Resolution Life

Please send this completed form to:
askus@resolutionlife.co.nz
or
Resolution Life, PO Box 1692, Wellington 6140, New Zealand
Please call us on 0800 808 267 if you have any queries.

Workplace Protection
Personal Statement

To be completed by the life to be insured

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

Resolution Life Plan number

Member number

Personal Details

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

☐ Male ☐ Female

First name(s) (please print)

Surname

Private address

Contact phone number
( )

Mobile number
( )

Date of birth
D D M M Y Y Y Y

Email address

Occupation

By providing your email address, you consent to receiving all future communications, including information about products and services offered by Resolution Life, to the above email address.*

In which industry do you work?

Employer name

Residence and Travel Details

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

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

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

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

Your Cover Details

☐ Death only
Amount of cover
$

☐ Death and TPD
Amount of cover
$

☐ Income Continuance
Amount of cover
$

☐ Trauma
Amount of cover
$

Current Annual Salary
$

*We may use or disclose your personal information to contact you for purposes relating to the administration, operation and management of your policies with us. We may also send you information about products and services offered by Resolution Life. You may opt out of receiving electronic marketing communications from us at any time.

Your Pursuits

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

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

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

   c. **Mountaineering/rock climbing** ☐ Yes ☐ No

   d. **Underwater diving** ☐ Yes ☐ No

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

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

NOTE: This is subject to approval by Resolution Life Underwriting.

If you answered yes to any of the pursuits in bold please complete the relevant questions within the Sports and Pastimes section of the Health, Sports and Pastimes Questionnaire.

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

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

Your Health

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

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

   If **yes,** on average, how many do you or did you smoke daily? ______ If you have stopped smoking. When did you stop? D D M M Y Y Y Y

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

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

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

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

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

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

   d. Diabetes or thyroid disorder? ☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

Your Health - continued

If you answered yes to any of the conditions in bold complete the relevant questions within the Health section of the Health, Sports and Pastimes Questionnaire.

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

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

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

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

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

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

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

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

   If **yes,** please provide details

8. **In the past 5 years have you:**

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

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

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

   If you answered yes to questions 8a, b or c, please provide name of doctor, date of consultation if known and condition.

   a.
   b.
   c.

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

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

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

Your Health - continued

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

If **yes,**

a. What is the expected date of birth?

D D M M Y Y Y Y

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

If **yes,** please provide details:

Other Insurance

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

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

If **yes,** provide details

Doctor Information

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

Name	Phone Number	Address

Please read - Important information, declaration and agreement

Duty of Disclosure

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

Any incorrect or misleading information or omission by you may affect your cover and/or entitlement to benefits.

Privacy Act Acknowledgement

Any personal information collected will be held by Resolution Life and used to evaluate and process this application (including completion of any necessary medical tests).

You authorise Resolution Life to use your information to:

- assess, and administer the claim, including obtaining advice and/or approvals in respect of that claim, managing any complaint or dispute that may arise in respect of the claim, and coordinating with any other insurer in respect of the assessment of the claim; and
- administer any insurance policies held with Resolution Life, including arranging and administering reinsurance in respect of insurance policies issued by Resolution Life.

You also authorise Resolution Life to disclose your information to its advisers, reinsurers and any other third party solely to the extent reasonably necessary for the above purposes. You also acknowledge that Resolution Life may be required to disclose your personal information if disclosure is required by law, for example where required by a government body or regulatory authority.

The information may also be used by Resolution Life or third parties to provide you with information about other products or serviced offered by Resolution Life. You have the right to ask for, see and, if incorrect, request correction of the information Resolution Life holds about you, by contacting **0800 808 267**.

References to “Resolution Life” includes the Resolution Life Group of companies, their subsidiaries (including Resolution Life Australasia Limited), associated companies, agents and companies authorised by Resolution Life to collect, administer and manage information on Resolution Life’s behalf.

The personal information will be held by Resolution Life, and may be held overseas. For further information regarding how Resolution Life collects, uses and stores your personal information please refer to our Privacy Policy which can be found at **resolutionlife.co.nz/privacy-policy**

Insurer Financial Strength Rating

Resolution Life Australasia Limited (Resolution Life) has an A (Strong) Insurer Financial Strength Rating given by Fitch Australia Pty Limited (Fitch Ratings), an approved rating agency, whose rating scale is set out below in summary form. For Fitch Rating’s full rating scale, please go to the Fitch Ratings website at **www.fitchratings.com**

Fitch Rating Scale

AAA Exceptionally strong	**AA** Very strong	**A** Strong	**BBB** Good	**BB** Moderately weak	**B** Weak	**CCC** Very weak	**CC** Extremely weak	**C** Distressed

Note: “+” or “-” may be appended to a rating to indicate the relative position of a credit within the rating category. Such suffixes are not added to ratings in the AAA category or to ratings below the CCC category.

Application and Declaration

PART A - APPLICATION TO RESOLUTION LIFE LIMITED

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

PART B - DECLARATIONS

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

I, PRINT FULL NAME OF LIFE TO BE INSURED

Date of birth D D M M Y Y Y Y

Signature of Life to be Insured

SIGN HERE

Dated D D M M Y Y Y Y

TOWN/CITY WHERE THIS WAS SIGNED

WEL231769 RL058 10/22

Resolution Life

Please send this completed form to:
askus@resolutionlife.co.nz
or
Resolution Life, PO Box 1692,
Wellington 6140, New Zealand
Please call us on **0800 808 267**
if you have any queries.

Resolution Workplace Protection

Health, Sports and Pastimes Questionnaires

If you answer 'yes' to any of the pursuits in **bold** in question 1 or the health conditions in **bold** in question 6 of the Resolution Life Workplace Protection Personal Statement, please complete the relevant parts of this questionnaire.

Detailed Health, Sports and Pastimes Questionnaires

Warning: You have a duty to **disclose all information** relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect or misleading information or omission by you may affect your entitlement to Benefits.

If you answered yes to any of the pursuits in **bold** in question 1 on page 2 of the Personal Statement, complete the relevant questionnaires below.

Title | First name(s) (please print) | Surname

Resolution Life Plan number | Member number (if known)

Aviation Questionnaire *(Relates to 1a on Personal Statement)*

a. Do you hold a current licence to fly aircraft? *(If yes, state type and period held)* ☐ Yes ☐ No

b. Do you intend to change the scope of your present licence? *(If yes, provide details)* ☐ Yes ☐ No

c. Have you ever had an accident or been charged with violating civil aviation regulations? *(If yes, provide details)* ☐ Yes ☐ No

d. Do you always use recognised airfields? *(If no, provide details)* ☐ Yes ☐ No

e. Provide details of type(s) of aviation you are involved in *(e.g. commercial, private, agricultural, aero club, helicopter, ultralight aircraft)*

f. Provide details of the number of hours flown

i. in total as a pilot | ii. in the last 12 months | iii. expected each year in the future

g. Do you intend to engage in any form of aviation other than the above categories? (e.g. ballooning, paragliding) *(If yes, provide details)* ☐ Yes ☐ No

Reminder: Complete the Declaration on page 8 once you have answered all relevant questions in this Questionnaire.

Detailed Health, Sports and Pastimes Questionnaires – *(continued)*

Warning: You have a duty to **disclose all information** relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect or misleading information or omission by you may affect your entitlement to Benefits.

If you answered yes to any of the pursuits in **bold** in question 1 on page 2 of the Personal Statement, complete the relevant questions below.

Title

First name(s) (please print)

Surname

Resolution Life Plan number

Member number (if known)

Motor Racing Questionnaire *(Relates to 1b on Personal Statement)*

a. Vehicle type

b. Engine size

c. Maximum speed

d. Number of times per year

e. Class i. Professional

ii. Amateur

f. Category of racing (e.g. touring cars)

g. Events (e.g. off-road or speedway)

Mountaineering/Rock Climbing Questionnaire *(Relates to 1c on Personal Statement)*

a. When did you commence mountaineering/rock climbing?

b. Do you climb, or intend to climb in New Zealand? *(If yes, provide details of locations)* Yes No

c. Do you climb, or intend to climb overseas? *(If yes, provide details of locations)* Yes No

d. To what maximum height do you climb? (metres)

e. On average, how many times a year do you climb?

f. i. Do you ever climb alone? Yes No

ii. Do you belong to a mountaineering club? Yes No

iii. Do you use breathing equipment? Yes No

iv. Do you climb in all seasons? Yes No

(If yes, provide details of locations)

g. Have you ever suffered any injury because of mountaineering or rock climbing? *(If yes, provide details of injury, treatment and recovery)* Yes No

Reminder: Complete the Declaration on page 8 once you have answered all relevant questions in this Questionnaire.

Detailed Health, Sports and Pastimes Questionnaires – *(continued)*

Warning: You have a duty to **disclose all information** relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect or misleading information or omission by you may affect your entitlement to Benefits.

If you answered yes to any of the pursuits in **bold** in question 1 on page 2 of the Personal Statement, complete the relevant questions below.

Title First name(s) (please print) Surname

Resolution Life Plan number Member number (if known)

Underwater Diving Questionnaire *(Relates to 1d on Personal Statement)*

a. Type of diving

b. Average depth

c. Maximum depth

d. Number of times per year

e. Class i. Professional

ii. Amateur

f. What certification do you hold?

g. Do you participate in sink hole, wreck or other hazardous diving? *(If yes, provide details, including how often)* Yes No

h. Do you dive at night? *(If yes, provide details)* Yes No

i. Have you ever had a diving accident or sickness? *(If yes, provide details)* Yes No

If you answered yes to any of the health conditions in **bold** in question 6 on page 2 of the Personal Statement, complete the relevant questions below.

Asthma Questionnaire *(Relates to 6e on Personal Statement)*

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

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

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

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

e. Do the attacks occur in a particular season or during exercise? *(If yes, provide details)* Yes No

f. How much time have you lost from work in the past due to asthma?

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

Reminder: Complete the Declaration on page 8 once you have answered all relevant questions in this Questionnaire.

Detailed Health, Sports and Pastimes Questionnaires – *(continued)*

Warning: You have a duty to **disclose all information** relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect or misleading information or omission by you may affect your entitlement to Benefits.

If you answered yes to any of the health conditions in **bold** in question 6 on page 2 of the Personal Statement, complete the relevant questions below.

Title | First name(s) (please print) | Surname

Resolution Life Plan number | Member number (if known)

Asthma Questionnaire *(Relates to 6e on Personal Statement) – (continued)*

h. Provide details of the doctor who you consult for your asthma:

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

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

k. Have you ever been hospitalised for asthma? *(If yes, provide details including dates)* ☐ Yes ☐ No

l. In the last three years, have you had a chest X-Ray or respiratory function test? *(If yes, provide details including dates)* ☐ Yes ☐ No

Depression/Anxiety/Nervous Condition Questionnaire includes stress, chronic fatigue and chronic pain syndrome *(Relates to 6f and 6g on Personal Statement)*

a. Have you ever suffered from, had treatment for, or been diagnosed with any of the following? Please tick appropriate boxes

- ☐ Stress
- ☐ Anxiety
- ☐ Chronic fatigue
- ☐ Depression
- ☐ Fears or phobias
- ☐ Chronic pain
- ☐ Inability to sleep
- ☐ Compulsive disorder
- ☐ Other – please specify
- ☐ OOS (Occupational Overuse Syndrome) /RSI (Repetitive Strain Injury)

b. What was the date of the **first** symptom? D D M M Y Y Y Y

c. What was the date of the **last** symptom? D D M M Y Y Y Y

d. Describe your symptoms fully

e. What was the cause of your disorder?

Reminder: Complete the Declaration on page 8 once you have answered all relevant questions in this Questionnaire.

Detailed Health, Sports and Pastimes Questionnaires – *(continued)*

Warning: You have a duty to **disclose all information** relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect or misleading information or omission by you may affect your entitlement to Benefits.

If you answered yes to any of the health conditions in **bold** in question 6 on page 2 of the Personal Statement, complete the relevant questions below.

Title | First name(s) (please print) | Surname

Resolution Life Plan number | Member number (if known)

Depression/Anxiety/Nervous Condition Questionnaire Includes stress, chronic fatigue and chronic pain syndrome *(Relates to 6f and 6g on Personal Statement) – (continued)*

f. How long did you suffer from the disorder?

g. Have you had any recurrence? *(If yes, provide full details)* Yes No

h. How long, if at all, have you been free of any signs or symptoms?

i. Provide details and nature of treatment for this condition, e.g. were you treated with tranquilisers or other drugs, did you undergo counselling, therapy or surgery?

j. When did treatment cease? *(If ongoing treatment – provide details, e.g. dosage and type of medication, counselling)* D D M M Y Y Y Y

k. Provide names and addresses of all doctors and health professionals consulted for these disorders, including approximate dates of consultations.

l. Name of doctor or health professional **last** consulted for this disorder and the date of the **last** consultation.

m. How much time have you lost from your employment due to this disorder?

n. Are you currently fit and well and able to do your work without stress or discomfort? *(If no, provide details)* Yes No

Reminder: Complete the Declaration on page 8 once you have answered all relevant questions in this Questionnaire.

Detailed Health, Sports and Pastimes Questionnaires – *(continued)*

Warning: You have a duty to **disclose all information** relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect or misleading information or omission by you may affect your entitlement to Benefits.

If you answered yes to any of the health conditions in **bold** in question 6 on page 2 of the Personal Statement, complete the relevant questions below.

Title

First name(s) (please print)

Surname

Resolution Life Plan number

Member number (if known)

Back/Neck Disorder Questionnaire Includes spinal condition, sciatica and whiplash
(Relates to 6i on Personal Statement)

a. ☐ Neck disorder ☐ Back disorder *(which part of the back is/was painful e.g. upper, lower, middle)*

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

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

Describe symptoms fully, including details of any radiation of pain down either the legs or arms:

d. What was the cause of the disorder (e.g. accident)?

e. Are you still receiving treatment? ☐ Yes ☐ No

f. What is or was the nature of the treatment? Include details of any medication, physical therapy or surgery

g. Have you had any investigations such as an X-Ray, CT Scan or MRI? *(If yes, what were the results?)* ☐ Yes ☐ No

h. Have you had any recurrence of this disorder? *(If yes, when and how often? Include number of recurrences, the causes and how long they lasted)* ☐ Yes ☐ No

i. Provide names and addresses of all doctors and health professionals consulted in relation to your back or neck disorder and approximate dates of consultations: ☐ Yes ☐ No

j. How long, if at all, have you been symptom free?

k. How much time have you lost from your employment due to this disorder?

Reminder: Complete the Declaration on page 8 once you have answered all relevant questions in this Questionnaire.

Detailed Health, Sports and Pastimes Questionnaires – *(continued)*

Warning: You have a duty to **disclose all information** relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect or misleading information or omission by you may affect your entitlement to Benefits.

If you answered yes to any of the health conditions in **bold** in question 6 on page 2 of the Personal Statement, complete the relevant questions below.

Title

First name(s) (please print)

Surname

Resolution Life Plan number

Member number (if known)

Arthritis, Joint or Muscle Disorder Questionnaires *(Relates to 6i on Personal Statement)*

a. State specific conditions/symptoms and diagnosis made:

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

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

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

e. Describe the symptoms fully

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

g. What was the nature of the treatment? *(If surgery, provide details, e.g. plates or screws inserted/removed, arthroscopy, etc.)*

h. Have you had any recurrence of this disorder? *(If yes, when and under what circumstances?)* ☐ Yes ☐ No

i. 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 consultations

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

k. How much time have you lost from your employment due to this disorder?

Reminder: Complete the Declaration on page 8 once you have answered all relevant questions in this Questionnaire.

Duty of Disclosure

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

Any incorrect or misleading information or omission by you may affect your cover and/or entitlement to benefits.

Privacy Act ("The Act")

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 Resolution Life already or in the future.

- The personal information collected will be held securely by Resolution Life and used to evaluate and process this application, to administer and service any product you have with Resolution Life, 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.
- You authorise Resolution Life to disclose your information to its advisers, reinsurers and any other third party solely to the extent reasonably necessary for the above purposes. You also acknowledge that Resolution Life may be required to disclose your personal information if disclosure is required by law, for example where required by a government body or regulatory authority.
- The Policy Owner may be told of your health assessment and may receive or provide, on your behalf any personal information for or related to, the purposes for which this application relates.
- The information may also be used to identify other products or services available by or through Resolution Life that may be suitable to your needs, and to offer those products to you.
- You have the right to ask and see the information Resolution Life holds about you. If you believe the information is wrong you may ask that it be corrected by contacting 0800 808 267.

For further information regarding how Resolution Life collects, uses and stores your personal information please refer to our Privacy Policy which can be found at **resolutionlife.co.nz/privacy-policy**

Insurer Financial Strength Rating

Resolution Life Australasia Limited (Resolution Life) has an A (Strong) Insurer Financial Strength Rating given by Fitch Australia Pty Limited (Fitch Ratings), an approved rating agency, whose rating scale is set out below in summary form. For Fitch Rating's full rating scale, please go to the Fitch Ratings website at **www.fitchratings.com**.

Fitch Rating Scale

AAA Exceptionally strong	**AA** Very strong	**A** Strong	**BBB** Good	**BB** Moderately weak	**B** Weak	**CCC** Very weak	**CC** Extremely weak	**C** Distressed

Note: "+" or "-" may be appended to a rating to indicate the relative position of a credit within the rating category. Such suffixes are not added to ratings in the AAA category or to ratings below the CCC category.

Declaration

1. I confirm the truth, accuracy and completeness of all statements given in this Questionnaire (whether in this Questionnaire form, given orally or in any other document in connection with this Questionnaire) which shall form the basis of any contract of insurance resulting from my personal statement and this supporting Questionnaire.
2. I have read and understand the section in this Questionnaire form headed 'Duty of Disclosure'. I understand that depending on my disclosure Resolution Life may request either: no further information; only specific information; or my full medical notes for the last five years. I recognise that Duty of Disclosure is not released solely because Resolution Life has requested my information from any health professional.
3. I have read and understand the section in this Questionnaire form headed 'Privacy Act'. I authorise Resolution Life to disclose any personal information about me that it holds to any person where that disclosure is necessary for one or more of the purposes for which the personal information was collected.

Signature of Life to be Insured

Print full name of Life to be Insured

Date of birth D D M M Y Y Y Y

Signature

SIGN HERE

Date signed D D M M Y Y Y Y

IMPORTANT INFORMATION *Please read*

Have you received financial advice on this product? (please tick) Yes ☐ No ☐

If yes, please ensure the following is completed by your Adviser.

For Adviser use only

I confirm I am: *(please tick one)* ☐ Financial Adviser ☐ Nominated Representative or ☐ Other (please specify) ____________

and I certify the information provided is correct and that I have complied with the requirements of the Financial Markets Conduct Act 2013, (as amended by the Financial Services Legislation Amendment Act 2019) and all other applicable laws.

Name ____________

FSPN: (please use Financial Advice Provider [FAP] FSPN if you are a Nominated Representative) ____________

WEL230664 RL097 06/22