Assurance Extra/Mortgage Extra/Medical Extra
Amendment Form

nib

nib policy number | | | | | | | | |

Policyowner name(s):

1.0 Amending Existing Policy

This application is for:	Applicant Name:	Applicant Name:	Applicant Name:	Applicant Name:	Applicant Name:	Applicant Name:
Adding a new person to the policy Please complete sections 1.1 – 6.0	◯	◯	◯	◯	◯	◯
Reducing the Major Medical excess to: ◯ nil ◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 Please complete sections 3.0 – 6.0	◯	◯	◯	◯	◯	◯
Reducing the Optional Specialists and Tests Benefit excess to $250 Please complete sections 3.0 – 6.0	◯	◯	◯	◯	◯	◯
Reducing the stand down period for Premium Cover to: ◯ 4 weeks ◯ 8 weeks ◯ 13 weeks ◯ 26 weeks ◯ 52 weeks Please complete sections 3.0 – 6.0	◯	◯	◯	◯	◯	◯
Adding options to Major Medical base cover Please complete sections 3.0-6.0 ◯ Optional Specialists and Tests Benefit with $250 excess ◯ Optional Major Medical Deluxe	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Adding Premium Cover to Assurance Extra and Mortgage Extra policies only Please complete sections 3.0-6.0 Premium Cover with the following waiting period: ◯ 4 weeks ◯ 8 weeks ◯ 13 weeks ◯ 26 weeks ◯ 52 weeks Applicants for Premium Cover must be aged between 18 and 55	◯	◯	◯	◯	◯	◯

Please call us on **0800 123 642** if you would like to:

a) increase your Major Medical excess; or

b) increase your Optional Specialists and Tests Benefit excess to match your Major Medical excess; or

c) increase your Premium Cover waiting period.

1.1 Adding second Policyowner

Applying to be insured ◯ Yes ◯ No

If the second Policyowner is not applying to be insured, sections 3.0 - 6.0 are not required for this applicant.

Applicant details

Title ◯ Mr Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other:

Surname

First name(s)

Date of birth d d m m y y y y

Gender ◯ Male ◯ Female

Occupation

Height (cm) Weight (kg)

Have you smoked any form of tobacco or any other substance in the last 12 months? ◯ Yes ◯ No

Are you a permanent New Zealand resident or New Zealand or Australian citizen residing in New Zealand? ◯ Yes ◯ No

If "No", do your work permits add up to at least two consecutive years, with 12 months or more left until expiry?
◯ Yes (please attach a copy of your passport and permits)
◯ No (unfortunately nib cannot offer you health insurance at this time)

Contact details

Home phone ( )

Work phone ( )

Mobile ( )

Email ( )

1.2 Additional applicants aged 16 and over

Note: Additional applicants cannot be Policyowners.

All applicants aged 16 and over must sign the declaration on page 12.

Applicant details

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other:

Surname

First name(s)

Date of birth d d m m y y y y

Gender ◯ Male ◯ Female

Occupation

Height (cm) Weight (kg)

Have you smoked any form of tobacco or any other substance in the last 12 months? ◯ Yes ◯ No

Are you a permanent New Zealand resident or New Zealand or Australian citizen residing in New Zealand? ◯ Yes ◯ No

If "No", do your work permits add up to at least two consecutive years, with 12 months or more left until expiry?
◯ Yes (please attach a copy of your passport and permits)
◯ No (unfortunately nib cannot offer you health insurance at this time)

Contact details

Home phone ( )

Work phone ( )

Mobile ( )

Email

Applicant details

Surname

First name(s)

Date of birth d d m m y y y y

Gender ◯ Male ◯ Female

Occupation

Height (cm) Weight (kg)

Have you smoked any form of tobacco or any other substance in the last 12 months? ◯ Yes ◯ No

Are you a permanent New Zealand resident or New Zealand or Australian citizen residing in New Zealand? ◯ Yes ◯ No

If "No", do your work permits add up to at least two consecutive years, with 12 months or more left until expiry?
◯ Yes (please attach a copy of your passport and permits)
◯ No (unfortunately nib cannot offer you health insurance at this time)

Contact details

Home phone ( )

Work phone ( )

Mobile ( )

Email

1.3 Additional applicants under age 16

Note: A parent or legal guardian must sign the declaration on page 12 for all applicants under age 16. The parent / legal guardian must be eligible for publicly funded health services.

Applicant details

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

Applicant details

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

Applicant details

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

Applicant details

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

Note: if there is not enough space for details of relevant persons to be insured, please complete an additional application form for those persons.

2.0 Premium payment details

We will continue to deduct premium from your current payment type and on the same frequency. If you pay by credit card or direct debit, we will amend your existing payment instruction (if applicable) and send you notice of your new premiums.

2.1 Effective date / Join date

The requested change to your policy will be made on the same (or nearest equivalent) date in the month that corresponds to the date in the month of your policy anniversary date, immediately after you request this change.

For example, if the policy anniversary date is 30 September and you request a change on 15 June, the effective date / join date (as applicable) of the change will be 30 June.

3.0 Full health declaration

To be completed in respect of all applicants named in section 1.1 to 1.3. If there are more than six applicants in total, additional applicants must complete a separate application form.

Important: This is a material part of your application. You must disclose details of any sign, symptom, treatment or surgery of any medical condition. When in doubt, disclose. If you experience any change in health before you receive your acceptance certificate you must let us know. Please refer to Section 6.0, 'All information is true, correct and complete'.

3.1 Health conditions

Have you ever been diagnosed with, had signs, symptoms, treatment or surgery of, or are you currently experiencing any of the following (whether or not medical advice has been sought)?	Applicant name:	Applicant name:	Applicant name:	Applicant name:	Applicant name:	Applicant name:
(a) Diabetes, abnormal blood sugar, insulin resistance, thyroid disorder or any other glandular condition	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(b) **Any breathing problems including asthma, lung, chest, respiratory disorders or bronchitis, TB, emphysema** (If "Yes", please complete the "Asthma or Respiratory Disorders" questionnaire in section 4.1)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(c) Liver disease or disorder (e.g. hepatitis, abnormal liver function tests)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(d) Kidney disease, kidney stones or kidney infections	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(e) **Epilepsy, neurological disease, multiple sclerosis, paralysis or stroke, dizzy spells, migraines, head injury, Parkinson's disease or transient ischaemic attack** (If "Yes", please complete the "Neurological Disorders" questionnaire in section 4.2)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(f) **Arthritis, rheumatism, gout, occupational overuse syndrome, or any disease or disorder, injury or ongoing pain to muscles, bones, tendons or joints, including hips, shoulders, back, neck, knees or wrists** (If "Yes", please complete the "Musculoskeletal Disorders" questionnaire in section 4.3)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(g) Bowel disorder, ulcers, colitis, ongoing abdominal pain, or any other disease / disorder of the gastro-intestinal tract, pancreas, or gall bladder	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(h) Hernia (e.g. hiatus, inguinal, umbilical or incisional)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(i) **High blood pressure and / or raised cholesterol** (If "Yes", please complete the "High Blood Pressure or Raised Cholesterol" questionnaire in section 4.4)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(j) **Rheumatic fever, heart murmur, heart disease or disorder (e.g. angina)** (If "Yes", please complete the "Heart Condition" questionnaire in section 4.5)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(k) **Indigestion, reflux, difficulty with swallowing or undiagnosed chest pain** (If "Yes", please complete the "Indigestion, Reflux or Undiagnosed Chest Pain" questionnaire in section 4.6)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(l) **Cancer, tumour, cyst, breast lump, moles, skin or any other lesion, abscess or ulcer** (If "Yes", please complete the "Cysts, Lesions or Tumours" questionnaire in section 4.7)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(m) Psoriasis, eczema or any other disorder of the skin, or any other allergic or chemical sensitivity reaction	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(n) Varicose veins, haemorrhoids, rectal bleeding, blood or bleeding disorder (e.g. anaemia or haemophilia)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(o) Eye disease or vision disorder other than wearing glasses (e.g. cataracts or glaucoma)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(p) **Disease of the ears, nose or throat including sinusitis, recurrent sore throat, tonsillitis, ear infections, or hay fever** (If "Yes", please complete the "Ear, Nose and Throat Disorders" questionnaire in section 4.8 and 4.9)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(q) Disease or disorder of the mouth / oral cavity including unerupted or impacted wisdom teeth (do not declare routine / orthodontic dental treatment)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(r) **Males only** – prostate condition, increased urinary frequency or urgency, slow urinary stream or problems passing urine, or sexual dysfunction likely to require treatment	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(s) **Females only** – abnormal cervical smear, endometriosis, pelvic examinations, irregular, heavy or painful menstrual bleeding, miscarriages, pregnancy complications, abnormal mammograms, abnormal ultrasounds or pelvic organ prolapse	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(t) Other genito-urological disorders, including urinary tract infections, blood in the urine, hypospadias, disease or disorder of the bladder, urethra, ureters, and testicles	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
(u) Any other illness, injury, condition, medical treatment, surgery or medication not covered above	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Note: If any questions in bold are answered "Yes", please complete the appropriate "Specific health questionnaire(s)" in sections 4.1 to 4.9. For all other questions that are answered "Yes", please provide further details in "Additional health information" in section 3.2.

3.2 Additional health information

This section must be completed if any questions in section 3.1 were answered "Yes", except those in bold, which are covered by the "Specific Health questionnaires" in sections 4.1 to 4.9. If more space is required, please use section 5.0 "Additional notes and information" on page 11.

Condition one

Name of condition

Applicant name

Question number

Date first diagnosed d d m m y y y y

Duration of condition

Date of full recovery d d m m y y y y

Symptoms (type, frequency and severity)

Investigation / treatment (tests, surgery, drugs / medication etc)

Have you ever been hospitalised or had any time off work or school as a result of this condition? ◯ Yes ◯ No
If "Yes", please provide details

Condition two

Name of condition

Applicant name

Question number

Date first diagnosed d d m m y y y y

Duration of condition

Date of full recovery d d m m y y y y

Symptoms (type, frequency and severity)

Investigation / treatment (tests, surgery, drugs / medication etc)

Have you ever been hospitalised or had any time off work or school as a result of this condition? ◯ Yes ◯ No
If "Yes", please provide details

Condition three

Name of condition

Applicant name

Question number

Date first diagnosed d d m m y y y y

Duration of condition

Date of full recovery d d m m y y y y

Symptoms (type, frequency and severity)

Investigation / treatment (tests, surgery, drugs/medication etc)

Have you ever been hospitalised or had any time off work or school as a result of this condition? ◯ Yes ◯ No
If "Yes", please provide details

Condition four

Name of condition

Applicant name

Question number

Date first diagnosed d d m m y y y y

Duration of condition

Date of full recovery d d m m y y y y

Symptoms (type, frequency and severity)

Investigation / treatment (tests, surgery, drugs/medication etc)

Have you ever been hospitalised or had any time off work or school as a result of this condition? ◯ Yes ◯ No
If "Yes", please provide details

3.3 Premier Cover

Only complete this section if you are applying to add or amend Premium Cover

Have any of your birth parents, brothers or sisters suffered from a stroke, bowel cancer, breast cancer, prostate cancer, heart condition, high blood pressure, raised cholesterol, diabetes, Huntington's disease, motor neurone disease, haemochromatosis, polycystic kidney disease or any other hereditary disorder? (If "Yes", please give details below) ◯ Yes ◯ No

Applicant name	Relationship	Condition	At what age did the family member suffer the condition?	Has this family member died before age 60?
				◯ Yes ◯ No
				◯ Yes ◯ No

Note: If you need more space, please use section 5.0 "Additional notes and information" on page 11

4.0 Specific health questionnaires

4.1 Asthma or respiratory disorders	Applicant name:	Applicant name:
(a) What respiratory disorder do you suffer from?		
(b) How old were you when you first suffered from the condition?		
(c) How often do you suffer from symptoms?		
(d) How long do the symptoms last for?		
(e) When did you last suffer from symptoms?		
(f) How often do you have an acute attack?		
(g) When was your last acute attack?		
(h) Are you on any medication to control your condition?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details, including type of medication, dosage and frequency		
(i) Have you required any time off work or school in the past five years as a result of this condition?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details, including number of times and average duration		
(j) Have you ever been hospitalised because of this condition?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(k) Have you ever been prescribed steroids, e.g. Prednisone?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(l) Have you or your doctor measured your peak flow in the last two years?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give the reading		

4.2 Neurological disorders	Applicant name:	Applicant name:
(a) Please name and state the health condition, (e.g. epilepsy, migraine, stroke, tremor etc)		
(b) When did you have your first attack or symptoms?		
(c) Please give details on the nature and duration of any medical treatment and date of last attack		
(d) What is the frequency of attacks / symptoms?		
(e) How long do the attacks / symptoms last?		
(f) Have you been referred to a specialist for treatment or investigation?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(g) Please give details of any ongoing treatment or medication required		

4.3 Musculoskeletal disorders	Applicant name:	Applicant name:
(a) Name of condition and body part affected		
(b) For spinal please specify area (e.g. neck, upper, mid or lower)		
(c) For limbs please specify left, right or both		
(d) When did you first suffer from this condition?		
(e) How severe is / was the pain?	◯ Mild ◯ Moderate ◯ Severe	◯ Mild ◯ Moderate ◯ Severe
(f) How often do you experience symptoms?		
(g) How long do the symptoms last?		
(h) What was the cause of this condition?		
(i) Do you or have you ever had pain, numbness or pins and needles in your arms, shoulders, buttocks or legs?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(j) Has this condition occurred more than once?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(k) Have you had any special investigations, X-rays, MRI, CT-scan or surgery?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(l) Have you ever had any time off work or school as a result of this condition?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(m) Please advise when you last experienced symptoms?		
(n) Please advise when you last had treatment for the condition (including surgery, medication, steroid injection, physio, chiropractic treatment)		
(o) Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery may be required?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		

4.4 High blood pressure or raised cholesterol	Applicant name:	Applicant name:
(a) Name of condition		
(b) Please advise how long ago you started being treated for this condition		
(c) What is your current medication?		
(d) Has your treatment changed in the last 12 months?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details and reason		
(e) How often is your condition checked?		
(f) For high blood pressure please advise your last three readings (most recent first). For raised cholesterol please advise your most recent result including total cholesterol, HDL, LDL, triglycerides and ratio. You may need to contact your practice nurse to provide this information prior to responding		
(g) Have you ever been referred to a specialist for treatment or investigation?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details, eg when, treatment and dosage		
(h) If you suffer from high blood pressure, has your blood cholesterol or lipids been measured?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		

4.5 Heart condition	Applicant name	Applicant name
(a) Name of the condition you suffer (or suffered)		
(b) How old were you when you first suffered the condition?		
(c) What treatment or surgery did you have?		
(d) Are there any residual effects?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(e) Have you been referred to a specialist for treatment or investigation?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(f) Please give details of any ongoing treatment or medication required		

4.6 Indigestion, reflux or undiagnosed chest pain	Applicant name:	Applicant name:
(a) Do you suffer from Please tick the condition	◯ Indigestion ◯ Chest pain ◯ Reflux	◯ Indigestion ◯ Chest pain ◯ Reflux
(b) What was the date you first noticed the symptoms?		
(c) Do you still suffer from these symptoms?	◯ Yes ◯ No	◯ Yes ◯ No
(d) Are the symptoms	◯ Mild ◯ Moderate ◯ Severe	◯ Mild ◯ Moderate ◯ Severe
(e) Please give details of the type of treatment and the duration		
(f) Have you ever been referred to a specialist for treatment or investigation?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details with dates and results		

4.7 Cancer, cysts, lumps, lesions or tumours	Applicant name:	Applicant name:
(a) Name and location of the condition		
(b) Please identify the histology	◯ Malignant or pre-malignant ◯ Benign ◯ Unknown	◯ Malignant or pre-malignant ◯ Benign ◯ Unknown
(c) How long ago was the initial diagnosis made? (Years / months)		
(d) Have you received any treatment in the last three years?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(e) Has the cyst / lesion / tumour been excised or removed?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details when it was excised or removed		
(f) Has there been any recurrence?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(g) Are you on any ongoing follow-up or have you been advised that a follow-up or further treatment is required?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		

4.8 Ear disorders	Applicant name:	Applicant name:
(a) Name of condition and when diagnosed		
(b) Describe the treatment you have received		
(c) Have you ever been referred to an ear, nose and throat specialist for treatment or investigation?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details		
(d) If your condition is ear infection please complete the following:		
(i) Date of last ear infection		
(ii) How frequent are the infections	per month / per year (delete one)	per month / per year (delete one)
(iii) Have you ever been examined for glue ear?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details and dates		
(iv) Have you ever had grommets inserted or been advised that grommets may be necessary?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes", please give details and dates when the grommets were inserted		

Please answer the following for all ear disorders:

(e) Please advise when you last experienced symptoms		
(f) Please advise when you last received treatment? Please give details including surgery and medication		

4.9 Nose, sinus and throat disorders	Applicant name:	Applicant name:
(a) Do / did you have any of the following:	◯ Nasal blockage ◯ Polyps ◯ Rhinitis or Hayfever ◯ Tonsillitis ◯ Adenoiditis	◯ Nasal blockage ◯ Polyps ◯ Rhinitis or Hayfever ◯ Tonsillitis ◯ Adenoiditis
Please give details including frequency of symptoms and when your last episode occurred		
(b) Please describe the treatment you have received?		
(c) Have you ever been referred to an ear, nose and throat specialist for treatment?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes" please give details including dates		
(d) Has a full recovery been made?	◯ Yes ◯ No	◯ Yes ◯ No
If "Yes" please advise when you last had treatment including medication and / or surgery		

5.0 Additional notes and information

Question number	Applicant name	

6.0 Important information and declaration

Commencement of the policy

Cover will commence on the date shown on the acceptance certificate as the commencement date (new policy), effective date (changes to policy) or join date (new person on policy) (as applicable), subject to any waiting period.

Privacy Act 1993 and Health Information Privacy Code 1994

This application collects your personal and health information.

The information we collect is used to:

- provide benefits for health and related services;
- determine eligibility to provide or receive an nib health or related service;
- administer this policy; and
- promote or market our current and future health and related services.

In providing our health and related services and using personal information in accordance with this policy, we may be required to collect information from or disclose an insured person's personal information to:

- Other nib companies.
- Your financial adviser.
- Health service providers including private health insurers, recognised private hospitals and public hospitals, doctors and medical specialists, and professional medical authorities, including the ACC and the Ministry of Health.
- Our contractors and service providers performing services including (but not limited to) legal services, marketing, market research, mail house services, and product development services.
- Our existing and future strategic partners in respect of co-branded covers and services.

Each policyowner and insured person authorises the collection of this information from and the disclosure of this information to such parties for the purposes set out above.

We may also be required to disclose an insured person's personal information to other individuals on their nib policy, or to individuals to whom the insured person has granted authority to act on their behalf. You authorise us to share information with other individuals on the policy.

The accuracy of personal information is important to us. We will take reasonable steps to ensure an insured person's personal information is accurate, complete and up-to-date. We rely on the insured person to advise of any changes to their contact details and any other personal information.

Where possible please provide an email address.

If an insured person believes that any personal information we hold is not accurate, complete or up-to-date, the insured person should contact us immediately.

Your personal information is collected and held by nib nz limited, 48 Shortland Street, Auckland.

Policy terms

If an illustration is attached to this application it forms part of the application and sets out the nib cover that you are applying for. The terms of your policy are set out in the Contract of Insurance for the nib cover you have selected. nib may accept the application on non-standard terms and this will be set out in the acceptance certificate or renewal certificate (whichever is the later). Each nib cover can be amended from time to time in accordance with its terms.

All information is true, correct and complete

Although we may obtain information from other parties (see nib's privacy policy) or from our historic files, we are not required to do so. All information must be disclosed in this application.

Each policyowner and insured person declares that all information given by them is true, correct and complete. If it is not, we may, at our discretion, cancel this policy from the commencement date, effective date or join date (as applicable).

If we cancel this policy, any premiums paid may be retained by us. If we have already made any claims payments, we may recover these from the policyowner.

If you have provided information on behalf of another person, you confirm that you are authorised to do so.

Signatures

Note: Before signing, please ensure you have answered all the questions and have read and understood section 6.0 'Important information and declaration' above.

Policyowner(s) and applicants aged 16 and over

To be signed by all additional applicants aged 16 and over, and existing policyowner(s).

Full name of applicant(s)	Date	Signature of applicant(s)
	d d m m y y y y	
	d d m m y y y y	
	d d m m y y y y	
	d d m m y y y y	

Applicants under age 16

To be signed on behalf of all applicants under age 16 by the relevant applicant's parent / legal guardian.

Note: The parent / legal guardian must be eligible for publicly funded health services.

Full name(s) of applicant(s)	Full name(s) of Parent / legal guardian(s)	Date	Signature of Parent / legal guardian(s)
		d d m m y y y y	
		d d m m y y y y	
		d d m m y y y y	
		d d m m y y y y	

Sign here

7.0 To be completed by the Adviser

Internal use only: Client number: Staff number:

Adviser nib UAN number:

Name of adviser:

Phone: ( )

Agreement number: B

Additional commission will be calculated on the same basis as the in-force policy.

To speed up acceptance of this application, may we contact your client directly for any underwriting requirements? ○ Yes ○ No

If yes, a copy of the information will be provided to you with the offer of terms. If no, we will forward any requirements directly to you.

Should any pages of this application not be received by nib, it will be assumed these pages are blank.

Checklist

Please check that you have completed the following:

- ○ Answered all the questions.
- ○ Provided additional information in the appropriate questionnaire if a question requires more details to be provided.
- ○ Carefully read and signed the 'Important information and declaration' section on page 12.
- ○ If any information has been completed on a separate sheet, it have been attached to this application, signed and dated.
- ○ If any person is not a permanent New Zealand resident or New Zealand or Australian citizen, a copy of their work permit(s) and passport has been attached to this application.

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nib

For more information

nib nz limited

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AFAPP 06-16
nib363901_0616
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