



Non Smoker Questionnaire

Life/Person Insured:

Policy Number:

Adviser Name:

Adviser Phone Number:

Questions

Please note: The information you provide below will not adversely affect the terms of your policy but may influence AMP's decision on whether to offer non-smoker premium rates or reduce existing terms that are applied to your policy.

- When did you last smoke?
- Since your policy commenced, have you suffered any serious illness or disability such as heart disorders, cancer or tumour, stroke, diabetes or respiratory disease? Yes No
- Have you been advised by a Medical Professional to stop smoking because of a specific medical condition? Yes No

Health Table

If you have answered 'Yes' to questions 2 or 3 please provide further details here.

Question No:	Date	Name & address of doctor, hospital or health professional consulted:
Details of condition, advice or symptoms including nature of treatment:		
Question No:	Date	Name & address of doctor/hospital or health professional consulted:
Details of condition, advice or symptom including nature of treatment:		

Declaration

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

- I have answered the questions in this personal statement truly, accurately and correctly regardless of whether or not they are in my own handwriting.
- I have read all the questions and answers. The information I have provided is full and complete and I have kept nothing back that might cause you to assess me as a greater risk to insure.
- I authorise AMP (including its agents) to obtain from, and to disclose to anyone, my personal information, to the extent that it is reasonably necessary for AMP to evaluate and administer the policy and consider any claim.

Signature of Life/Person Insured:

Date:

Phone Number:

Email: