NZAS RETIREMENT FUND
Your Super. Your Future.

MEDICAL INSURANCE QUESTIONNAIRE

NAME____
Surname Given Names

HOME ADDRESS____

DATE OF BIRTH: ____/____/____ TITLE: Mr/Mrs/Ms/Miss (Please circle one)

LEVEL OF COVER REQUIRED: ☐ 12% pa (medium level) ☐ 16% pa (top level)

Please note, this questionnaire is not related to your employment or entitlement to membership of the Fund. Its purpose is solely to assess your state of health for insurance purposes.

FAMILY DOCTOR:____

ADDRESS:____

1. Have you ever been declined, deferred or accepted on special terms for a policy of life or disability insurance?

   ☐ Yes (Details)____

   ☐ No

2. Have you ever had any heart trouble, chest pain, rheumatic fever, high blood pressure, kidney or liver disease, mental or nervous disorder, ulcers, cancer, tumours, asthma, diabetes, gout, epilepsy or suffered from alcoholism?

   ☐ Yes (Details)____

   ☐ No

3. Have you ever had any illness (other than minor ailments such as colds or flu), injury or medical examination, medical advice or surgery not mentioned above within the last 5 years?

   ☐ Yes (Details)____

   ☐ No

Provide details for any “Yes” answers. (include doctor’s name and address and dates of treatment.)

(PTO)

DECLARATION

(Please read very carefully before signing)

I hereby declare that:

(a) The statements and other disclosures made in this application are true to the best of my knowledge and belief.

(b) I understand that as a result of this questionnaire, I may be required to undergo a medical examination.

(c) Any known pre-existing condition has been disclosed.

d) Failure to make this declaration truthfully may invalidate the cover provided.

(d) I have read and understand the conditions and/or information relating to the insurance cover in the Product Disclosure Statement and this application form.

I consent to any doctor or medical specialist who has treated me divulging to the Trustee and/or administrators of the Fund any medical or health related information that may be required on the understanding such information shall be privileged and confidential.

Signed:_______________________________ Date:___/___/___

Please send form to the Human Resources Officer, NZAS on completion.