Premier Health Business™ / Priority Health Business™
Full Application Form

Policy number | Group number | Adviser number

Group name

This application is for: ◯ A new Premier Health Business policy ◯ A new Priority Health Business policy
◯ Adding an Option / module ◯ Adding a person ◯ Changing an excess

1.0 Details of the cover

1.1 Premier Health Business policy Options

Additional Options chosen for this policy

◯ Specialist Option ◯ GP Option ◯ Proactive Health Option
◯ Dental, Optical and Therapeutic Option
◯ Non-PHARMAC Plus Option
◯ $20,000 ◯ $50,000
◯ $100,000 ◯ $200,000
◯ $300,000

Serious Condition Lump Sum Option:

Employee: ◯ $20,000 ◯ $50,000
Spouse / Partner: ◯ $20,000 ◯ $50,000

1.2 Priority Health Business policy modules

Additional modules chosen for this policy

◯ Module 1: Other Surgical Cover
◯ Module 2: Cancer and Non-Surgical Hospitalisation Cover
◯ Module 3: Trauma Cover
Employee: ◯ $10,000 ◯ $20,000 ◯ $50,000
Spouse / Partner: ◯ $10,000 ◯ $20,000 ◯ $50,000
◯ Module 4: General Practitioner (GP) Cover
◯ Module 5: Specialist and Other Diagnostic Cover
◯ Non-PHARMAC Plus Option
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000

If you'd like to select different Options for people on the same policy, each person will need to complete a separate application form.

1.3 Excess options

The excess amount you currently have will depend on what has been negotiated for your group.
Please contact nib for the options applicable to you.

◯ Nil ◯ $250 ◯ $500 ◯ $1000 ◯ $2000 ◯ $4000 ◯ $6000 ◯ Other excess amount as negotiated by my employer

2.0 Details of person(s) to be insured (applicants)

2.1 Personal details – employee

Note: Employee is always a policyowner

Applying to be insured? ◯ Yes ◯ No

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

Surname

First name(s)

Employee start date d d m m y y y y

Employee number

Site location

Employee status ◯ Full time ◯ Part time

Date of birth d d m m y y y y

Gender assigned at birth ◯ Male ◯ Female

Height (cm) Weight (kg)

Occupation

Have you smoked any form of tobacco, e-cigarettes, vaping or other substance in the last 12 months? ◯ Yes ◯ No

Are you a permanent New Zealand resident, 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 11 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)

2.2 Personal details – spouse / partner (if applicable)

Policyowner ◯ Yes ◯ No

Applying to be insured? ◯ Yes ◯ No

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

Surname

First name(s)

Date of birth d d m m y y y y

Gender assigned at birth ◯ Male ◯ Female

Height (cm) Weight (kg)

Occupation

Have you smoked any form of tobacco e-cigarettes, vaping or other substance in the last 12 months? ◯ Yes ◯ No

Are you a permanent New Zealand resident, 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 11 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)

2.0 Details of person(s) to be insured (applicants) – Continued

Contact details
Home phone ( )
Work phone ( )
Mobile ( )
Email ( )

Contact details
Home phone ( )
Work phone ( )
Mobile ( )
Email ( )

All correspondence will be sent to the email address of the policyowner(s) where a valid email address is provided.

2.3 Details of children to be covered under policy

Includes dependent children under age 21 **Note:** If there are more than four dependent children to be covered, please provide details in **section 6.0** "Additional notes and information".

Child one
Surname
First name(s)
Gender assigned at birth ◯ Male ◯ Female
Date of birth
If child is 12 years or above please complete the following:
Height (cm) Height (kg)

Child three
Surname
First name(s)
Gender assigned at birth ◯ Male ◯ Female
Date of birth
If child is 12 years or above please complete the following:
Height (cm) Height (kg)

Child two
Surname
First name(s)
Gender assigned at birth ◯ Male ◯ Female
Date of birth
If child is 12 years or above please complete the following:
Height (cm) Height (kg)

Child four
Surname
First name(s)
Gender assigned at birth ◯ Male ◯ Female
Date of birth
If child is 12 years or above please complete the following:
Height (cm) Height (kg)

3 Premium payment details

I / we wish to pay our premiums

◯ By the alternate payment method as negotiated by my employer

◯ Monthly by direct debit (Please complete the attached Direct Debit Authority)

3.1 Start date

The start date is the nearest group billing cycle date, immediately after the application is received by nib.

4.0 Full health declaration

To be completed in respect of the first and second applicants, and any children named in **section 2.3.**
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.

4.1 Health conditions

Have you ever been diagnosed with, had signs or 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 5.1)	◯ 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 5.2)	◯ 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 5.3)	◯ 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 5.4)	◯ 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 5.5)	◯ 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 5.6)	◯ 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 5.7)	◯ 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 5.8 and 5.9)	◯ 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 disorders 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 5.1 to 5.9**.
For all other questions that are answered "Yes", please provide further details in "Additional health information" in **section 4.2.**

4.2 Additional health information

This section must be completed if any questions in **section 4.1** were answered "Yes", except those in bold, which are covered by the "Specific Health questionnaires" in **sections 5.1 to 5.9**. If more space is required, please use **section 6.0** "Additional notes and information".

Condition one	Question number
Applicant / Child name	
Name of condition	
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? If "Yes", please provide details.	◯ Yes ◯ No

Condition two	Question number
Applicant / Child name	
Name of condition	
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? If "Yes", please provide details.	◯ Yes ◯ No

Condition three	Question number
Applicant / Child name	
Name of condition	
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? If "Yes", please provide details.	◯ Yes ◯ No

Condition four	Question number
Applicant / Child name	
Name of condition	
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? If "Yes", please provide details.	◯ Yes ◯ No

4.3 Premier Health Business Serious Condition Lump Sum Option / Priority Health Business. Module 3: Trauma Cover

Only complete this section if you are applying for Premier Health Business Serious Condition Lump Sum Option or Priority Health Business Module 3: Trauma Cover.
Note: This Option is only available to applicants age 16 to 70.

Have any of your birth parents, brothers or sisters suffered from a stroke, bowel cancer, prostate cancer, breast 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 6.0 "Additional notes and information".

5.0 Specific health questionnaires

5.1 Asthma or respiratory disorders		Applicant / Child name:	Applicant / Child 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, eg 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		

5.2 Neurological disorders		Applicant / Child name:	Applicant / Child name:
(a)	Please state 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		

5.3	Musculoskeletal disorders	Applicant / Child name:	Applicant / Child 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		

5.4	High blood pressure or raised cholesterol	Applicant / Child name:	Applicant / Child 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		

5.5	Heart condition	Applicant / Child name:	Applicant / Child 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		

5.6	Indigestion, reflux or undiagnosed chest pain	Applicant / Child name:	Applicant / Child 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		

5.7	Cysts, lesions or tumours	Applicant / Child name:	Applicant / Child name:
Please complete this section for cancer, tumour, cyst, breast lump, moles, skin or any other lesion or abscess			
(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		

5.8	Ear disorders	Applicant / child name:	Applicant / child 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		

5.9	Nose, sinus and throat disorders	Applicant / child name:	Applicant / child 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		

6.0 Additional notes and information

Question Number	Applicant / Child name	

7.0 Business replacement

The Financial Markets Conduct Act requires Advisers to exercise care, diligence and skill when providing clients with financial advice. That advice should include an accurate explanation of the differences between your existing and proposed policy/benefits, the advantages and disadvantages of switching, and the reasons why replacement is your best option.

Note: If your or a previously insured person's health has changed since the start date of the policy(ies) to be replaced, you may not be able to obtain the same acceptance terms. If the existing policy is with another insurer, you'll need to contact the old insurer directly to cancel the policy. We strongly suggest you do not cancel any existing policy until everything necessary has been disclosed to nib, the new policy has been issued and you are happy that you and any previously insured persons are appropriately insured.

Business replacement advice

Is this application for health insurance to replace any existing health insurance policy for any of the lives insured, or any health insurance policy that has been cancelled in the last six months? ○ Yes ○ No

Applicant to confirm:

I confirm that I have been provided with all the information and advice in relation to moving the health insurance for all lives insured to nib, or replacing an existing nib policy.

Adviser to confirm:

I, _____ confirm that I have provided the applicant(s) all the necessary information and advice for them to make an informed decision to move their insurance to nib, or replace an existing nib policy. I confirm that this change is in the best interests of the applicant(s).

8.0 Important information and declaration

Start of cover
Cover commences under the nib health policy on the date shown on the Acceptance Certificate for the applicable:

- start date (new policy), or
- join date (new person on policy)

subject to any waiting period referred to in the policy.

Privacy Act 2020 and Health Information Privacy Code 2020
Collection and use
This Application collects each applicant's and insured person's personal and health information. nib will use the information it collects to:

- determine each applicant's and insured person's eligibility for the policies and options applied for, and
- administer the policies, and
- promote and/or market our current and future health and related services and health related products of nib's business partners, and
- consider claims and provide the benefits and health related services under the policies.

Insurance law requires each applicant and insured person to comply with his or her duty of disclosure to nib when applying for insurance. To the extent nib collects personal and health information under that duty, the supply of it to nib is mandatory. If any applicant or insured person fails to provide information required by the duty of disclosure, nib may decline the application or, if nib has issued a policy, it may have the right to cancel the policy retrospectively.

Intended recipients
In providing our health and related services and using personal information, we may collect information from or disclose personal information to:

- nib and its related companies and business partners, and
- all other co-applicants named in this application and all insured persons, and
- any applicant's insurance adviser or other individual who a person has granted authority to access information on their behalf, and
- at claim time:
  - all necessary health service providers
  - any of nib's contractors or service providers assisting it with administering and meeting each applicant's and insured person's claim

Each applicant and insured person authorises the collection of information from and the disclosure of information to the intended recipients named for the purposes set out above.

Access and correction
The accuracy of personal information is important to us. We will take reasonable steps to ensure an person's information is accurate, complete and up-to-date. We rely on the applicant and/or insured person to advise of any changes to their contact details and any other personal information. Each applicant and insured person has the right to access and correct their personal and health information held by nib. nib nz limited, 48 Shortland Street, Auckland collects and holds the personal and health information.

All information provided is true and complete
Each applicant and insured person declares that:

- all the information he or she has provided in this Application is true and complete, and
- where he or she has provided information on behalf of a co-applicant and/or an insured person, he or she has the authority to do so.

Signatures

Note: Before signing, please ensure you have answered all the questions and have read and understood **section 8.0** 'Important information and declaration' above.

Policyowner(s) and applicants aged 16 or over

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

Sign here

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	

Adviser details

Adviser number	
Agreement number	B

To speed up acceptance of this application, may we contact your customer direct for further information?

◯ Yes ◯ No

Name of adviser	
Phone	( )

Financial strength rating

nib nz limited has an A (Strong) financial strength rating given by S&P Global Ratings Australia Pty Ltd.

A Strong	AAA (Extremely Strong) AA (Very Strong) A (Strong) BBB (Good)	B (Weak) CCC (Very Weak) CC (Extremely Weak)	SD or D (Selective Default or Default) R (Regulatory Action) NR (Not Rated)

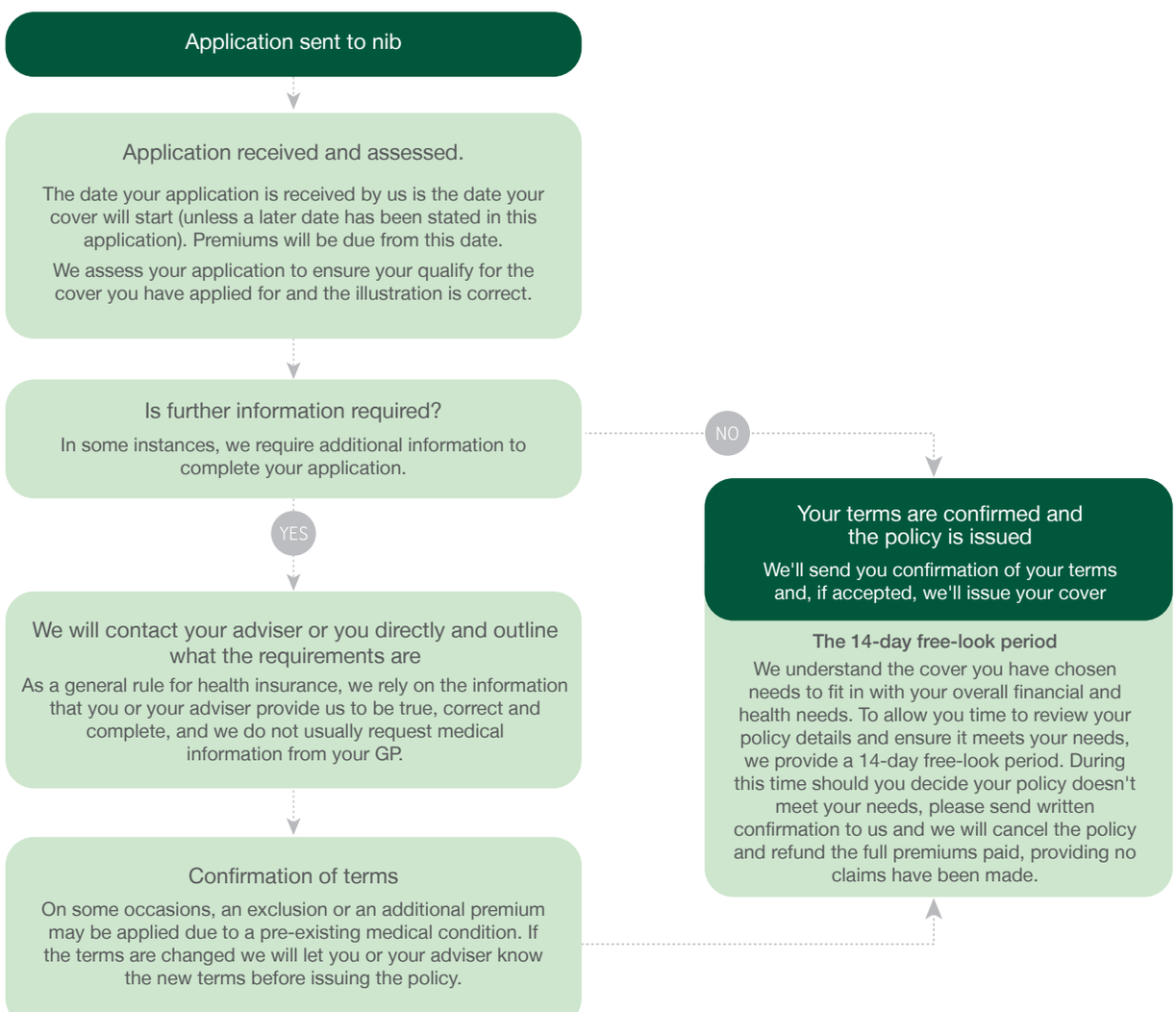
Checklist

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
- ◯ If paying by direct debit, the direct debit attached has been completed
- ◯ If any information has been completed on a separate sheet, it has 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 have been attached to this application.

Next steps for your application

We want to make the application process as easy as possible. Below is an outline of the process. If you have any questions, please contact us at newbusiness@nib.co.nz or talk to your adviser.



Direct Debit Authority

Your personal details

Policy Number:

Office use only: STB ☐

Policyholder name:

I would like to pay: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Annually

Preferred start date: D D / M M / Y Y Y Y

Account information

Name of my account to be debited (acceptor)

Name of my bank:

Bank | Branch | Account | Suffix

Initiator's Authorisation Code

0 6 5 4 4 8 3

Approved

5448 | 11/17

From the acceptor to [insert name of acceptor's bank] **(my bank):**

I authorise you to debit my account with the amounts of direct debits from nib with the authorisation code specified on this authority in accordance with this authority until further notice.

I agree that this authority is subject to:

- The bank's terms and conditions that relate to my account, and
- The specific terms and conditions listed below.

Account Holders signature/s

Authorised signature/s:

X

Date D D / M M / Y Y Y Y

Specific conditions relating to notices and disputes

I may ask my bank to reverse a direct debit up to 120 calendar days after the debit if:

- I don't receive a written notice of the amount and date of each direct debit from the initiator, or
- I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.

The initiator is required to give a written notice of the amount and date of each direct debit in a series of direct debits no later than the date of the first direct debit in the series. The notice is to include:

- the dates of the debits, and
- the amount of each direct debit.

If the bank dishonours a direct debit but the initiator sends the direct debit again within 5 business days of the dishonour, the initiator is not required to give you a second notice of the amount and date of the direct debit.

If the initiator proposes to change an amount or date of a direct debit specified in the notice, the initiator is required to give you notice:

- no less than 30 calendar days before the change, or
- if the initiator's bank agrees, no less than 10 calendar days before the change.

Please return completed form to: **newbusinessteam@nib.co.nz**

For more information

nib nz limited

PO Box 91 630, Victoria Street West, Auckland 1142
Email: newbusiness@nib.co.nz

nib.co.nz

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