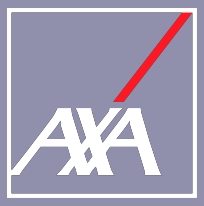

XL Insurance

Personal Statement Form

Welcome to AXA XL

DUTY OF DISCLOSURE: WHAT YOU NEED TO TELL US

The purpose of this Personal Statement is to prompt you to provide information we may consider relevant to the assessment of your application ("Application") for insurance.

We understand that the questions we ask in this form may be sensitive and completing the form may take time, but it is very important that you give us all the information asked for, as this may affect your Application for insurance.

It is important that you understand your duty to provide truthful, complete and correct information about yourself, including your health and medical history.

This means you should:

› Always tell the truth (including if your circumstances change after you have completed this Personal Statement but before the policy is issued);
› Answer questions as fully as you can, including as much detail relating to your current and past circumstances as possible;
› Include all information, even if you're unsure it is relevant;
› Tell us if you don't know the answer to any question; and
› Ask questions if there is anything you're not sure of.

If a claim arises, we will look further into your personal history. If we discover that you haven't told us something material, we may either alter the terms of the insurance issued in relation to your Application (which might affect your claim) or we may avoid the insurance issued in relation to your Application from its inception which means that you would not be able to make a claim, as no policy would exist. It does not matter if the new information is about a condition unrelated to your claim.

Life to be assured

Mr/Mrs/Miss/Ms/Mx	Last name	First names
Previous name (if changed)		
Mailing address	Street	
	Suburb	Town/City / Postcode
Home address (if different)		
Contact details	Home phone ( ) / Business phone ( ) / Mobile ( )	
	Email	
Date of birth (dd/mm/yyyy)	/ /	Place of birth

☐ Male ☐ Female ☐ X

In the last 12 months, have you smoked tabacco or any other substance and/or used smoking alternatives (e.g. e-cigarettes, vaping, nicotine gum or patches)? ☐ Yes ☐ No If Yes, please give details of each substance including date started (or stopped) and quantity per day:

Occupation
(please include duties)

Your Insurance Details

(a) Has any insurance you currently have, or have applied for (eg Life, Critical Illness, Income Protection), ever been declined, deferred or modified including any loadings or exclusions? If YES, please give details below: ☐ Yes ☐ No

DATE	INSURANCE COMPANY	TYPE OF INSURANCE DECLINED		DEFERRED	SPECIAL TERMS	REASON

(b) Have you ever claimed benefits from ACC, WINZ or an insurer due to sickness, injury or treatment for injury (eg physiotherapy)? ☐ Yes ☐ No

If If you have answered YES, please give details below, and give details of the condition in the **General Health Questionnaire** in SECTION 5

CLAIM DATE	TYPE OF CLAIM	REASON/CONDITION

Personal Statement

(a) Please indicate your New Zealand residency status

☐ Citizen/ Permanent resident ☐ Resident Visa / Work Permit (please enclose a copy) ☐ Long-term business visa and permit (please enclose a copy) ☐ Other (please enclose a copy)

How long have you resided in New Zealand?

Years Months

(b) Do you intend to live, work or travel overseas within the next 12 months?

☐ Yes ☐ No If YES, please tick purpose and give details below ☐ Live ☐ Work ☐ Travel

Country | Start date | Duration

(c) Do you participate, intend to participate, or in the last three years have you participated, in any hazardous occupation or pursuit, including but not limited to activities such as motor racing, aviation, martial arts, parachuting, scuba diving, or motor boat racing? If YES, please give details:

☐ Yes ☐ No

PASTIME/PURSUIT	NO. OF YEARS PARTICIPATED AND DETAIL OF EXPERIENCE	FREQUENCY OF PARTICIPATION PER ANNUM	MAXIMUM HEIGHT, DEPTH, SPEED, RECORD ATTEMPTS	GEOGRAPHIC LOCATION	EQUIPMENT DETAILS

(d) What is your height and weight?

cm/feet/inches | kg/stone/lb

(e) In the last 12 months, has your weight varied by more than 10 kg?

☐ Yes ☐ No If YES, please give full details

(f) Do you drink alcohol?

☐ Yes ☐ No If YES, please give full details

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

(g) Have you ever used any drug not prescribed by a doctor, or used over the counter medications not in accordance with the manufacturer's directions, or received medical advice, counselling or treatment for the use of alcohol, drugs or gambling?

☐ Yes ☐ No If YES, please give full details

Personal Statement continued

(h) **Family history**

Has any parent, sister or brother (blood relative) before the age of 60, received treatment or been diagnosed with one of the following conditions: Diabetes, Stroke, Dementia, Kidney disease, Heart disease, Cancer*, Huntington's disease, Polycystic kidney, Multiple Sclerosis, Any other hereditary or familial disease? If yes, please give details including age of diagnosis.

☐ Yes ☐ No

**For Cancer please specify type*

(i) **Doctor's or General Practitioner's details**

Please give the details of usual Dr or GP name and contact details and if this has changed in the past 12 months, please also provide previous details.

Medical professional and clinic

Doctors name

Does this professional hold your records? ☐ Yes ☐ No

Clinic name

Business phone
( )

Clinic address

Years attended

(k) Have you ever had any signs or symptoms of, or been teste d or treated for, or diagnosed with any of the following?

If you have answered YES to any of the below, please complete the **General Health Questionnaire** in SECTION 5.

1	Brain or neurological disorders (e.g. stroke, paralysis, epilepsy, Multiple Sclerosis, Motor Neurone Disease, Bell's palsy, Transient Ischaemic Attack TIA), brain haemorrhage and brain injury, seizures, fits, fainting, unexplained loss of consciousness or blackouts, cerebral palsy, any migraine or frequent headaches)	☐ YES	☐ NO
2	Any other disorder of the central nervous system not already mentioned.	☐ YES	☐ NO
3	Nervous or mental disorders/illness, stress, depression, fatigue, anxiety, low mood, phobia, sustained poor sleep or lack of energy.	☐ YES	☐ NO
4	Any other Mental illness or psychological problems that have required any kind of medical attention, time off work, hospital treatment or referral to a psychiatrist.	☐ YES	☐ NO
5	Any disease or disorder of the eyes, ears, nose or throat (eg sinusitis, rhinitis, tonsillitis or ear infections, loss of sight, hearing or speech etc.)	☐ YES	☐ NO
6	Thyroid disorder or any other glandular condition	☐ YES	☐ NO
7	Respiratory disorder (eg asthma, bronchitis, bronchiolitis, sleep apnoea, shortness of breath, breathing problems etc.)	☐ YES	☐ NO
8	Heart disease (including heart attack, angina, valve defect, cardiomyopathy, heart defects from birth or heart surgery), chest pain, heart murmur, high blood pressure, high cholesterol, irregular heart beat, hole in the heart or any other chest complaint.	☐ YES	☐ NO
9	Any condition of the gastrointestinal tract or bowel, or digestive system (eg irritable bowel, Crohn's disease, ulcers, colitis, reflux)	☐ YES	☐ NO
10	Liver disease or disorder (eg hepatitis, fatty liver, abnormal liver function test)	☐ YES	☐ NO
11	Diabetes, abnormal blood sugar level or sugar in the urine	☐ YES	☐ NO
12	Kidney, bladder, or urinary problems (eg kidney reflux, kidney stones, urin ary incontinence)	☐ YES	☐ NO
13	Cancer, tumour, cyst, breast lump, abnormal moles, or any other lesion	☐ YES	☐ NO
14	Skin disorder (ie a part of the skin that has an abnormal growth or appearan ce) or any other skin condition (eg eczema, dermatitis)	☐ YES	☐ NO
15	Any pain, injury, disease or disorder of your muscle(s), joint(s) or bone(s) (including arthritis, rheumatism, gout)	☐ YES	☐ NO
16	Blood disorders (eg leukemia, anaemia, blood clots, bleeding tendencies) or varicose veins	☐ YES	☐ NO
17	Disease or disorder of the immune system (eg systemic lupus erythemat ous/SLE, rheumatoid and/or psoriatic arthritis, AIDS or HIV antibodies)	☐ YES	☐ NO
18	Disease or disorder of the reproductive tract (eg hydrocele, testicular lump, prostate enlargement, abnormal test, torsion, phimosis, endometriosis, fibroids, abnormal smears, gynaecological disorders, irregular, heavy or painful menstrual bleeding, painful and/or abnormal periods)	☐ YES	☐ NO
19	Any other illness or condition not listed above or any investigation currently ongoing, or current symptoms/abnormality that you have not sought advice but intend to (please state).	☐ YES	☐ NO
20	'Are you currently taking any medication prescribed or otherwise? (please state)?	☐ YES	☐ NO

General Health Questionnaire

Please complete this section if you answered YES to any of the selected questions in SECTION 3 and 4. If you need extra space to provide your response, please use the NOTES on pages 10 and 11 and write 'refer to notes' next to the original question.

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

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

General Health Questionnaire (continued)

If you need extra space to provide your response, please use the NOTES on pages 10 and 11 and write 'refer to notes' next to the original question.

	CONDITION 5	CONDITION 6
(a) Name of condition		
(b) Date of first symptoms	Day / Month / Year	Day / Month / Year
(c) Date of last symptoms	Day / Month / Year	Day / Month / Year
(d) Have you ever been hospitalised or had time off work or school as a result of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(e) Have there ever been any subsequent problems, impairments or after-effects from this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(f) Are you currently receiving treatment or follow-up or been advised that treatment or follow-up is required?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(g) Have you ever had any recurrence of this condition?	☐ YES – please give full details at (h) ☐ NO	☐ YES – please give full details at (h) ☐ NO
(h) Please give full details if you have answered YES to questions (d), (e), (f) or (g) above		

Declaration and consent

Please read your duty of disclosure and declaration carefully, then complete the disclosure check boxes and sign the bottom of page 9 to show your acceptance of these terms. Failure to make the following declaration truthfully may invalidate any insurance issued in relation to your Application.

Important Notice – Your Duty of Disclosure
Before You enter into a contract of insurance with an insurer, You have a duty to disclose to the insurer every matter that you know, or could reasonably be expected to know, is material to the insurer's 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 the insurer before You renew, extend, vary or reinstate a contract of general insurance.
You are to give Us in writing as soon as possible of every change materially varying any of the facts or circumstances existing at the commencement of this insurance. Your duty, however, does not require disclosure of a matter:+
• That diminishes the risk undertaken by the insurer;
• That is common knowledge;
• That Your insurer knows or, in the ordinary course of his/her business, ought to know; and
• As to which compliance with Your duty is waived by the insurer

NON-DISCLOSURE
If you fail to comply with Your duty of disclosure, the insurer may be entitled to reduce their liability under the contract in respect of a claim or may cancel the contract.
If you non-disclosure is fraudulent, the insurer may also have the option of avoiding the contract from its beginning.

PRIVACY
AXA XL Underwriting Agencies Limited collects uses and retains your personal information only in accordance with the principles in current relevant legislation. Your personal information will be used by AXA XL Underwriting Agencies Limited, or any third party that we provide the information to, for the purpose of assessing your application or your entitlement to benefits and for administration of a claim and for planning, product development and research purposes.

Your personal information includes:
• any information provided in relation to your claim;
• any information that is health information or sensitive information;
• any other personal information that you may provide to AXA XL Underwriting Agencies Limited or its third party contractors;
• any information relating to the insurance policy on your life, including terms and conditions and claims history;
• details of your employment including position, period of employment, remuneration, hours worked and duties performed; and
• any other information relating to your income and solvency.

To process your application AXA XL Underwriting Agencies Limited may need to collect your personal information from third parties such as your Union, insurance broker, claims reference services, government organisations (for example Accident Compensation Corporation agencies or taxation offices), any forensic accountant retained by, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the "Parties"). You agree that the Parties may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other insurers, our reinsurers, and government agencies (where we are compelled to by law). These third parties may be located outside New Zealand.

You agree to us using and disclosing your personal information pursuant to this Application Privacy Consent. In the event of any conflict between the documents, this Privacy Consent shall be determinative. This consent remains valid unless you alter or revoke it by giving written notice to our Compliance Officer.

If you do not consent to the terms of this Claims Privacy Consent or revoke your consent, may not be able to process or assess your application.

APPLICANTS DECLARATION
I declare that to the best of my knowledge the particulars are true and correct, and that I have not withheld any information that is relevant to this application.

I accept that wilful or reckless exaggeration or inflation of information could result in automatic forfeiture of my claim and the policy shall be void.

I request and authorise any hospital, doctor, or other person who has attended or examined me over the last thirty six (36) months to furnish to or its representative all information concerning any medical deficiency, consultations, prescriptions, or treatments including X-ray plates and copies of all hospital or medical records, so that they may be included as a part of the a pplication submitted. A photocopy of this authorisation will be considered as effective and valid as the original.

I authorise the disclosure to AXA XL Underwriting Agencies Limited of personal information held by any other person or organisation regarding or affecting this claim and authorise AXA XL Underwriting Agencies Limited to release to any other relevant person or organisation information regarding or affecting this claim.

Full names of Life to be Assured

Signature of
Life to be Assured

X

Date (dd/mm/yyyy)
/ /

Notes

Notes

axaxl.com

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