian of the proposed Life/Person Insured in all cases*

8. Have any of the Child's parents, brothers or sisters suffered from: heart disease, stroke, high blood pressure, diabetes, cancer, polycystic kidney disease, Huntington's disease, mental disorder or depression, haemophilia, hypertrophic cardiomyopathy or any other disease which may be inherited? ☐ Yes ☐ No

If 'Yes', provide details:

Family member	Condition/illness	Age at onset	Age at death
Example: Mother *(e.g. Mother, Father, etc.)*	Condition: Cancer Type: Lung *(if cancer or heart disease, please specify condition AND type)*	53 *(approximate)*	— *(approximate)*

9. Has the Child at any time ever suffered from any symptoms or received advice for, OR considering seeking advice including tests, treatments, or investigations for any of the following (even if they have not seen a doctor):

a. Heart, blood vessel or other blood circulation disorder ☐ Yes ☐ No

b. Blood disorder, Anaemia, haemophilia ☐ Yes ☐ No

c. Kidney, bladder, prostate, urinary complaint or kidney stone ☐ Yes ☐ No

d. Liver, Gall bladder, stomach, bowel or other gastrointestinal disorder (e.g. hepatitis, hernia, irritable bowel syndrome) ☐ Yes ☐ No

e. Brain, neurological or other nerve pathway disorder (e.g. stroke, epilepsy, migraines) ☐ Yes ☐ No

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

g. Cancer, tumour (malignant or benign) growth of any kind or breast lump even if the Child hasn't seen a doctor ☐ Yes ☐ No

h. Ears/nose/eyes, speech or skin disorder ☐ Yes ☐ No

i. Diabetes or thyroid disorder ☐ Yes ☐ No

j. Bone, joint, ligament, cartilage, limb or musculoskeletal disorder, pain, strain or injury (incl. back or neck disorder, spinal condition, sciatica, whiplash) ☐ Yes ☐ No

k. Chronic fatigue, fibromyalgia, fibrositis, myalgia, chronic pain syndrome ☐ Yes ☐ No

l. Lung condition or other breathing or respiratory disorder ☐ Yes ☐ No

m. Infections or sexually transmitted illness (other than cold/flu and minor childhood illnesses) ☐ Yes ☐ No

n. Any other illness, injury, operation or disability ☐ Yes ☐ No

If you answered 'Yes' to any of the questions from 'a. to n.', please provide details below:

Question number: ______ **Date symptom(s) started:** D D M M Y Y Y Y **Date symptom(s) ceased:** D D M M Y Y Y Y

Details of condition, advice or symptom including nature of treatment:

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

Question number: ______ **Date symptom(s) started:** D D M M Y Y Y Y **Date symptom(s) ceased:** D D M M Y Y Y Y

Details of condition, advice or symptom including nature of treatment:

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

Question number: ______ **Date symptom(s) started:** D D M M Y Y Y Y **Date symptom(s) ceased:** D D M M Y Y Y Y

Details of condition, advice or symptom including nature of treatment:

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

Verification details - *To be completed and copies of original documents required to be provided to AMP*

Verification of identity for each Policy Owner or anyone paying premiums on this Policy

AMP requires the identity of each Policy Owner and anyone paying premiums on policies to be verified.

This form is to be completed by an Adviser or AMP employee.

Please complete below for each Policy Owner who is not a payer for the Policy. For example, where there are two Policy Owners and the premium is coming from an account that only one Policy Owner is signatory to, this form must be completed for the other Policy Owner.

Note: If this application relates to Level Life Cover to age 100, or with zero premium ages of 65 or 70, please complete (in leiu of the section below) the applicable Customer Identity Verification form found on amp.co.nz within the Product Information and Forms Investments section.

Documents used to verify identity

Details (and a photocopy) of one primary or two secondary documents must be provided.

- A **Primary document** must contain a photograph and can be a passport (personal details page), firearms licence, credit card with photograph, foreign identify card, New Zealand driver's licence.

- A **Secondary document** can be a birth certificate, certificate or membership of a professional body, credit card, evidence of a bank account in your name (e.g. deposit slip), community services card, tertiary identification, employee identity card, international driver's licence.

For a Policy Owner under the age of 18, a copy of either a birth certificate or a passport (personal details page) will be sufficient. No additional documents are required.

A company or incorporated society

- A **primary document** can be a certificate of incorporation, certificate of registration.

- A **secondary document** can be a credit card, evidence of a bank account in the company's name.

Identity verification - Policy Owner

Please complete below for each Policy Owner or anyone paying premiums on this Policy.

Identification details - Policy Owner 1 or person paying.

Does the person have an existing policy/product with AMP which they pay using a direct debit from an account in their name?

☐ Yes Policy/client number

☐ No If 'No', please complete the identification details and declaration below:

Primary/secondary document description

Document number **Expiry date:** D D M M Y Y Y Y

Secondary document description

Document number **Expiry date:** D D M M Y Y Y Y

Identification details - Policy Owner 2 or person paying.

Does the person have an existing policy/product with AMP which they pay using a direct debit from an account in their name?

☐ Yes Policy/client number

☐ No If 'No', please complete the identification details and declaration below:

Primary/secondary document description

Document number **Expiry date:** D D M M Y Y Y Y

Secondary document description

Document number **Expiry date:** D D M M Y Y Y Y

Declaration

I declare that I have seen an original of each document detailed above, verifying identity. I have no reason to believe that each person is not who he or she claims to be.

Signature of Adviser or AMP employee

Date D D M M Y Y Y Y

Third party payer

If the payer is not a Policy Owner or Life/Person Insured, please provide name and address details below.

Name | or Business name

Address | Phone ( )

Payment

Is payment by an existing direct debit?

☐ Yes Please provide Policy number: ☐ No Please complete the appropriate Direct Debit Authority Forms.

Payment details for Lifetrack and Businesstrack only

Frequency of payments

Please indicate your payment frequency: ☐ Yearly ☐ Half-Yearly ☐ Quarterly ☐ Monthly ☐ Four weekly *(Lifetrack only)* ☐ Fortnightly

If you have a preferred monthly payment date please nominate a day between day 1 and 28 of the month:

If your chosen lodgement date does not coincide with the date we activate your policy, can we debit your bank account/credit card for an interim payment without contacting you? *Please note by selecting 'No', activation of your policy may be delayed.* ☐ Yes ☐ No

Credit card payments for Lifetrack and Businesstrack only

☐ Visa ☐ Mastercard

Card number

Expiry date M M Y Y

Cardholder's name (Please print as shown on card)

I authorise AMP to debit my specified card with Lifetrack/Businesstrack regular insurance premiums for which this application relates. This authority shall stand, in respect of the above specified card and in respect of any card issued to me as a replacement, until I notify AMP in writing of cancellation (for regular insurance premiums).

Cardholder's signature

Date D D M M Y Y Y Y

The National Mutual Life Association of Australasia Limited ABN 72 004 020 437
(Incorporated in Victoria, Australia), AMP, PO Box 1692, Wellington 6140, New Zealand

Credit Card Authority Form -
Payment details for Risk Protection Plan only

1. Instruction to Debit Credit Card

☐ Please deduct my first premium payment only from my credit card.

Please note that fortnightly and monthly frequencies are not available if you only pay your first premium by credit card.

Please select frequency for first premium: ☐ Quarterly ☐ Half-Yearly ☐ Yearly

☐ Please deduct all my premiums from my credit card.

Please select frequency from the following options: ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-Yearly ☐ Yearly

If your application for insurance is accepted, we will set up your recurring credit card arrangement after we issue your policy documentation and send confirmation of subsequent premium payments separately.

2. Card details

Cardholder's name

Title: Given name *(s) (please print)*: Surname:

☐ Visa ☐ Mastercard

Credit Card number

Expiry date

M	M	Y	Y

Premium payer daytime telephone number

( )

Once this application for insurance has been accepted, can we debit your credit card for your first premium payment without contacting you? ☐ Yes ☐ No*

**Please note, by selecting 'No', activation of your policy may be delayed.*

Cardholder's signature:

Date:

D	D	M	M	Y	Y	Y	Y

Paying premiums by instalments may increase the total annual premiums payable. Should you require further information please contact us.

Initial terms of the arrangement

In terms of the recurring credit card payment arrangements between us and signed by you, we undertake to periodically debit your nominated credit card for the agreed amount stated in your Policy Schedule.

Changes to the arrangement

If you want to make changes to the drawing arrangements, contact us. These changes may include deferring the drawing or altering the schedule or stopping an individual debit or suspending the payment authority or cancelling the payment authority completely.

Confidentiality

All personal customer information held by us will be kept confidential except the information provided to other financial institutions to initiate the drawing to your nominated credit card account and to administer your policy by us.

Disputes

If you believe that a drawing has been initiated incorrectly, we encourage you to take the matter up directly by contacting us. If you do not receive a satisfactory response from us to your dispute, you can also contact your financial institution. You will receive a refund of the drawing amount disputed if we can not substantiate the reason and evidence your authorisation for the drawing. Note that your financial institution will ask you to contact us to resolve your dispute prior to involving them.

Your Commitment to us

It is your responsibility to ensure that: your nominated credit card account can accept direct debits (your financial institution can confirm this); that on the drawing date there are sufficient cleared funds in the nominated credit card account; and that you advise us if the nominated account is transferred or closed. If your drawing is returned or dishonoured by your financial institution, we may re-draw on your account after four (4) business days, or contact you to arrange alternate payment. Any transaction fees payable by us in respect of the above may be added to your account at our discretion.

AMP Life Limited ABN 84 079 300 379 (Incorporated in New South Wales, Australia)
Level 21, AMP Centre, 29 Customs Street West, PO Box 55, Auckland 1140, New Zealand

Direct Debit Authority Form -
Lifetrack or Businesstrack applications only

Authority to accept Direct Debit. Not to operate as an assignment or agreement.

Authorisation code | 1 | 2 | 1 | 3 | 6 | 3 | 3 |

Bank account details for Direct Debit

Bank account from which payments are to be made:

Account name | Bank | Branch | Account | Suffix

To the bank manager

Bank name: | Branch name: | Town/City:

I/We authorise you until further notice to debit my/our account with all amounts which AMP Life Limited (hereon referred to as the initiator), the registered initiator of the above authorisation code, may initiate by direct debit. I/We acknowledge and accept that the Bank accepts this authority only upon the conditions listed on the bottom of this page.

Information to appear on my/our bank statement

Payer particulars: D I R E C T | | D E B I T

Payer code: A M P | | L I F E | | L T D

Payer reference: R E F E R E N C E | | N O

Your signature(s) | Date: D D M M Y Y Y Y

For bank use only

Date received: D D M M Y Y Y Y

Recorded by: | Checked by:

Approved
1363
11 | 12

Bank | Bank stamp

Conditions of this Direct Debit Authority

1. The Initiator

a. Undertakes to give notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the first direct debit is drawn (but not more than 2 calendar months). This notice will be provided either:
   i. in writing; or
   ii. by any other means which provides a verifiable record of the initiated transaction and where the Customer has provided prior written consent to the Initiator. Where the Direct Debit system is used for the collection of payments which are regular as to frequency but variable as to amounts, the Initiator undertakes to provide the Acceptor with a schedule detailing each payment amount and each payment date. In the event of any subsequent change to the frequency or amount of the direct debits, the Initiator has agreed to give advance notice at least 30 days before the change comes into effect. This notice must be provided either:
   iii. In writing; or
   iv. by electronic mail where the Customer has provided prior written consent to the Initiator.

b. May, upon the relationship which gave rise to this Authority being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Authority. Upon receipt of such notice the Bank may terminate this Authority as to future payments by notice in writing to me/us.

c. May, upon receiving an "authority transfer form" (dated after the day of this authority) signed by me/us and addressed to a bank to which I/we have transferred my/our bank account, initiate Direct Debits in reliance of that transfer form and this Authority for the account identified in the authority transfer form.

2. The Customer may:

a. At any time, terminate this Authority as to future payments by giving written notice of termination to the Bank and to the Initiator.

b. Stop payment of any direct debit to be initiated under this authority by the Initiator by giving written notice to the Bank prior to the direct debit being paid by the Bank.

c. Where a variation to the amount agreed between the Initiator and the Customer from time to time to be direct debited has been made without notice being given in terms of clause 1. above, request the Bank to reverse or alter any such direct debit initiated by the Initiator by debiting the amount of the reversal or alteration of a direct debit back to the Initiator through the Initiator's Bank, PROVIDED such request is made not more than 120 days from the date when the direct debit was debited to my/our account.

3. The Customer acknowledges that:

a. This authority will remain in full force and effect in respect of all direct debits made from my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the Bank.

b. In any event this authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.

c. Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the direct debit has not been paid in accordance with this authority. Any other disputes lie between me/us and the Initiator.

d. Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility or liability in respect of:
   i. the accuracy of information about Direct Debits on Bank statements
   ii. any variations between notices given by the Initiator and the amounts of Direct Debits.

e. The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/ us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.

f. Notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.

4. The Bank may:

a. In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.

b. At any time terminate this authority as to future payments by notice in writing to me/us.

c. Charge its current fees for this service in force from time-to-time.

d. Upon receipt of an "authority to transfer form" signed by me/us from a bank to which my/our account has been transferred, transfer to that bank this Authority to Accept Direct Debits.

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The National Mutual Life Association of Australasia Limited ABN 72 004 020 437
(Incorporated in Victoria, Australia), AMP, PO Box 1692, Wellington 6140, New Zealand

Authority to accept Direct Debit. Not to operate as an assignment or agreement.

Direct Debit Authority Form - **Risk Protection Plan only**

Authorisation code | 1 | 2 | 1 | 3 | 6 | 2 | 5 |

Bank instructions

Bank account from which payments are to be made:

Name of Bank Account | Bank | Branch | Account | Suffix

Please attach an encoded deposit slip to ensure your number is loaded correctly

Please select frequency from the following options: ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

To the bank manager

Bank name: | Branch name: | Town/City:

I/We authorise you until further notice, to debit my/our account with all amounts which The National Mutual Life Association of Australasia Limited (hereinafter referred to as the Initiator) the registered Initiator of the above Authorisation Code, may initiate by Direct Debit. I/We acknowledge and accept that the Bank accepts this authority only upon the conditions listed below.

Information to appear on my/our bank statement

Payer particulars | Payer code

Plan/policy number

Your signature(s) | Date (D D M M Y Y Y Y)

For bank use only

Date received: (D D M M Y Y Y Y) | Recorded by: | Checked by:

Approved
1362
01 | 13

Bank | Bank stamp

Original - retain at branch

Conditions of this Authority to accept Direct Debits

1. The Initiator

a. Undertakes to give notice to the Acceptor of the commencement date, frequency and amount at least 10 calendar days before the first direct debit is drawn (but not more than 2 calendar months). This notice will be provided either:
   i. in writing; or
   ii. by electronic mail where the Customer has provided prior written consent to the Initiator

   Where the Direct Debit system is used for the collection of payments which are regular as to frequency, but variable as to amounts. The initiator undertakes to provide the Acceptor with a schedule detailing each payment amount and each payment date. In the event of any subsequent change to the frequency or amount of the Direct Debits, the initiator has agreed to give advance notice of at least 30 days before changes come into effect. This notice must be provided either:
   iii. In writing; or
   iv. by electronic mail where the Customer has provided prior written consent to the Initiator.

Or

a. Will not initiate a direct debit on my/our account unless authorisation is received from me/us in accordance with the terms and conditions agreed between me/us and the initiator of each amount to be debited from my/our account.

b. Has agreed to send notice of the net amount of each direct debit and the due date of debiting after receiving authorisation from me/us under clause (a) but no later than the date the direct debit will be initiated. This notice must be provided either:
   i. In writing; or
   ii. by electronic mail where the Customer has provided prior written consent to the Initiator.

   The notice will include the following message: "The amount $..... was direct debited to your bank account on (initiating date)."

c. May, upon the relationship which gave rise to this Authority being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Authority. upon receipt of such notice the Bank may terminate this Authority as to future payments by notice in writing to me/us.

2. The Customer may:

a. At any time, terminate this Authority as to future payments by giving written notice of termination to the Bank and to the Initiator.

b. Stop payment of any direct debit to be initiated under this authority by the Initiator by giving written notice to the Bank prior to the direct debit being paid by the Bank.

c. Where a variation to the amount agreed between the Initiator and the Customer from time to time to be direct debited has been made without notice being given in terms of clause 1. (a) above, request the Bank to reverse or alter any such direct debit initiated by the Initiator by debiting the amount of the reversal or alteration of a direct debit back to the Initiator through the Initiator's Bank, PROVIDED such request is made not more than 120 days from the date when the direct debit was debited to my/our account.

3. The Customer acknowledges that:

a. This authority will remain in full force and effect in respect of all direct debits made from my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the Bank.

b. In any event this authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.

c. Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the direct debit has not been paid in accordance with this authority. Any other disputes lie between me/us and the Initiator.

d. Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility or liability in respect of:
   i. the accuracy of information about Direct Debits on Bank statements
   ii. any variations between notices given by the Initiator and the amounts of Direct Debits.

e. The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/ us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.

f. Notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.

4. The Bank may:

a. In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.

b. At any time terminate this authority as to future payments by notice in writing to me/us.

c. Charge its current fees for this service in force from time-to-time.

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Please read - Important information, Declaration and Agreement

Duty of Disclosure

Until there is a contract of insurance resulting from this application, you have a continuing legal duty to tell us everything you know (or ought to know) material to the risk to be insured. This means you must tell us 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. This duty applies from the time you complete this application until cover commences, which is when we accept your application, issue a policy to you and we have received payment of the first premium. You must advise AMP of any changes that occur up until cover commences. If you fail to do so, AMP may at its discretion decline a claim, avoid or void the policy from inception, decline to pay any benefits, or take other action as specified in the policy. When in doubt, please disclose.

Privacy Act 1993 Acknowledgement

The following relates to the personal information provided in this application (and any accompanying documents and communications) and the personal information that may be held about you by AMP already or in the future.

- The personal information collected will be held by AMP and used to evaluate and process this application (including completion of any necessary medical tests) to administer and service any product you have with AMP and to consider any claims. If any of the information asked for is not provided this application may be declined or the service may be withdrawn.
- The Policy Owner may be told of your health assessment.
- The information may also be used to identify and offer other products or services available by or through AMP that may be suitable to your needs.
- AMP holds information about you securely.
- You have the right to ask, see and if incorrect, request correction of the information AMP holds about you by contacting 0800 808 267.

Declaration and Agreement - Life/Person Insured

Please read each statement and sign below to show you understand and agree with all of them:

- I request that AMP provides insurance to which this application relates.
- AMP's standard terms and conditions will apply and any special conditions including premium loadings and/or exclusions applied from the policy's commencement. I will be deemed to have accepted those special conditions unless I notify AMP in writing.
- I confirm the truth, accuracy and completeness of all statements and answers given in support of this application (whether in this application form, orally, in any tele-interview or in any other form or document in connection with this application) regardless of whether or not they are in my own handwriting, which shall form the basis of any contract of insurance resulting from this application.
- I have read and understand the section headed 'Duty of Disclosure' and have disclosed everything material to the risk to be insured. If I fail to do so, AMP may at its discretion decline a claim, avoid or void the policy from inception, decline to pay any benefits, or take other action as specified in the policy. I understand that my duty of disclosure is not released solely because AMP request further information as a result of my application.
- Any insurance granted by AMP in connection with this application will be granted on the basis that there has been no change in my occupation, personal health, family medical history, or anything else that might affect the risk for which AMP is providing cover prior to written acceptance of the risk by AMP and the payment of the first premium.
- I have read and understand the section in this application headed 'Privacy Act 1993 Acknowledgement' and I authorise AMP (including its agents) to obtain from, and to disclose to, anyone my personal information (including any medical and lifestyle information held by any health or medical practitioner, medical laboratory, hospital, ACC, previous insurer or other relevant entity or organisation) to the extent that is reasonably necessary for AMP to evaluate and administer this application, administer the policy and consider any claim. I agree that a photocopy of this authority shall be sufficient evidence to anyone of my consent to such release of my personal information to AMP (including its agents).
- The preceding authorisation specifically acknowledges that it may be reasonably necessary for AMP to request such information for a specified period in certain circumstances. This includes (but is not limited to) circumstances in which AMP considers any medical or health conditions(s) I have (had or may have now or in the future) to be material or potentially material in evaluating and administering this application, administering the policy and considering any claim. If I do not authorise AMP to request and obtain such information, AMP may be unable to evaluate or administer this application and the policy or consider any claim.
- I am aware that a registered nurse may be in contact with me if I require a Paramedical to complete this application.
- If blood tests are required in connection with this application, the tests may include one for the presence of antibodies to the AIDS virus. In the event that the test for AIDS antibodies is positive, I understand that my general practitioner or doctor (as named in my tele-interview or 'Doctor information' section on page 7) will be advised of the result unless another doctor is named below.
- I request that any policy issued by AMP as a result of this application be issued on the New Zealand Register of AMP.
- I understand and agree that if any direct debit or credit card premium payment for this policy is dishonoured, any outstanding premium will be collected at the same time as my next direct debit.
- If the Life/Person Insured is under the age of 20 at the commencement date of this policy the premiums will be based on smoker rates. If on reaching the age of 20 the Life/Person Insured is a non-smoker you can request AMP to change the Life/Person Insured's status to that of a non-smoker, with effect from the next anniversary date of this policy. Smoker and non-smoker premium rates for Life/Person Insured under the age of 20 are the same, but differ for those Lives/Persons Insured over the age of 20.

Name of doctor/clinic: Phone: ( )

Address:

Signature

- I authorise AMP to use a photocopy of this signed Declaration and Agreement as confirmation of all the above authorisations.
- References to "AMP" includes the AMP group of companies, their subsidiaries (including The National Mutual Life Association of Australasia Limited and AMP Life Limited), associated companies and agents including companies authorised by AMP to collect information on AMP's behalf.

Name of proposed Life/Person Insured

Full name of Parent or Legal Guardian if signatory is under age 16

Signature of proposed Life/Person Insured

Signature of Parent or Legal Guardian if signatory is under age 16

Location (Town/City) of signing

Date D D M M Y Y Y Y

Insurer Financial Strength Rating

AMP Life Limited is the insurer offering insurance under Lifetrack or Businesstrack and has an AA- insurer financial strength rating given by Standard & Poor's Australia Pty Ltd, an approved rating agency.

The National Mutual Life Association of Australasia Limited is the insurer offering insurance under the Risk Protection Plan (RPP) and has an AA- financial strength rating given by Standard & Poor's Australia Pty Ltd, an approved rating agency.

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

Financial strength ratings may change from time to time. Contact AMP or your Adviser to confirm AMP insurers' current ratings or go to the rating agency's website at www.standardandpoors.com

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

Plus (+) or minus (-) signs following ratings from 'AA' to 'CCC' show relative standing within the major ratings categories.

For more information contact your Adviser or call AMP on 0800 808 267.

Declaration and Agreement – Policy Owners (Important – please read)

Each Policy Owner please read each statement and sign below to show you understand and agree with all of them.

- I request that AMP provides insurance to which this application relates.
- AMP's standard terms and conditions will apply and any special conditions including premium loadings and/or exclusions apply from the policy's commencement. I will be deemed to have accepted those special conditions unless I notify AMP in writing.
- I confirm the truth, accuracy and completeness of all statements and answers given in support of this application (whether in this application form, orally, in any tele-interview or in any other form or document in connection with this application) regardless of whether or not they are in my own handwriting, which shall form the basis of any contract of insurance resulting from this application.
- I have read, understand and agree to the 'Important information' section on page 27 in its entirety.
- I have read and understand the 'Duty of Disclosure' section on page 27 and I agree that the Life/Person Insured has disclosed everything material to the risk to be insured. If the Life/Person Insured fails to do so, AMP may at its discretion decline a claim, avoid or void the policy from inception, decline to pay any benefits, or take other action as specified in the policy.
- Any insurance granted by AMP in connection with this application will be granted on the basis that there has been no change in the Life/Person Insured's occupation, personal health, family medical history, or anything else that might affect the risk for which AMP is providing cover prior to written acceptance of the risk by AMP and the payment of the first premium.
- I understand and agree that if any direct debit or credit card premium payment for this policy is dishonoured, any outstanding premium will be collected at the same time as my next direct debit.
- I am aware that by reason of the Life Insurance Act 1908, the amount payable under any policy issued by AMP as a result of this application may:
  a. if the Life/Person Insured dies under the age of 10 years, be limited to the total of:
     - the premiums paid under the Policy issued on the Life/Person Insured and interest thereon at the date of the death of the Life/Person Insured; and
     - the amount that, when added to any other sum permitted to be paid by any other company or by any friendly society, equals $2,000 or such larger sum as may from time to time be prescribed; and

  b. if the Life/Person Insured dies under the age of 16 years, the amount payable will be payable only to a person who is part of a limited class of persons, including the parents or guardians of the Life/Person Insured, the executor or administrator of such a person and any assignee of the Policy approved by the District Court.
- "AMP" includes the AMP group of companies, their subsidiaries (including AMP Life Limited and The National Mutual Life Association of Australasia Limited), associated companies and agents including companies authorised by AMP to collect information on AMP's behalf.

Signature of Policy Owner(s) - If a Company is a Policy Owner, please provide the signatures (x2) of the duly authorised signatories of the company.

Print name | Signature

Print name | Signature

Print name | Signature

Town/City where this was signed | Date D D M M Y Y Y Y

Parent/Guardian: Please print full name and sign if the Child (proposed Life/Person Insured) is aged under 16 ☐ Parent ☐ Guardian

Print name | Signature

Parent/Guardian - Date of birth D D M M Y Y Y Y | Date D D M M Y Y Y Y

For Adviser Use Only

I confirm that I am a: ☐ AFA ☐ QFE Adviser ☐ RFA or ☐ Other Please specify:

and I certify the information provided in this section is correct and that I have complied with the requirements of the Financial Advisers Act 2008 and all other applicable laws.

Name | FSPN*

Adviser number

**Please use your QFE's FSPN if you are a QFE Adviser.*

Advice on Replacement Business

Information

The completion of this form is a requirement of AMP aligned with the FSC Standard for Term Life and Disability, Trauma and/or Income Protection products. A Policy Owner or Life/Person Insured may find this advice helpful in deciding whether to replace an existing contract or policy.

Details of new policy contract

Type	Policy number	Insurer

Policy being replaced

Type	Policy number	Insurer	Policy issue date

Details of replacement – statement by Adviser

a. The specific reasons for the replacement of this existing contract/Policy are:

b. The Policy to be replaced cannot adequately fulfil the owner's objectives because:

c. The following risks are NOT covered by the new contract/Policy which WERE covered by the old contract/Policy:

Name of Adviser

Address of Adviser

Phone

( )

Adviser signature

Date:

D D M M Y Y Y Y

Applicant acknowledgement

I/We acknowledge there may be advantages and disadvantages involved in replacing an existing contract/policy such as:

1. There are sometimes establishment costs (including commission) in setting up a contract/policy. Replacing it with a new contract/policy may involve further establishment costs;
2. If the policy which is being replaced was purchased on the life insured at a young age, the same or similar benefits in the new policy may now cost more;
3. A change in health, pastimes or occupation of the life insured may affect insurability and the new policy may contain restrictions, limitations, and/or be more costly;
4. In a new policy the Suicide Exclusion Clause may recommence;
5. Conditions or benefits may be more (or less) favourable under the contract/policy which is being replaced (for example, the contract duration, wordings and/or benefit definitions may differ).

I/We also acknowledge that his information was provided and explained before I/We signed the application for the new contract/policy.

I am/We are aware I/We may cancel this application, in writing, within the 'free look' period of 14 days, which begins on the third business day after the Policy Document is posted to me/us. In the event, AMP will refund any premium, deposit or other payment made in respect of the new contract/policy.

Signature of Applicant

Print name

Signature

Date:

D	D	M	M	Y	Y	Y	Y

Client details/reference

Interim Cover Certificate

Proposed Life/Person Insured:

Full name

Policy Owner(s):

Full name

Date of application

D D M M Y Y Y Y

Lifetrack and Businesstrack - Interim cover terms and conditions

This is a limited form of free cover, which we provide while assessing an application for a new policy or an increase to an existing policy. To qualify, this application must be accompanied by a cheque for the first premium or a completed direct debit or credit card authority.

At the time of application, the Person Insured is covered by interim cover. This cover means that should they:

- die;
- suffer an injury; or
- suffer an illness,

we will consider paying a claim. Any interim cover claim payments are at our discretion and are made on an ex-gratia basis.

Cover amounts

The total maximum interim cover for any Person Insured is the proposed amount of cover within the application to a maximum of:

- $600,000 for all lump sum covers.
- $2,500 monthly sum insured for all income covers payable on disablement.

Claim conditions

Note that a claim due to illness under interim cover will only be paid if:

- the Person Insured certifies that they are well at the time of application;
- they were not contemplating seeking medical advice in the 30 days following their application; and
- their sickness is not the result of a condition that was already apparent at the time of application.

Interim cover will cease at the earliest of:

- the start date of the cover;
- the date AMP declines the risk proposed for cover on the application:
- 60 days after the date on which the application was signed; or
- if the customer withdraws their application – the date of withdrawal.

Interim cover exclusions

AMP will not under any circumstances consider making a payment if the event giving rise to the claim arose from:

- the Person Insured or Policy Owner causing the Person Insured to die or suffer an injury or illness that we would have covered;
- any form of motor racing if motor racing is a usual pastime;
- any person who owes a duty of care to the child proposed for cover under children's trauma (that duty arising from family or household relationships), intentionally committing an act which gives rise to the claim; or
- accidents occurring before the application was signed.

Risk Protection Plan - Interim cover terms and conditions

1 PROVISIONAL DEATH COVER

This cover is provided until the Policy Commencement Date or until 60 days after the date of your application shown above, whichever is the earlier, provided:

- the proposed Life Insured is aged between 10 and 65; and
- the cover does not cease earlier in accordance with clause 4.

THE BENEFIT AND CONDITIONS

What amount is payable on Death? The amount proposed for life insurance on the proposed Life Insured up to a maximum Benefit of $1,000,000 under this and all similar covers or any other maximum sum fixed by law.

What types of insurance are covered? Risk Protection Plans providing a Life Insurance sum insured payable on death.

Is a premium required? A deposit equal to the first annual premium or instalment of premium must have been paid with the proposal and received by us, or an effective deduction authority held by us.

What Deaths are NOT covered?

a) Suicide, whether sane or insane;

b) Death directly or indirectly caused or contributed to by any of the events or conditions in clause 3.

2 PROVISIONAL MAJOR TRAUMA AND/OR PROVISIONAL DISABLEMENT PROTECTION COVER

This cover is provided until the Policy Commencement Date or until 60 days after the date of your application shown above, whichever is the earlier, provided that the cover does not cease earlier in accordance with clause 4.

THE BENEFIT AND CONDITIONS

What amount is payable on Major Trauma or Disablement? The amount proposed for Major Trauma or Disablement Protection cover on the Life Insured up to a maximum benefit of $500,000 under this and all similar covers.

Is a premium required? A deposit equal to the first annual premium or instalment of premium must have been paid with the proposal and received by us, or an effective deduction authority held by us.

What do we mean by Major Trauma or Disablement? Where the Life Insured suffers a Major Trauma (as defined in the policy document – excluding Major Traumas with a Ninety Day Waiting Period) or becomes Totally and Permanently Disabled. The definition of Total and Permanent Disablement for the purpose of this cover will be based on the 'Any Occupation' version. The Claimable Event must occur for the first time after this cover commences.

What Major Traumas and Disablements are NOT covered? Where the Major Trauma or Disablement is directly or indirectly caused or contributed to by any of the events or conditions listed in clause 3.

3 TERMS AND CONDITIONS FOR PROVISIONAL COVERS

Death, Major Trauma or Disablement directly or indirectly caused or contributed to by any of the following events or conditions are excluded:

- intentional self-injury, including intentionally contracted infection by bacteria or virus, or any attempt thereat;
- making or attempting to make a flight in an aircraft (other than as a fare paying passenger on a regularly scheduled flight);
- taking intoxicating liquor or drugs;
- any condition which occurred, or for which symptoms existed (or for which medical treatment was recommended by a doctor) before the date shown on this certificate;
- participating in criminal acts.

We will not pay if you or the proposed Life Insured have not complied with their duty of disclosure or have misstated any facts in relation to this application. We will also not pay where an existing contract of insurance held with AMP is being replaced.

No Benefit is payable if (based on full disclosure of all relevant matters) this application would not have been accepted by our Underwriters standard terms.

4 PROVISIONAL COVER PERIOD

When does each Provisional Cover commence?

If the signed and completed application, and either a premium or deduction authority referred to above are received at AMP:

- within three days of the date of your application shown on this certificate – then provisional cover commences on the date of your application; or
- later than three days after the date of your application shown on this certificate – then provisional cover commences on the date of receipt at AMP.

Any provisional cover ceases:

a) If your application is deferred or declined, on the date on which you are notified by AMP of its decision; or

b) If you withdraw the application, on the date of the withdrawal; or

c) On the Policy Commencement Date; or

d) 60 days after the date of your application shown on this certificate.

For Adviser Use Only

Adviser name

Phone ( )

Agency number

Email address

% new business commission

% renewal

	Servicing Adviser	Adviser	Adviser
Name			
Number			
Stamp			

If commission is split:

Adviser 2 name

Phone ( )

Agency number

Email address

% new business commission

% renewal

Adviser 3 name

Phone ( )

Agency number

Email address

% new business commission

% renewal

Commission Options *(tick one)*

Lifetrack

☐ Upfront ☐ Level

Risk Protection Plan

☐ Upfront ☐ Level ☐ Hybrid 1 ☐ Hybrid 2 ☐ Hybrid 3 ☐ Dial Down (applies to Upfront only)

Adviser notes

Have you attached an illustration to this proposal? ☐ Yes

Is any other documentation attached to this proposal? ☐ Yes ☐ No

If 'Yes', provide details below:

Other reference

If you are taking over the servicing of an existing Policy from another Adviser, have you enclosed written approval from the client? ☐ Yes ☐ No

Additional notes