



# Deferred Completion Form

Note: Information marked with this symbol must be completed

## Office Use

Policy number:

Adviser number:

Proposed Person Insured last name:

Date of birth: day / month / year

Proposed Person Insured given names:

Your answers help us to assess your insurance "risk". You need to disclose "all material facts". A material fact is one that may influence us in deciding on what terms and conditions and for what premiums we may offer you cover. If you don't tell us "all material facts", we can refuse to pay a future claim, cancel your policy, and retain any premiums paid.

## A: Questions for all covers

Since completing the Personal Statement on day / month / year has any of the following occurred?

1 In the last three years have you taken regular medication or had any medical procedure, consultation, investigation or test or are you considering seeking medical advice? (Include such things as ultrasounds, ECG's, scans, changing moles and self detected breast lumps, but do not include contraception, colds, flu, normal pregnancy check-ups or occasional mild headaches.) Yes No

If 'Yes', please give details

2 Has there been any change in your occupation, state of health, family history or hazardous activities (eg diving or motor racing)? Yes No

If 'Yes', please give details

3 Has an application for life insurance on your life been declined, deferred or accepted on special terms by any life insurance provider? Yes No

If 'Yes', please give details

## B: Personal Information

### Privacy Acknowledgement

This statement relates to the personal information that I (as the Proposed Person Insured) am providing here and the personal information that may be held about me by AMP already or in the future:

- The personal information collected will be held by AMP and will be used to process this application (including completion of any necessary medical tests) and to administer and service any product I have with AMP. If any of the information asked for is not provided, this application may be declined or the services may be withdrawn.
The Policy Owner may be told of my health assessment.
The information may also be used to identify other services or products available from or through AMP that may be suitable to my needs and to offer those products to me.
AMP includes all the members of the AMP Group of companies and their subsidiaries, associated companies and agents.
AMP holds information about me securely.
I have the right to ask to see the information AMP holds about me. If I believe that the information is wrong I may ask that it be corrected. To request information about myself I can contact 0800 808 267.

### Declaration

Please read each statement and sign below to show you understand and agree with them:

- I have answered all the questions in this 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 nothing back that might cause you to assess me as a greater risk to insure.
I authorise AMP to obtain from and to provide to any other insurer or medical practitioner information relating to this insurance or to any insurance I have held and to any claim that I have made or may make.
Any insurance granted by AMP Life Limited 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 prior to written acceptance of the risk by AMP Life Limited and the payment of the first premium.

## Signatures

Signature of Proposed Person Insured:

Signature of Parent or Legal Guardian (if signatory is under age 16):

Location (town/city) of signing:

Date: day / month / year