RESET

Please send this completed form and supporting documents to:

NZRT Customer Services
Freepost 170, PO Box 55
Shortland Street, Auckland 1140
Email workplaceadmin@amp.co.nz

New Zealand Retirement Trust (NZRT)
Personal Statement for Superannuation Benefits

This form is to be completed by the person applying to be insured ("You"). You must answer every question (where applicable) fully and truthfully. Your answers help us to assess your insurance risk. 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.

(a) Your personal details

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

Gender
☐ Male ☐ Female

Date of birth
D D M M Y Y Y Y

First name(s)

Surname

Name of NZRT Superannuation Plan

Home address

Postcode

Home phone
( )

Work phone
( )

Mobile phone
( )

Personal email

Duty of Disclosure

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(b) Lifestyle and sports/pastimes

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

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

☐ Aviation ☐ Parachuting ☐ Hang-gliding ☐ Motor Sport (incl. car, bike, boat) ☐ Underwater Diving
☐ Caving ☐ Rock climbing ☐ Mountaineering ☐ Martial arts ☐ Rugby/Football
☐ Equestrian activity ☐ Other (please specify)

If you have answered Yes to any of the above, please complete details on the next page.

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(b) Lifestyle and sports/pastimes - continued

	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"geographically?		
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 ☐

If you need to list more than 2 activities, please use 'Additional notes' section on page 7.

(c) Residency and Travel section

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

   If 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 or the United Kingdom?** ☐ 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

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(d) Occupational details

1. What is your current occupation?

What is your current annual income?

Fully describe your duties:

Are you thinking of changing your job? ☐ Yes ☐ No

If Yes, please give full details:

(e) Details of other insurance

1. Do you already have Life, Lump Sum Disablement or Trauma Insurance with AMP or any other company, or are you currently applying for insurance with any other company? ☐ Yes ☐ No

If Yes, please give details below (*exclude this application*).

Company	Type of Insurance	Benefit amount	Reason for cover	Please tick one		
				Applied for	Current	To be replaced
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

2. Have you ever had an application for life cover declined, deferred or approved with special conditions (eg exclusions of loadings) applied? ☐ Yes ☐ No

If Yes, please give details below (*exclude this application*).

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(f) 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: 10g of pure alcohol; 30 ml of straight spirits, 100ml 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: _____

(g) 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. **What the consultation was for:**

6. **What was the outcome/result of the consultation:**

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(g) Doctor information - continued

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

If 'Yes', please provide Specialist details:

Doctor's name

Doctor's address

How long have you been a patient of this doctor or medical clinic? ☐☐ months ☐☐ years

What was the approximate date of your last consultation? D D M M Y Y Y Y

What was the purpose and the outcome/result of the consultation?

If this doctor does not hold your full medical details, who does?

(h) Family history

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

Family member *(e.g. mother, father, etc.)*	**Condition / Illness** *(*if cancer or heart disease, please specify type)*	**Age at onset** *(approximate)*	**Age at death** *(if applicable)*

(i) 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 ☐

(j) 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:

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(k) 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)?

Please note, the following are only examples, if you have had a medical condition that is not listed, tick the 'other' box.

If condition or disorder is in **bold**, please complete a Health Questionnaire, available from your Adviser or our Customer Service Team on **0800 800 267**. For any other conditions or disorders, please complete the Health Information Table in section (l) overleaf.

A. Heart, blood vessel or other blood circulation disorder

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

B. Blood disorders

- ☐ Anaemia
- ☐ Haemophilia
- ☐ Haemochromatosis
- ☐ Other
- ☐ No

C. Lung or other breathing/respiratory disorder

- ☐ **Asthma**
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ No
- ☐ Pleurisy
- ☐ Other
- ☐ Sleep apnoea

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

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

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

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

F. Brain, neurological or other nerve pathway disorder

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

G. Psychiatric or psychological disorder (including stress)

- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Schizophrenia**
- ☐ **Panic attack**
- ☐ No
- ☐ **Breakdown**
- ☐ **Stress -** (worrying enough for you to talk to Doctor/Counsellor)
- ☐ **Suicide attempt**
- ☐ **Post traumatic stress disorder (PTSD)**
- ☐ **Other**

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

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

I. Bone, joint, muscle, ligament, cartilage, limb or other musculo-skeletal disorder, pain, or strain or injury

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

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(k) Health details – continued

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

☐ Psoriasis ☐ Hearing disorder ☐ Tinnitus ☐ Dermatitis ☐ No

☐ Allergic or chemical sensitivity reaction ☐ Eye or Vision Disorder (excluding prescription glasses) ☐ Other

K. Other condition

☐ **Diabetes** ☐ Rheumatoid arthritis ☐ Chronic fatigue ☐ Thyroid disorder ☐ No

☐ Gout ☐ Fibromyalgia ☐ Abnormal blood sugar ☐ Insulin resistance

☐ Chronic pain ☐ Other

L. Other than details covered in A-K above:

Have you taken regular medication, or had any medical procedure, consultation, investigation or test in the last five years or are you considering seeking medical advice? ☐ Yes ☐ No

If Yes, please provide details in the Health Information tables in Section (l). *(You don't need to mention cold/flu medicine or contraceptive medication.)*

M. Have you ever used recreational drugs (such as heroin, cocaine, amphetamines, barbiturates, etc.) or received advice or treatment for alcohol use? ☐ Yes ☐ No

If Yes, please provide details in the Health Information tables in Section (l).

(l) Health information table

If you answered Yes to any of the Questions in (j) Health Details, please provide details in the table below.

Q. no	Condition	Symptoms		Treatment	Test results *(None, Normal, Other - please specify)*	Time off work	Dr/Hospital
		Start date	Date ceased				

Addtional notes

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(m) Privacy Act 1993 Acknowledgement

This statement 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 will be 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 services may be withdrawn.
- The information may also be used to identify and offer other products or services available from or through AMP that may be suitable to your needs.
- AMP includes all the members of the AMP Group of companies and their subsidiaries, associated companies and agents.
- AMP holds information about you securely. It does not share with or sell my personal information to others outside of AMP.
- You have the right to ask, see and if incorrect, request correction of the information AMP holds about you by contacting Customer Services on **0800 800 267**.

(n) Declaration

I declare that:

- I have answered all the questions in the Personal Statement truly 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 back nothing that might cause you to assess me as a greater risk to insure. 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.
- I authorise any Medical Practitioners who have been or who may in the future be consulted by me, to disclose to AMP or any Legal Tribunal any information which they may have acquired with regard to myself. I have read and understand the section in this application headed 'Privacy 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.
- 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.

Signature of Proposed Person Insured

Date D D M M Y Y Y Y

At

In the presence of:
(Name of Witness)

Signature of Witness

Date D D M M Y Y Y Y