# Medical Information Consent

I consent to Asteron Life Limited seeking medical information from any doctor or other medical provider I have consulted, to the extent this is reasonably necessary to evaluate my insurance application, administer any policy that arises from the application, and consider claims against and validity of that policy.

I understand that a third party may also be used to process this information request for Asteron Life Limited.

I authorise any such doctor or other medical provider to provide such information to Asteron Life Limited.

I agree that a photocopy of this consent is as valid as the original.

**Applicants personal details**

Title

Family name

Given name(s)

Is registered under (if different from above)

Date of birth

Postal address

Post Code

**My Doctor is**

Name of Doctor/ Practice

Phone

Street address

Signature of the Person to be Insured

Date

**Asteron Life**
Level 13 Asteron Centre, 55 Featherston Street, PO Box 894, Wellington 6140, NZ
Ph: **0800 737 101** (Contact Centre hours: Mon–Fri 8am–6pm)
Fax: 0800 246 067 Email: newbusiness@asteronlife.co.nz Web: asteronlife.co.nz

Issuer: Asteron Life Limited

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