

Supplementary Personal Statement

Smoking status update form

OnePath Life (NZ) Limited (OnePath)

Private Bag 92131, Victoria Street West, Auckland 1142

Phone: 0508 464 999 (toll free)

Fax: 0508 464 777 (toll free)

Email: insurance@onepath.co.nz

Details of life assured

Policy number(s) if known

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Surname First name

Middle name Date of birth

Please answer the following questions

- During the last 12 months have you smoked tobacco, e-cigarettes or any other substance? Yes ☐ No ☐
If **yes**, please state **type(s)** and **quantity** per day
Type(s) Quantity
- During the last 12 months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc.) or anti-smoking medication (e.g. Zyban, Champix, etc.)? Yes ☐ No ☐
If **yes**, please state **type(s)** used and **length of time** you have been using this
Type(s) Years Months
- Have you any intention to resume smoking in the future? Yes ☐ No ☐
- Have you ever been advised by a medical practitioner or physician to give up smoking on specific medical grounds? Yes ☐ No ☐
If **yes**, please provide full details

- Do you have, or has a medical practitioner told you that you have a medical condition associated with smoking? Yes ☐ No ☐
If **yes**, please provide full details

Declaration

I/We, the life assured and policy owner(s):

- i. declare that the information in this Supplementary Personal Statement is true, correct and no material information has been left out.
- ii. agree and confirm that the information in this Supplementary Personal Statement forms part of my/our contract of insurance.
- iii. understand the information provided in this Supplementary Personal Statement, together with any other statements made in connection with it, will be used by OnePath to decide whether or not to adjust the premiums payable under the above-mentioned policy.
- iv. understand that if any information in this Supplementary Personal Statement is untrue, incorrect or incomplete OnePath may, at its discretion, either reduce the insurance cover benefits under my/our policy/ies to the amount that would have been offered for the premiums actually paid or adjust the premiums retrospectively to reflect the true, correct and complete information.

Name of life assured (please print)

 DD / MM / YYYY

Signature of life assured

 X

Name(s) of policy owner(s) (please print)

 DD / MM / YYYY

Signature(s) of policy owner(s)

 X