



# Application for Non Smoker Rates

Adviser name:

Adviser e-mail:

In connection with the Proposal on the Life of:

Proposal/Policy No.  Life Insured's Date of Birth  /  /

## DUTY OF DISCLOSURE NOTICE

### Your duty of disclosure

If you are the Policy Owner, you have a duty to tell us anything that you know, or could reasonably be expected to know, which may affect our decision to insure you and any other Life Insured and on what terms.

You have this duty until we agree to insure you, and also before you extend, vary or reinstate the Policy.

You do not need to tell us anything that:

- reduces our risk; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If you are a Life Insured (other than the Policy Owner), any failure by you to tell us this information may be treated as a failure by the Policy Owner to comply with this duty of disclosure.

### If you do not tell us something

If you are the Policy Owner, and you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may reduce the amount you have been insured for, based on a statutory formula. (We may only exercise this right within 3 years of entering into the Policy if it provides death cover.)

If we choose not to avoid the Policy or reduce the amount you have been insured for, if your Policy does not provide death cover, we may vary the contract in a way that places us in the same position we would have been in if you had told us everything you should have.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed.

We may apply these rights separately to each type of cover that we consider could form a separate policy.

## SPECIAL NOTICE

Non Smoker rates are available following acceptance of a satisfactory Non Smoker declaration from the Life Insured. The premium under the policy will then be reduced accordingly.

## STATEMENT BY LIFE INSURED

1. Have you smoked tobacco or any other substance (including e-cigarettes) during the last 12 months? .....  Yes  No  
If 'Yes', please state the daily quantity and what forms. (Please note 'packet' is not sufficient detail.)

2. Have you ceased smoking for medical reasons? If 'Yes', please provide details below.....  Yes  No

3. Since the commencement of your policy with AIA Australia, have you had, been told you had, or received any advice or investigation or treatment for any of the following:
- Chronic asthma or bronchitis, tuberculosis, obstructive airways disease or other respiratory disorder?.....  Yes  No
  - Heart attack, chest pains, stroke, diabetes or any other heart disorder? .....  Yes  No
  - Cancer, cyst, tumour or growth of any kind?.....  Yes  No

If 'Yes', please provide details below.

... continued overleaf

## DECLARATION

I/We declare that this APPLICATION FOR NON SMOKER RATES shall be deemed to be incorporated in the said Policy and form(s) part of the contract contained therein. If it is necessary to re-issue the Policy, the Company is hereby authorised to do so in the form currently used and subject to the terms and conditions applicable at this date.

I/We have read and consent to the handling, collection, use and disclosure of my/our personal and sensitive information in the manner described in the AIA Australia Privacy Policy available on the AIA Australia website at [www.aia.com.au](http://www.aia.com.au) as updated from time to time or by calling AIA Australia on 1800 333 613, including exchange with third parties located in Australia and overseas.

I/We have read the notice on this application regarding disclosure and understand what is meant by that notice.

Signature of Life Insured:

Date:

(If Company, affix Company Stamp)

Signature of Policy Owner(s) *(If two lives, both signatures are required)*

Signature of Policy Owner 1:

Address of Policy Owner 1:

Signature of Policy Owner 2:

Address of Policy Owner 2:

## MEDICAL AUTHORITY

*(Name of Life Insured)*

I,

authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter), to disclose to AIA Australia Limited, full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of Life Insured:

Date: