Application

Thanks for choosing AIA Australia to protect you and your financial wellbeing.

This application form is used to apply for a new replacement policy or an increase on an existing policy for one of the following products:

- **Total Care Plan**
- **Total Care Plan Super***
- **SMSF Plan***
- **Income Care***
- **Income Care Plus***
- **Income Care Platinum***
- **Life Protection**
- **Income Protection* or**
- **Other legacy CommInsure productsfor life insurance and/or income protection* cover.**

*** Please note, the availability of Income Care, Income Care Plus, Income Care Platinum, Income Care Super or Essential Cover (within Total Care Plan Super) and Income Protection or Essential Cover (within SMSF Plan) covers is solely limited to customers who already hold income protection under an existing Tailored Protection policy or a policy previously issued by The Colonial Mutual Life Association (CMLA) prior to 1 April 2021. In such cases, these existing customers may be issued a new replacement policy with income protection, where the requested change is not possible as a variation to the current policy.**

In no circumstances is a change from a non-Agreed Value income protection policy to an Agreed Value policy permitted.

Sending your application to us

You can send the application to us via Email or mail. Please note that we must receive the application in the following order: adviser details page, AIA Australia quotation, application and personal statement.

Email

Attach the PDF of the scanned application (in the order stated above) and send to **Au.LNBApplications@aia.com**

Mail
Send the application to:

AIA Australia
Underwriting Department
PO Box 319
Silverwater NSW 2128

What happens next?

As soon as we receive your application, we'll review it to ensure that you've provided all the information asked for. If you missed some of the information, we'll phone you and collect the information we need.

If we need more medical information such as medical reports, medical examinations or blood tests, we'll arrange them as quickly as possible.

Once all the required information has been received and reviewed, we'll let you know the outcome of your application and if we've accepted your application, we'll issue your policy schedule.

Sometimes we may offer different cover or terms than what you applied for. If we do, we'll send a Provisional Offer for you to consider before we issue your policy schedule.

We'll keep your adviser informed of the progress of your application and any additional information we need.

Interim Accident Cover while you wait

While we're considering your application we'll insure you for accidents for up to 90 days – at no extra cost.

Checklist for applicants

To ensure that this application is processed as quickly as possible, please use this checklist when completing and submitting all relevant paperwork.

☐ Quotation

☐ Application

Application			Outside super	Inside super
	Duty to take reasonable care	pages 4-5	☐	☐
A	Purpose of the policy	page 6	☐	
B	Policy owner details	pages 6-7	☐	
		page 8		☐
C	Life insured/Member details	page 9	☐	☐
D	Nomination of beneficiaries	page 10	☐ (Total Care Plan – optional)	
E	Nomination of beneficiaries	pages 11-14		☐ (Total Care Plan Super – optional)
F	Premium payment details	page 15	☐	☐
G	Contribution details	page 16		☐
H	Tax File Number	page 16		☐

Checklist for applicants

Personal Statement	1 Life, TPD, Trauma	2 Income Protection*	3 Essential Cover	4 Accident Cover
Section A – Job details	☐	☐	☐	☐
Section B – Income details	☐	☐	☐	
Section C – Insurance history details	☐	☐	☐	
Section D – Habits	☐	☐		
Section E – Height and weight	☐	☐	☐	
Section F – Doctor's details	☐	☐	☐	
Section G – Family history details	☐	☐		
Section H – Medical history details	☐	☐		
Section I – Additional medical details	☐	☐		
Section J – Medical history (Essential Cover only)			☐	
Section K – General health questionnaire	☐	☐	☐	
Section L – Alcohol and drug use	☐	☐	☐	
Section M – Residence and travel	☐	☐	☐	☐
Section N – Pastimes and activities	☐	☐	☐	☐
Section O – Specific questionnaires	☐	☐		
Section P – Pastimes and activities questionnaires	☐	☐	☐	☐
Section Q – Child's personal details	☐			

Declaration	Life, TPD, Trauma	Income Protection*	Essential Cover	Accident Cover
Section R – General declaration	☐	☐	☐	☐

* Income Protection includes Income Care, Income Care Plus, Income Care Platinum, Income Care Super, Business Overheads Cover and Income Protection within SMSF Plan.

Other Requirements

- ☐ Complete the Business Overheads Cover Supplementary Personal Statement (if Business Overheads Cover is being applied for)
- ☐ If you are applying for a new Total Care Plan, Income Care, Income Care Plus or Income Care Platinum policy, complete the relevant Interim Accident Cover Certificate (located in the Tailored Protection Combined Product Disclosure Statement (PDS) and Policy)
- ☐ Sign the Medical authority (page 47)
- ☐ Sign the Financial authority (page 48)
- ☐ Complete the Pathology Request form (pages 50 and 51)
- ☐ Arrange Premium Payment, either by:
  - ☐ Direct Debit Authority/Credit Card Authority (pages 52 and 53)
  - ☐ Super Payment Rollover Authority form (pages 56 and 57)
  - ☐ Employer Contributions via SuperStream (page 58)
  - ☐ Cheque **(For half yearly or yearly payments only. Please make cheques payable to 'AIA Australia Limited').**
- ☐ Authority to cancel replaced policy (page 59)
- ☐ Complete the Adviser details section (page 60)

Application

This form is to be used to apply to AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia) for the issue of Insurance Products named within it, and where applicable to Colonial First State Investments Limited ABN 98 002 348 352 AFSL 232468 (referred to as the 'Trustee'), the Trustee of the Colonial First State FirstChoice Superannuation Trust ABN 26 458 298 557 (FirstChoice Trust) for membership of the FirstChoice Trust.

This application form can be used to apply for a new replacement policy or an increase to your existing policy for one of the following products:

Total Care Plan, Total Care Plan Super, SMSF Plan, Income Care, Income Care Plus, Income Care Platinum, Life Protection, Income Protection or other legacy CommInsure products.

Before you sign this Application

If you are applying for a new replacement policy for Total Care Plan, Income Care, Income Care Plus or Income Care Platinum (other than via a continuation option or option to convert), this Application accompanies the Combined Product Disclosure Statement (PDS) and Policy applicable to the policy cover you are applying for. The PDS contains a summary of the important information in relation to the policy you are applying for. This information will help you to understand the product and to decide whether it is appropriate to your needs. You should have received a PDS with this Application. If you have not received a PDS please contact your Adviser or an AIA Australia Customer Service Representative on **13 1056**.

If you are applying for a new replacement policy, the information provided in this application and in the application for the existing policy forms the basis of this application and will, together with any special conditions, form the basis of the replacement policy. This application is to be made as if it included in full the information provided in the application for the existing policy. AIA Australia relies on the accuracy of the information provided in this application and the application for the existing policy in deciding whether to accept this application; this information must be true, complete and correct as at the date it was given.

Customers applying for a new Total Care Plan, Income Care, Income Care Plus, or Income Care Platinum policy who are exercising a Continuation Option which converts their existing cover, should refer to the Tailored Protection PDS dated 14 September 2021.

Total Care Plan Super members and SMSF Plan customers applying for a replacement policy should refer to the CommInsure Protection PDS issued 23 September 2018 (including the supplementary PDS' dated 1 November 2019

For customers wishing to make an alteration to their existing insurance policy, such as an increase in cover, please refer to the original PDS and Policy Document you were issued and any Significant Event Notices (SEN) you may have received communicating policy enhancements provided to you since that time.

A Quotation must be attached to this application showing the benefits and options you are applying for. If you have not received a Quotation, please contact your Adviser or an AIA Australia Customer Service Representative on **13 1056**.

About this application

The life insurance policy being applied for with this application is a consumer insurance contract within the meaning of the Insurance Contracts Act 1984 (Cth). When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so, on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty applies to a new contract of insurance and also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. There are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). These are intended to put us in the position we would have been in if the duty had been met.

Your cover could be avoided (treated as if it never existed), or its terms may be varied. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Before we exercise any of these remedies, we will explain our reasons and what you can do if you disagree.

Guidance for answering our questions

You are responsible for the information provided to us. When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before your cover starts

After you have completed this application but before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

If you need help

It's important that you understand this information and the questions we ask. Ask us or a person you trust, such as your adviser for help if you have difficulty understanding the process of buying insurance or answering our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help. If you want, you can have a support person you trust with you.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please contact us immediately and we'll let you know whether it has any impact on the cover.

Applicant acknowledgement and declaration

I have read and understood my duty to take reasonable care as set out on page 4 and explained to me by my adviser. I am aware of the consequences of non-disclosure. I understand my duty to disclose any changes to any circumstances continues after this application has been submitted until the application has been accepted in writing.

Applicant name 1

Applicant name 2

Signature of applicant

Date / /

Signature of applicant

Date / /

Life to be insured acknowledgement and declaration

I have read and understood the duty to take reasonable care as set out on page 4 and I am aware of the consequences of non-disclosure.
I understand the duty to disclose any changes to any circumstances continues after this application has been submitted until the application has been accepted in writing.

Life to be insured name 1 (if different to Applicant)

Life to be insured name 2 (if different to Applicant)

Signature of life to be insured

Date / /

Signature of life to be insured

Date / /

Adviser acknowledgement and declaration

I have provided the applicant with the relevant Product Disclosure Statement (PDS) applicable to the policy/cover being applied for as set out on page 4.

I have made the applicant and the life to be insured aware of the duty to take reasonable care set out on page 4 and have explained the consequences of non-disclosure.

Adviser name

Signature of adviser

Date / /

Application

Section A – Purpose of the policy

If you are applying for cover inside super only, go directly to part B on page 8.

To be completed by the policy owner(s)

Please indicate the purpose of the policy for the life/lives to be insured (tick (✔) the appropriate box below)

	Life to be insured 1	Life to be insured 2
Personal/Family	☐	☐
Value of your business	☐	☐
Business loan	☐	☐
Key person	☐	☐
Financial interest in business (Buy-Sell)	☐	☐

Please note: if you wish to select the Guaranteed Insurability Option (Business Events) or the Business Safe Cover Option under Total Care Plan, the purpose of your application which you indicated above will determine the business event for which you can increase your cover under the relevant option.

Section B – Policy owner details – Outside super

To be completed by the policy owner(s)

This policy is to be owned by (please tick (✔) the appropriate box below):

☐ **The life/lives insured.**

Note: for Income Protection applications, a separate policy will be issued for each life insured. Under each policy, the life insured will, as owner, be insuring their own life.

	Total Care Plan
Life 1	☐
Life 2	☐
Lives 1 and 2 (joint tenants)	☐

OR

☐ **Individual/s other than the life insured (not available for Income Protection policies).**

	Total Care Plan
Policy owner 1	☐
Policy owner 2	☐
Policy owner 1 and 2 (joint tenants)	☐

Policy owner 1

Title | Surname

Given name(s)

Date of birth
/ /

Residential address

Suburb | State | Postcode

Mailing address (if different to residential address)

Suburb | State | Postcode

Home phone number ( ) | Business phone number ( ) | Mobile phone number | Fax number ( )

Email address

Policy owner 2

Title | Surname

Given name(s)

Date of birth
/ /

Residential address

Suburb | State | Postcode

Mailing address (if different to residential address)

Suburb | State | Postcode

Home phone number ( ) | Business phone number ( ) | Mobile phone number | Fax number ( )

Email address

OR

☐ **A family trust/company.**

Note: for Income Protection applications, the life insured must have a controlling interest in the **family trust/company**, such that they can ensure that the proceeds of the policy will ultimately be paid to them.

	Total Care Plan	Income Protection
Family trust/Company	☐	☐

Trust/Company name(s)

ABN

Mailing address

Suburb | State | Postcode

Phone number ( ) | Fax number ( )

Email address

Section B – Policy owner details – Inside super

OR

☐ **A Self-Managed Super Fund (SMSF).**

	SMSF Plan
Superannuation fund	☐

For SMSF Plan applications, the life insured must be a member of the SMSF named in this application.

Details of policy owner(s)

To be completed by the trustee(s) of the superannuation fund which will own the policy(ies).

Full name of the superannuation fund

Superannuation fund number

Trustee's address for communications

Suburb	State	Postcode

Phone number ( )

Fax number ( )

Details of trustee

Company/ Trustee name

ABN

OR

Individual trustee name(s) (if more than two individuals, please attach further names).

First individual trustee

Title Surname

Given name(s)

Second individual trustee

Title Surname

Given name(s)

OR

☐ **Total Care Plan Super**

If you are applying for a Total Care Plan Super only, go directly to part C on page 9.

Section C – Life to be insured/Member details

To be completed by the life/lives to be insured (only one life insured per Total Care Plan Super Policy).

Life to be insured 1

Personal Details

Title | Surname

Given name(s)

Date of birth
/ /

Residential address

Suburb | State | Postcode

Mailing address (if different to residential address)

Suburb | State | Postcode

Home phone number | Business phone number | Mobile phone number | Fax number
( ) | ( ) | | ( )

Email address

Life to be insured 2

Personal Details

Title | Surname

Given name(s)

Date of birth
/ /

Residential address

Suburb | State | Postcode

Mailing address (if different to residential address)

Suburb | State | Postcode

Home phone number | Business phone number | Mobile phone number | Fax number
( ) | ( ) | | ( )

Email address

Section D – Nomination of beneficiaries (optional) – Total Care Plan only (non-super)

To be completed by the policy owner(s)

Under section 48A of the *Insurance Contracts Act 1984*, you may nominate up to five beneficiaries to receive death claim proceeds from the Total Care Plan policy. Your valid nomination will ensure that any death claim proceeds payable under the policy will be paid in the designated portions directly to the nominated beneficiary/ies such that the proceeds will not be paid to you or your estate. Please refer to the PDS for further details.

Title	Full name of beneficiary	Address	Date of birth	Relationship to policy owner(s)	% split
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		

Total = 100%

Section E – Non-lapsing death benefit nomination form – Total Care Plan Super only

Membership details

Total Care Plan Super existing member

Please provide your current policy/membership number

What is a non-lapsing death benefit nomination?

A non-lapsing death benefit nomination is a request by you to the trustee of the FirstChoice Trust to pay your death benefit to the person or persons nominated. The Trustee may consent to your nomination if your nomination satisfies the requirements described in the following paragraphs.

The Trustee is required to follow your nomination if, prior to your death, you complete and it receives your valid non-lapsing death benefit nomination, and the Trustee consents to that nomination.

The nomination remains valid until you revoke or make a new nomination. This can provide you with greater certainty as to who will receive your death benefit when you die.

Who can I nominate?

A valid non-lapsing death benefit nomination can only nominate your legal personal representative and/or your dependants.

Your legal personal representative is the person appointed on your death as the executor or administrator of your estate.

Your dependants are:

- **your current spouse**

This includes the person at your death to whom you are married or with whom you are in a de facto relationship (whether of the same sex or a different sex) or in a relationship that is registered under a law of a State or Territory.

- **your child**

This includes any person who at your death is your natural, step, adopted, ex-nuptial or current spouse's child, including a child who was born through artificial conception procedures or under surrogacy arrangements with your current or then spouse.

- **any person financially dependent on you**

This includes any person who at your death is wholly or partially financially dependent on you. Generally, this is the case if the person receives financial assistance or maintenance from you on a regular basis that the person relies on or is dependent on you to maintain their standard of living at the time of your death.

- **any person with whom you have an interdependency relationship**

This includes any person where at your death:

- you have a close personal relationship with this person
- you live together with this person
- you or this person provides the other with financial support, and
- you or this person provides the other with domestic support and personal care.

An interdependency relationship is not required to meet the last three conditions, if the reason these requirements cannot be met is because you or the other person is suffering from a disability.

In establishing whether such an interdependency relationship exists, all of the circumstances of the relationship are taken in to account, including (where relevant):

- the duration of the relationship
- whether or not a sexual relationship exists
- the ownership, use and acquisition of property
- the degree of mutual commitment to a shared life
- the care and support of children
- the reputation and public aspects of the relationship (such as whether the relationship is publicly acknowledged)
- the degree of emotional support
- the extent to which the relationship is one of mere convenience, and
- any evidence suggesting that the parties intended the relationship to be permanent.

If you are considering relying on this category of dependency to nominate a person, you should consider talking to your legal adviser and completing a statutory declaration addressing these points as evidence of whether such a relationship exists.

How do I nominate more beneficiaries?

If you wish to nominate more beneficiaries, you can attach their nomination details to this form. The attachment must be headed 'Attachment to Non-lapsing Death Benefit Nomination Form'.

The attachment must include your full name and account number, the full names of the beneficiaries, their date of birth, their relationship to you and the percentage of the benefit to be paid to each person. The attachment must also be signed and dated by you. The same two witnesses who sign section 5 of this form must also sign and date the attachment and include in the attachment the declaration "I declare that I am over the age of 18 and this non-lapsing nomination was signed and dated by the member in my presence".

How do I make a valid non-lapsing death benefit nomination?

To make a valid non-lapsing death benefit nomination:

- you must be at least 18 years of age
- you must complete in writing this non-lapsing death benefit nomination form available in the most up-to-date PDS or on our website or by calling 13 1056
- you must only nominate your legal personal representative and/or a person(s) who is your dependant
- you must provide the full name, date of birth and the relationship which exists between you and each of the nominated beneficiaries
- you must ensure that the proportion payable to each person nominated is stated and the total allocation adds up to 100%.
- your nomination must not be ambiguous in any way
- you must sign the non-lapsing death benefit nomination form in the presence of two witnesses who are both at least age 18 and are not nominated by you as a beneficiary on the form.

For your validly completed non-lapsing death benefit nomination to be effective you must send your nomination and the Trustee must receive and consent to your validly completed non-lapsing death benefit nomination prior to

your death.

You may seek to revoke your nomination or make a new non-lapsing death benefit nomination at any time by completing a new non-lapsing death benefit nomination form in writing, available in the most up-to-date PDS or on our website or by calling 13 1056.

Is my nomination effective?

It is important to be aware before completing a non-lapsing death benefit nomination that if your non-lapsing death benefit nomination is valid and the Trustee consents to that nomination, the Trustee must follow the nomination and it cannot be overruled by the Trustee.

However, if you nominate a person who is not your legal personal representative or a dependant when you die, then your nomination will not be valid to the extent that it relates to that person despite any consent granted by the Trustee.

If you nominate your legal personal representative, your death benefit will be paid to your estate and distributed in accordance with your Will or the laws of intestacy. This means that the distribution may be challenged if someone disputes your Will or the distribution of your estate.

If you nominate one or more of your dependants, your death benefit will be paid directly to them.

If a person nominated on your non-lapsing death benefit nomination form is no longer a dependant at the date of your death, then the proportion of your death benefit which would have been payable to that person will be paid to your legal personal representative.

Please note this will **not** apply if you revoke a nomination made for your Total Care Plan Super policy which commenced before 1 April 2017.

Tax may be withheld from your death benefit when paid to your dependants or distributed from your estate. There are differing tax treatments of death benefits depending on how old you are, how old your nominated beneficiaries are and who you nominate and whether it is paid as a pension or lump sum.

How is my death benefit paid?

At the time of your death, the trustee will contact the people you have nominated in your non-lapsing death benefit nomination to ensure that they are still a dependant or your legal personal representative.

The trustee is also generally required to establish the identity of this person before paying out your death benefit.

If you have nominated one or more of your dependants, they may be provided the choice of taking their proportion of the death benefit as a lump sum cash payment or a pension.

Please note, however, that from 1 July 2007 if you have nominated a child, the death benefit must be paid to them as a lump sum cash payment unless the child:

- is under age 18
- is under age 25 and is financially dependent on you, or
- has a certain type of disability.

If your child does receive your death benefit as a pension, they must commute it to a tax-free lump sum by age 25 unless they remain disabled.

Where a death benefit is paid to your legal personal representative, it must be paid as a lump sum.

What if I don't have a valid non-lapsing death benefit nomination?

Your death benefit will be paid to your legal personal representative if:

- at the time of your death, you have not completed or the Trustee has not received and consented to a valid non-lapsing death benefit nomination
- you have revoked your last non-lapsing death benefit nomination and you have not made a new non-lapsing death benefit nomination
- the person or persons you have nominated cannot be identified or are not your dependant or legal personal representative at the time of your death, or
- the Trustee determines that the whole of your non-lapsing death benefit nomination is otherwise invalid.

This is general information only and does not take into account your personal circumstances. Please talk to your financial adviser for more information on non-lapsing death benefit nominations and your personal estate planning needs.

Please note the above will **not** apply if you revoked your nomination on a Total Care Plan Super policy which has a policy commencement date before 1 April 2017.

Important information

It is important to review your nomination regularly to ensure it is still appropriate to your personal circumstances and reflects your wishes. If, after making a non-lapsing death benefit nomination, you marry, separate or divorce, enter a de facto relationship (including same-sex), have a child, or if someone you nominate has died, or someone becomes or is no longer financially dependent upon you or in an interdependency relationship with you, then you should review your non-lapsing death benefit nomination or consider making a new nomination.

Section E – Non-lapsing death benefit nomination form – Total Care Plan Super only

Dependant 1

Title | Full name | Date of birth | Gender | **% of death benefit**

Address

State Postcode

☐ Spouse ☐ Financial dependant ☐ Child ☐ Interdependant

Dependant 2

Title | Full name | Date of birth | Gender | **% of death benefit**

Address

State Postcode

☐ Spouse ☐ Financial dependant ☐ Child ☐ Interdependant

Dependant 3

Title | Full name | Date of birth | Gender | **% of death benefit**

Address

State Postcode

☐ Spouse ☐ Financial dependant ☐ Child ☐ Interdependant

Dependant 4

Title | Full name | Date of birth | Gender | **% of death benefit**

Address

State Postcode

☐ Spouse ☐ Financial dependant ☐ Child ☐ Interdependant

Legal Personal Representative (Your Estate) — **% of death benefit**

Total must equal 100%. This includes any additional nominations you attach to this form. Please refer to page 11 and 12.

Total

100%

Declaration

I understand/declare that:

- if this nomination is consented to by the trustee of the FirstChoice Trust, any existing death benefit nomination in respect of my Total Care Plan Super Policy to which this application relates will be revoked and replaced
- any beneficiary nominated by me, other than my legal personal representative, must be a dependant within the meaning of the Superannuation Industry (Supervision) Act 1993 (SIS Act). A dependant includes my spouse, child, a person who is financially dependent on me or with whom I have an interdependency relationship
- at the time of making this nomination, the beneficiary or beneficiaries nominated by me are dependants within the meaning of the SIS Act
- if my nomination is invalid in whole or in part, or cannot be followed for any reason or because a beneficiary/ beneficiaries is no longer a dependant at the date of my death, then that proportion of my benefit will be paid to my legal personal representative (unless I revoked a nomination on my Total Care Plan Super policy which has a policy commencement date before 1 April 2017)
- my beneficiary/beneficiaries and I will be bound by the provisions of the trust deed relating to non-lapsing death benefit nominations
- I may at any time revoke or replace a non-lapsing death benefit nomination in accordance with FirstChoice Trust's procedures and with the consent of the Trustee
- this nomination applies to the application above or the policy number(s) identified on this form
- I have read the PDS and agree to be bound by the provisions of the trust deed governing the FirstChoice Trust (as amended).

I acknowledge that the FirstChoice Trust and/or its related entities will not be liable to me or other persons for any loss suffered (including consequential loss) where transactions are delayed, blocked, frozen or where the Group refuses to process a transaction or ceases to provide me with a product or service.

A nomination is not considered valid unless it has been completed correctly and the Trustee receives it. Any alterations to your form must be initialled by yourself and both witnesses or it will be invalid. A nomination will not be effective until the Trustee of the FirstChoice Trust has consented to it. You should regularly review your nomination to ensure that the nominated beneficiary/ beneficiaries remain eligible to receive the portion of your death benefit specified in this nomination and that this nomination accurately reflects your wishes.

Signing this form

This form must be signed and dated in the presence of two witnesses. Each witness must be over 18 years old and must not be a person nominated on this form.

Applicant's/Member's signature

✗

Date

/ /

Declaration by two witnesses required to validate a non-lapsing death benefit nomination

I hereby declare that this non-lapsing death benefit nomination was signed and dated by the applicant/member in my presence.
I confirm that I am at least 18 years old and I am not a person who has been nominated on this form.

First witness name (please print)

First witness signature

✗

Date

/ /

Second witness name (please print)

Second witness signature

✗

Date

/ /

Note: any alteration to the completed form must be initialled by you and both witnesses. Both witnesses must sign this form on the same date as the member.

Section F – Premium payment details

Please tick (✔) the appropriate boxes for initial premium and ongoing method of payment

Note: if direct debit or credit card is selected, the premium will not be debited until the application is accepted.

Is payment to be included in an existing AIA Australia direct debit or credit card authority? (not applicable for Employer paid contributions)

Yes ☐ ▶ **Please provide existing policy number** _____

No ☐

Method of payment	Initial premium	Ongoing payment
Direct debit (page 52) **We will treat payments made by direct debit to Total Care Plan Super policies (if applicable) as personal contributions.**	☐	☐
Credit card (page 53) **We will treat payments made by credit card to Total Care Plan Super policies (if applicable) as personal contributions.**	☐	☐
Rollover money from super (including rollovers from an account in the FirstChoice Trust). Transfers or rollovers can only be made from any complying super fund (pages 56 and 57)	☐	☐
Employer Contributions via SuperStream – arrange with your employer to pay your TCPS premiums with Employer contributions. Please complete the Employer Payment Instructions form and give to your employer (page 58). **The contribution type(s) you and/or your employee wish to make is included in the Contribution Transaction Request (CTR). This must accompany your payment made via Direct Credit or BPAY®.** For further details contact our Customer Service Consultants on **13 1056** between 8 am and 6 pm (AEST/AEDT), Monday to Friday.	☐	☐
Direct to AIA Australia (cheque must be attached). This payment method is only available for yearly and half-yearly premiums.	☐	☐

If you are not the life insured, please go to page 45 and sign the General declaration.

If you are the life insured, please complete the Personal Statement starting on page 17 before signing the General declaration.

Important: Please complete the below question if you are applying for a Total Care Plan Super policy.

If you have a First Choice Employer account, do you consent to the Trustee confirming to AIA Australia that you have that account? AIA Australia will use this information for the purpose of compliance with Future of Financial Advice (FOFA) laws relating to the payment of adviser commission.

☐ Yes

☐ No

Note: If consent is not provided, AIA Australia can't continue processing this application.

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Section G – Contribution details – Total Care Plan Super Only

Under superannuation law, the trustee of the FirstChoice Trust may accept Total Care Plan Super contributions if you meet certain age and/or working requirements.

Are you aged 67 to 74?

☐ No - You do not need to complete this section. Please **proceed to H**

☐ Yes - Please complete the declaration below

I declare that (cross only **one** of the boxes):

☐ I have met the work test prior to making the contribution because I have worked in paid employment for at least 40 hours over 30 consecutive days this financial year.

OR

☐ I have met the **work test exemption** because:

- I met the work test last financial year, and
- I had a total superannuation balance (across all my superannuation accounts) of less than $300,000 at the end of last financial year, and
- I have not claimed the work test exemption in any previous financial year.

OR

☐ I have **not** met either the work test or the work test exemption.

Type of contribution

The contribution type(s) you and/or your employee wish to make is included in the Contribution Transaction Request (CTR). This must accompany your payment made via Direct Credit or BPAY.

Note: If your premiums are to be paid by superannuation contributions from your employer, please select “Employer Contribution via SuperStream” in Section F (page 15)

Section H – Tax File Number notification (TFN) – Total Care Plan Super Only

Under the Superannuation Industry (Supervision) Act (SIS) the Fund is authorised to collect your TFN and to use it for lawful purposes. These purposes may change due to legislative change.

The lawful purposes for which your TFN can be used are as follows:

- the trustee of the FirstChoice Trust can validate your TFN by means of an electronic validation service provided by the ATO for the purpose of ensuring the information we have about you on our record is accurate and up to date
- the ATO can give your TFN to the trustee of the FirstChoice Trust if:
  - you haven’t quoted your TFN to the trustee of the FirstChoice Trust but you have provided your TFN to other providers previously or
  - the TFN you provide to the trustee of the FirstChoice Trust doesn’t match the records the ATO holds for you. Where this occurs, the trustee of the FirstChoice Trust is required to update the record it holds for you unless you have instructed it not to record your TFN
- your TFN can be communicated to the other fund when you request a rollover, unless you have provided your written instruction to the contrary.

While it’s not an offence to withhold your TFN, providing it to the trustee of the FirstChoice Trust has the following advantages:

- tax on contributions won’t increase
- other than the tax that ordinarily applies, no additional tax will be deducted when you draw down your super benefits
- it will be easier to trace all your different super accounts so you receive all your super benefits when you retire.

Another advantage is that the Fund can accept all types of contributions that can be made. This is important for Total Care Plan Super for the reasons explained below.

Under superannuation law the trustee of the FirstChoice Trust can’t accept member contributions unless it has your TFN. Member contributions include all personal contributions you make and contributions made by any person on your behalf other than your employer. As the Trustee can’t accept member contributions until it has your TFN, it won’t be able to arrange insurance cover for you because it won’t have any contributions to pay for the cover.

If employer contributions are to be made for you and the trustee of the FirstChoice Trust doesn’t have your TFN, the trustee of the FirstChoice Trust won’t be able to arrange insurance cover for you because, after deducting extra tax from the contribution, the contribution won’t be enough to pay the premium.

TFN

Applicant’s/Member’s signature

✗

Date

/ /

Personal statement

You need to complete all sections of this Personal Statement unless you are applying for Essential Cover and/or Accidental Death Cover only. If you are applying for Essential Cover only, please fill out those sections marked with ESS
If you are applying for Accidental Death Cover only, please fill out those sections marked with AD

Life to be insured

Surname	Given name(s)	Date of birth
		/ /

Customer contact

AIA Australia is committed to assessing insurance applications as quickly as possible. To do this, our representatives may need to contact you directly. Please nominate your preferred contact day and time. If you leave this blank we will make contact anytime from 8am to 6pm, Monday to Friday.

Most convenient day to call

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any

Preferred method of contact	Contact phone number/email	Preferred contact time (Monday to Friday 8 am to 6 pm)	
Home phone number ☐	( )	from ☐ am ☐ pm	to ☐ am ☐ pm
Business phone number ☐	( )	from ☐ am ☐ pm	to ☐ am ☐ pm
Mobile phone number ☐		from ☐ am ☐ pm	to ☐ am ☐ pm
Email address ☐			

Section A – Job details ESS AD

1 What is the main job you are working in? | What industry do you work in?

2 What is your employer's name (or business name if self-employed)?

3 What is your actual business address (not a PO box)?

Suburb	State	Postcode

4 Does your main job involve performing in any of the following hazardous duties or environments?

Working at heights above 15 metres (for more than 10% of the time) Yes ☐ No ☐
Working in armed forces or with firearms Yes ☐ No ☐
Working on oil or gas rigs/platforms Yes ☐ No ☐
Working underground or handling explosives Yes ☐ No ☐
Underwater diving Yes ☐ No ☐

Please provide full details of the hazardous duty including but not limited to the percentage of time on the duty.

Are you applying for an increase in TPD or income protection cover or for new TPD Cover, Income Care, Income Care Plus, Income Care Platinum, Income Care Super, Essential Cover, Business Overheads Cover or Income Protection within SMSF Plan?

Yes ☐ ▶ **Please complete the questions below**

No ☐ ▶ **Go to Section B – Income details**

OR if you are applying for Accidental Death Cover only, go to Section M – Residence and travel

5 What is your employment status? (please tick (✔) the appropriate box)

☐ Self-employed (or employee of own company)*/Contractor ☐ Employed ☐ Unemployed
☐ Home duties ☐ Student ☐ Retired

***If "Self-employed", please complete Q5a to Q5d below, otherwise go to Q6**

a How long have you operated in this capacity?

Years	Months

b What percentage of the business do you own?

%

c How many people do you employ (excluding yourself)?

Full-time	Part-time

d Has your business made a net operating loss over the last 12 months?

Yes ☐ ▶ **Please complete the table below**

No ☐ ▶ **Go to question 6**

The reason for the loss	
The amount of the loss	
How long has the business operated at a loss?	
Is the business still operating at a loss?	
If no longer operating at a loss, how long has this been the case and why?	

6 How many hours do you work in an average week?

☐ 0 - 19 ☐ 20 - 39 ☐ 40 - 59 ☐ 60 - 79 ☐ 80 hours or more

7 What is the nature of the work in your main job?

Note: the list below represents the physical nature of duties only.

Nature of duty	**Percentage (%) time spent on each duty**	
Administration/clerical (e.g. filing, computer work, office duties)		%
Light manual work (e.g. deliveries, lifting under 5kg)		%
Supervision of manual work		%
Care of dependants/homemaker (only if TPD and job is home duties)		%
Manual work (e.g. cleaning, lifting over 5kg, carpentry, plumbing)		%
Total	**= 100%**	

8 In the next 12 months do you intend to change your job, duties or employment situation?

Note: A change in employment situation would include being made redundant.

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q9**

Please provide full details of the intended changes to include when you are intending to make the changes and the details of your new job, duties or employment situation.

9 Are you currently on, or in the next 12 months do you intend to take unpaid leave?

Note: This may include unpaid leave such as parental leave, carers leave, or a sabbatical.

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q10**

Please provide full details to include the reason for the leave, the length of time you expect to be on leave and the date the leave is due to start.

10 Do you have any other jobs?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q12**

a What are your other jobs?

b What are the duties of your other job(s)?

Nature of duty	Percentage (%) time spent on each duty	
Administration/clerical (e.g. filing, computer work, office duties)		%
Light manual work (e.g. deliveries, lifting under 5kg)		%
Supervision of manual work		%
Care of dependants/homemaker (only if TPD and job is home duties)		%
Manual work (e.g. cleaning, lifting over 5kg, carpentry, plumbing)		%
Total	**= 100%**	

c How many hours do you work in your other job(s) in an average week?

d What is your yearly income from your other job(s)?

11 In the last 12 months have you changed your job (this is not changing employers - rather changing the type of work you do - for example a farmer to a dentist) or gone from being employed to self-employed?

Yes ☐ ▶ **Please complete below** No ☐ ▶ **Go to Section B – Income details**

Date of change	
Previous Job	
Previous Duties	
Previous employment status	

Section B – Income details

If you are applying for:

Essential Cover complete **Q1** only

Life, Trauma and **TPD** complete **Q1 "This year" only** as per your relevant employment status

Income protection range including **Business Overheads Cover** complete all questions relevant to your employment s ESS

If you are an **Employee**:

1 a Annual Income

What is your annual income (excluding employer superannuation contributions) from your main job before tax?

Note: only include salary, fees, commission, regular overtime, fringe benefits and bonuses.

Financial Year	Period		Annual income earned
This Year	**01/07/**	**– 30/06/**	$
Last Year	**01/07/**	**– 30/06/**	$
Previous Year	**01/07/**	**– 30/06/**	$

b Employer superannuation contributions

How much superannuation does your employer contribute for you, including salary sacrifice?

Financial Year	Period		Employer superannuation contributions
This Year	**01/07/**	**– 30/06/**	%
Last Year	**01/07/**	**– 30/06/**	%
Previous Year	**01/07/**	**– 30/06/**	%

If you are **Self-employed**:

Annual Income

1 a What is your annual income generated directly due to your personal exertion before tax, less your share of business expenses incurred?

Note: Include terms such as eligible payments to your spouse, share of depreciation, share of director's fees, share of profit from a trust or supporting service company. Please exclude trail commission.

Financial Year	Period		Annual income earned
This Year	**01/07/**	**– 30/06/**	$
Last Year	**01/07/**	**– 30/06/**	$
Previous Year	**01/07/**	**– 30/06/**	$

b Superannuation contributions (only complete if you're applying for SCO)
What is the amount of superannuation contributions you make for yourself from your annual income stated above?

Financial Year	Period		Superannuation contribution		
This Year	**01/07/**	**– 30/06/**	$	or	**%**
Last Year	**01/07/**	**– 30/06/**	$	or	**%**
Previous Year	**01/07/**	**– 30/06/**	$	or	**%**

2 Do you receive other income from investments (e.g. interest, dividends, net rental income), which **exceeds 25%** of your current annual income?

Yes ☐ ▶ **Please complete below** No ☐ ▶ **Go to Q3**

Please provide details of other income from investments	Average income over the past 3 years
Dividends and interest	$
Net rental income (your rental income after eligible expenses have been deducted)	$
Other source of income (please specify):	$
Total	**$**

3 How would your income be replaced if you were unable to work due to illness or disability?
Note: This does not include trail commission.

☐ Sick pay ☐ Pension ☐ Company profit
☐ Salary Continuance Insurance ☐ Other ☐ No ongoing income

		Number of Days	
Sick Pay (how many days sick pay do you have available to you?)			
	Type of Pension	**Amount of benefit payable**	**Duration of benefit to be paid (months)**
Pension		$	
	Amount of profit payable	**How long will you receive these profits (months)**	
Company Profit	$		
	Type of Benefit	**Amount of benefit payable (per month)**	**Duration of benefit to be paid (months)**
Salary Continuance Insurance		$	
	Source of Income	**Amount of Income (per month)**	**Duration of Income (months)**
Other		$	

4 In the last 3 years have you been made bankrupt, placed in receivership, liquidation, or are you currently in the process of being assessed for bankruptcy or insolvency?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section C – Insurance history details**

How many times have you been bankrupt?	
Have you been discharged?	
Date(s) of discharge	
Name of Business/employer at time of bankruptcy	
Details of any ongoing financial commitments	

Note: for Business Overheads Cover applications, please complete the Business Overheads Cover Supplementary Personal Statement located on the AIA Australia adviser site.

Section C – Insurance history details

ESS

If you are applying for **Essential Cover** complete **Q3** only.

The next two questions are about life insurance*. You may have this cover as part of your super or you may have bought it separately.

***Life insurance includes:**

Cover which pays out if you die (Life cover)

Cover which pays if you get sick or seriously injured (Trauma, Total and Permanent Disability (TPD), Salary Continuance or Income Protection cover).

1 Other than this application, do you have or have you recently applied for any life insurance* with AIA Australia, Colonial First State, or any other insurance company or under any superannuation scheme?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q2**

Insurer	Type of cover	Insured amount	Policy number (if known)	Waiting Period	Benefit Payment Period	Date Policy commenced	To be replaced by this cover*?
		$				/ /	Yes ☐ No ☐
		$				/ /	Yes ☐ No ☐
		$				/ /	Yes ☐ No ☐
		$				/ /	Yes ☐ No ☐

Note: If you are 60 or older and you are applying for income protection with a benefit period to the policy anniversary before your 70th birthday, you will need to provide us with evidence of your existing income protection cover. You can provide the evidence with this application or at claim time.

If the policy to be replaced is an existing policy, please complete the Authority to cancel on page 59.

*** Important Note for Applicants/Policy owners: If it has been indicated above (i.e. by ticking 'Yes') that certain cover is to be replaced by the cover now being applied for, any new cover AIA Australia issues is conditional on the other cover being cancelled before an insured event occurs under that cover. This means any new cover AIA Australia issues does not apply until the other cover has been cancelled as required.**

2 Have you ever had an application for life insurance* refused, been asked to pay higher premiums or had exclusions or special terms applied?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q3**

Insurer	Type of cover	Terms offered	Reason for terms	Date policy commenced
				/ /
				/ /

3 Are you **claiming** or have you **ever claimed** under legislation or any other insurance policy **providing accident or sickness benefits**?

Note: This includes Life Insurance, Travel or Credit Card insurance, Superannuation, Workers Compensation, Disability Pension and/or Veterans affairs.

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section D – Habits**
OR if you are applying for Essential Cover, go to Section E – Height and weight

Benefit type/Source	Reason for claim	Date claim made	Total claim amount	Date claim finalised
		/ /	$	/ / **OR** ongoing ☐
		/ /	$	/ / **OR** ongoing ☐

Section D – Habits

1 When was the last time you smoked tobacco or any other substance, used e-cigarettes, nicotine patches or nicotine replacement products?

☐ This week
☐ In the past 3 months
☐ In the past 12 months
☐ 1 - 5 years ago
☐ More than 5 years ago
☐ Never ▶ **Go to Q3**

2 If you have smoked in the last year, please indicate type and amount smoked. (please tick (✔) all that are appropriate)

Type smoked	Per day	Per week	Per month	Per year
☐ Cigarettes				
☐ Cigars				
☐ Pipes				
☐ E-Cigarettes				
☐ Hookah				
☐ Tobacco that is chewed or sniffed				
☐ Nicotine Replacement (gum/patches/sprays etc.)				

3 On average how many standard drinks do you typically consume in a week?

☐ 0 ☐ 1 - 7 ☐ 8 - 14 ☐ 15 - 21 ☐ 22 - 28 ☐ 29 - 35 ☐ 36 -42 ☐ 50 or more

4 If you drink alcohol what is the average number of drinks you would have in a single session?

☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ 7 - 8 ☐ more than 8

Section E – Height and weight

ESS

1 What is your height and weight?

Height	cm	**OR**	feet	inches
Weight	kg		stone	lbs

2 Has your weight changed by more than 5 kg in the last 12 months?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section F – Doctor's details**

3 Did you gain or lose weight?

☐ Gain ☐ Lose

4 What was the reason for your weight change?

☐ Diet and/or exercise ☐ A medical condition or illness ☐ Pregnancy

☐ As a side effect of medication ☐ Weight loss surgery ☐ I don't know

5 If you lost weight, how much weight did you lose?

Section F – Doctor's details

ESS

1 Please provide the name and address of the last doctor or medical centre that you consulted.

Doctor's name or medical centre

Address

Suburb	State	Postcode

Phone number ( ) Fax number ( )

2 Have you changed doctor in the last 12 months?

Yes ☐ ▶ **Please provide the name and address of your previous doctor or medical centre below**

No ☐ ▶ **Go to Q3**

Doctor's name or medical centre

Address

Suburb	State	Postcode

Phone number ( ) Fax number ( )

3 Are you applying for Essential Cover only?

Yes ☐ ▶ **Go to Section J – Medical history (Essential Cover only)**

No ☐ ▶ **Go to Section G – Family history details**

Section G – Family history details

The next few questions are about your family's medical history. You should only answer about your mother, father, sisters or brothers.

Have your natural parents, brothers or sisters ever had any of the following conditions?

Heart problems, cardiomyopathy, stroke, or sudden death Diabetes Any Dementia, Alzheimer's or Parkinson's disease Cancer of any type (specify type of cancer in table below e.g. breast or colon cancer) Motor Neurone Disease, Huntington's disease, Multiple sclerosis, Muscular Dystrophy or Polycystic kidney disease Any other condition which runs in your family	Yes ☐ No ☐

If you answered 'Yes' please complete table below, otherwise go to Section H – Medical history details

Family member	Condition	Approximate age diagnosed

Note: If you have a favourable genetic test result, for example, to show that you are not carrying a gene pattern associated with developing an illness that runs in your family, you may choose to disclose the result.

Section H – Medical history details

1 Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following even if you have not seen a doctor?

a **Asthma, bronchitis** or **any other condition affecting your lungs or breathing** such as chronic obstructive pulmonary disease (COPD), shortness of breath, sleep apnoea, COVID-19, emphysema, recurrent pneumonia Yes ☐ No ☐

Note: You do not need to tell us about common colds or flu or one-off chest infections that you have fully recovered from

b **Diabetes** managed with or without medication, **raised blood sugar levels** or **sugar in your urine** including diabetes in pregnancy, insulin resistance, impaired glucose tolerance Yes ☐ No ☐

c **Cysts** or **lumps**. **Moles** which have changed shape or colour, bled, are itchy, have increased in size or have recently appeared Yes ☐ No ☐

d **Sunspots**, **skin lesion** or **skin cancer** such as Melanoma, BCC (Basal Cell Carcinoma) or SCC (Squamous Cell Carcinoma) Yes ☐ No ☐

Note: Warning signs of skin cancer include sores that don't heal, itchiness, tenderness or pain, redness or swelling of the skin.

e **Back** or **neck** pain or a condition affecting your back or neck such as sciatica, whiplash, trapped nerves, disc issues, ankylosing spondylitis or scoliosis Yes ☐ No ☐

f **Joint** or **muscle pain,** any type of **arthritis** or a condition affecting your **bones, joints, muscles** or **limbs** such as gout, ligament, tendon and muscle injuries, carpal tunnel syndrome and repetitive strain injuries or fractures or dislocations Yes ☐ No ☐

g Regardless of whether or not you have seen a doctor, required treatment or required any time off in the last 10 years, have you had or sought medical advice, counselling or treatment for **depression**, **anxiety**, **stress**, **panic attacks** or **post-natal depression** Yes ☐ No ☐

h Have you ever had any other **mental health condition**, **behavioural disorders**, **addiction** or **eating disorder** such as **schizophrenia**, **bipolar disorder** or **psychosis**, **PTSD** (Post Traumatic Stress Disorder), **addiction** or eating disorders, **ADHD** (Attention Deficit Hyperactivity Disorder), **asperger's** or **autism** and/or attempted suicide or self-harm Yes ☐ No ☐

Note: If you have already told us about any mental illness, anxiety, depression or stress in response to a previous question, there is no need to tell us about this again here.

i **Raised blood pressure** or **cholesterol** managed with or without medication Yes ☐ No ☐

If you have answered **'Yes' to any part of Q1 a to i above,** please complete the **Specific questionnaire** on the related condition in **Section O – Specific questionnaires** on **page 34-40.**

2 Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following even if you have not seen a doctor?

a A heart, artery or vein condition, disease or surgery on your heart or arteries or veins such as chest pain, angioplasty, stent or bypass, angina or heart attack, abnormal heart beat/palpitations, heart valve or heart structure abnormalities or cardiomyopathy Yes ☐ No ☐

b Multiple sclerosis, Parkinson's disease or any other neurological condition such as motor neurone disease, dementia or Alzheimer's, muscular dystrophy, cerebral palsy or paralysis Yes ☐ No ☐

c Numbness, pins and needles, tremor, change in skin sensation, tingling, muscle weakness or difficulty with coordination Yes ☐ No ☐

d A stroke, brain haemorrhage or injury or surgery to your brain including mini stroke or transient ischaemic attack (TIA) or cerebral aneurysm Yes ☐ No ☐

e Cancer or tumour Yes ☐ No ☐

f Thyroid, glandular, pituitary or pancreatic disorder such as hyperthyroid, Addison's disease or Grave's disease Yes ☐ No ☐

g Any condition affecting your bowel or digestive system such as reflux or Barrett's oesophagus, Crohn's disease or colitis, irritable bowel syndrome, ulcers or polyps Yes ☐ No ☐

h Any condition affecting your liver or gallbladder such as hepatitis, fatty liver, gallstones or an abnormal blood test or scan of your liver Yes ☐ No ☐

i Varicose veins, haemorrhoids or hernia Yes ☐ No ☐

j Any condition affecting your kidneys, bladder, testes or prostate such as raised PSA (Prostate Specific Antigen), blood or protein in your urine or kidney or bladder stones Yes ☐ No ☐

k Epilepsy, fits of any kind, fainting episodes, dizziness or recurrent headaches or migraines Yes ☐ No ☐

l Chronic fatigue syndrome (CFS), myalgic encephalomyelitis (ME), fibromyalgia, chronic pain, persistent fatigue or tiredness or sleep disorder such as unresolved insomnia Yes ☐ No ☐

m Psoriasis, eczema, dermatitis or any other skin disorder Yes ☐ No ☐

n Anaemia, bleeding disorder, blood clots, DVTs, haemochromatosis or any other blood disorder Yes ☐ No ☐

o Any issue affecting your eyes or sight such as blurred, double or impaired vision, cataracts, glaucoma or retinal detachment Yes ☐ No ☐

Note: You do not need to tell us about short or long sightedness

p Any issue affecting your ears, balance or hearing such as tinnitus, meniere's disease or labyrinthitis, balance problems or dizziness, hearing corrected by hearing aids Yes ☐ No ☐

If you have answered **'Yes' to any part of Q2 a to p above,** please complete the **General health questionnaire(s)** in **Section K on page 30-31 for each of these conditions.**

Section I – Additional medical details

The next section is about medical conditions, tests or investigation that you haven't yet told us about.

Note: You do not need to tell us about anything here that you have already disclosed.

1 In the last two years have you consulted a doctor or health professional?

Note: You do not need to tell us about minor issues such as cold or flu, contraception, IVF or uncomplicated pregnancy.

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q2**

a When was this consultation?

/ /

b What was the condition/reason for the consultation?

c What was the result of the consultation? (please tick (✔) **ONLY ONE** of the below)

All clear/ normal/ full recovery – no test or prescribed treatment required (other than contraceptive and cold/ flu medication) ☐

Tests conducted – results pending ☐

Not fully recovered yet ☐

Referred to specialist/health professional ☐

Ongoing treatment/surveillance/ongoing monitoring ☐

2 Have you been referred to a specialist or had, or been advised to have, any medical investigations, tests or surgery? Such as minor injuries or strains, a blood test or biopsy, ultrasound, x-ray, CT or MRI scan or ECG or other heart investigation.

Note: You do not need to tell us about uncomplicated pregnancy, terminations or infertility or routine smear tests or mammograms not requiring further investigation.

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q3**

What was the reason for seeking advice, treatment, tests or surgery?

3 Are you currently being tested for or do you have any signs or symptoms of ill health or disability?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q4**

Please provide details of tests being conducted, signs or symptoms

4 In the last 5 years, due to injury or illness, have you been off work for more than five consecutive days?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q5**

Please provide details of the condition and the total time off work

5 In the last 5 years have you had to work reduced hours or have you altered your duties due to sickness or injury?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q6**

Please provide details of the condition, altered duties and the number of reduced hours

6 Have you been prescribed medication or treatment for a period of 4 weeks or more?
Including minor injuries or strains, prescriptions from a doctor, even if you did not take them, counselling or physiotherapy.
Note: You do not need to tell us about antibiotics for one-off chest infections, contraception or fertility or dental treatment

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q7**

Please provide details of the medication or treatment and the condition

7 Do you have total cover (applied for including any cover with another insurer or superannuation fund) of more than

- $500,000 of lump sum death cover, or
- $500,000 of total and permanent disability (TPD) cover, or
- $200,000 of trauma and/or critical illness cover, or
- $4,000 a month in total of any combination of income protection and salary continuance or
- $4,000 a month of business overheads cover?

Yes ☐ ▶ **Please complete 7a**

No ☐ ▶ **Go to Q8**

Note: If you have a favourable genetic test result, for example, to show that you are not carrying a gene pattern associated with developing an illness that runs in your family, you may choose to disclose the result.

a Have you had, or do you intend, in the next 12 months to have a genetic test?

Yes ☐ **Please complete 7b and 7c below**

No ☐ **Go to Q8**

Note: If you have had a genetic test as part of a medical research study conducted by an accredited university or medical research institution where

- your individual test result has not been and will not be provided to you, or
- you have specifically asked not to receive the test results,

then you may answer 'No'

b What is/was the reason for your genetic test?

c What was the result of your genetic test?

or, test has not been done yet ☐

8 Have you within the last two years suffered a needle stick injury?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q9**

Please provide details of date of incident(s), including dates and results of follow up blood test

9 Have you ever had a positive test for Hepatitis B or C (including carrier), Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) or are you awaiting the results of such a test? (please tick (✔) the appropriate box)

☐ Have had a positive test ☐ Awaiting results of test ☐ Don't know ☐ No

10 a In the last 5 years, have you had sexual intercourse without a condom with the following persons?

(i) Someone who might have exposed you to the Human Immunodeficiency Virus (HIV) infection Yes ☐ No ☐

(This may include unprotected sexual intercourse with someone other than your regular partner whose HIV status is unknown to you.)

(ii) Someone who injects non-prescribed drugs Yes ☐ No ☐

(iii) Someone who is a sex worker Yes ☐ No ☐

(iv) Someone who is infected with Human Immunodeficiency Virus (HIV) infection Yes ☐ No ☐

(v) Someone who is infected with Hepatitis B Yes ☐ No ☐

(You may answer 'No' if you are vaccinated and have immunity for Hepatitis B.)

(vi) Someone who is infected with Hepatitis C Yes ☐ No ☐

b In the last 5 years, have you been diagnosed with or experienced symptoms of Sexually Transmitted Infection/s (STIs) (examples, chlamydia, gonorrhoea, syphilis)? Yes ☐ No ☐

Additonal questions (for female life to be insured only)

11 Have you ever had an abnormal pap smear or a +ve HPV test?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q12**

a If '**Yes**', What type of abnormality did you have and when did you have the test(s)? (please complete as applicable)

Result	Please tick (✔) all that apply	Date	Date	Date
Unsatisfactory	☐	/ /	/ /	/ /
HPV +ve	☐	/ /	/ /	/ /
CIN 1/LSIL	☐	/ /	/ /	/ /
CIN 2 or CIN 3/HSIL	☐	/ /	/ /	/ /
Cis (carcinoma in situ)	☐	/ /	/ /	/ /
Other (please state)	☐	/ /	/ /	/ /
Don't know	☐	/ /	/ /	/ /

b What treatment did you receive for the abnormal results? (please complete as applicable)

Follow-up/ Surveillance	Please tick (✔) all that apply	Date	Result (Normal/Abnormal/ Other)	Date	Result (Normal/Abnormal/ Other)
Colposcopy	☐	/ /		/ /	
Biopsy	☐	/ /		/ /	
Laser/Lletz	☐	/ /		/ /	
Hysterectomy	☐	/ /		/ /	
Other (please state)	☐	/ /		/ /	
No Treatment or Follow-up	☐	/ /		/ /	
Awaiting Follow-up	☐	/ /		/ /	

c What follow-up or surveillance have you undergone? (please complete as applicable)

Follow-up/ Surveillance	Please tick (✔) all that apply	Date	Result (Normal/Abnormal/ Other)	Date	Result (Normal/Abnormal/ Other)
Pap smear	☐	/ /		/ /	
HPV	☐	/ /		/ /	
Other (please state)	☐	/ /		/ /	
No Treatment or Follow-up	☐	/ /		/ /	
Awaiting Follow-up	☐	/ /		/ /	

12 Have you had an HPV test before?

Yes ☐ ▶ **Please complete below** No ☐ ▶ **Go to Q13**

a What was the result?

☐ Positive ☐ Negative

b Was the negative HPV test within the last 3 years?

Yes ☐ No ☐

13 Have you ever had an abnormal breast ultrasound or mammogram?

Yes ☐ ▶ **Please complete below** No ☐ ▶ **Go to Q14**

a How long ago was this?

/ /

b Was this fully investigated by the following? (please tick (✔) all that are appropriate)

☐ Ultrasound ☐ Fine needle aspiration ☐ Mammogram ☐ Not investigated

☐ Other (please specify):

c What was the result/outcome of your test? (please tick (✔) the appropriate box)

☐ Test conducted – results pending ☐ Test conducted – results all clear and normal

☐ Ongoing treatment/investigations ☐ Ongoing monitoring

d Have you been advised by your doctor that this condition was due to cancer, tumour or abnormal cells?

Yes ☐ No ☐

14 Have you ever experienced any changes to your breasts, even if you have not consulted a doctor or medical practitioner? Including cysts, lumps or lumpiness, changes to the nipple, discharge, redness or dimpling or pain that does not go away.

Yes ☐ ▶ **Please complete below** No ☐ ▶ **Go to Q15**

a How long ago was this?

☐ In the last 6 months ☐ 6-12 months ago ☐ 12-36 months ago ☐ 3-5 years ago ☐ More than 5 years ago

b What was the diagnosis/name of the condition?

c Are you undergoing or awaiting referral, tests, investigations, the results of any investigations or tests/surgery for this condition?

d Is this condition still present, disappeared or been removed?

e Was this fully investigated by the following? (please tick (✔) all that are appropriate)

☐ Ultrasound ☐ Fine needle aspiration ☐ Mammogram ☐ Not investigated

☐ Other (please specify):

f Date of last investigation or treatment including surgery

/ /

g What was the result/outcome of your test? (please tick (✔) the appropriate box)

☐ Test conducted – results pending ☐ Test conducted – results all clear and normal

☐ Ongoing treatment/investigations ☐ Ongoing monitoring

h Have you been advised by your doctor that this condition was due to cancer, tumour or abnormal cells?

Yes ☐ No ☐

15 Have you ever had or sought treatment for any gynaecological condition? Such as ovarian cysts or polycystic ovaries (PCOS), endometriosis or fibroids, hysterectomy, abnormal bleeding.

Note: you do not need to tell us about fertility treatment or contraception

Yes ☐ ▶ **Please provide details below** No ☐ ▶ **Go to Q16**

Name of condition	**Date of consultation**	**Outcome of consultation** e.g all clear, resolved, further treatment or investigation required	**Time off work**	**Date of last symptoms**	**Have you fully recovered?**
	/ /			/ /	
	/ /			/ /	

16 Are you pregnant?

Yes ☐ ▶ **Please complete below** No ☐ ▶ **Go to Section L – Alcohol and Drug Use on page 32**

a How many weeks pregnant are you?

b Have you had any complications with the pregnancy or any medical investigations planned other than routine pre-natal screening?
Note: Complications include raised blood pressure, raised glucose, anaemia, other abnormal blood tests, abnormal scans or post-natal depression.

Yes ☐ ▶ **Please complete below** No ☐ ▶ **Go to c**

Please tick (✔) the appropriate box

☐ Gestational diabetes ☐ Pre-eclampsia (high blood pressure)

☐ Other (please specify):

c Are you intending to return to work within 12 months of the start of your maternity leave?

Yes ☐ No ☐

d After maternity leave will you be returning to your current job with the same duties?

Yes ☐ No ☐ ▶ **Please provide details below**

Details:

e On your return to work are you intending to work 20 hours or more per week?

Yes ☐ No ☐

f Are you intending to work from home full time instead of your usual place of work at any stage before your maternity leave begins?

Yes ☐ No ☐

Section J – Medical history (Essential Cover Only) ESS

1 Have you ever had or received any medical advice, treatment, investigation or operation or been hospitalised in the last 5 years in relation to:

a Cancer, heart complaints including chest pain, alcohol or drug abuse, diabetes, stroke, paralysis, neurological disorders including epilepsy, multiple sclerosis Yes ☐ No ☐

b Mental or nervous disorders including anxiety or fatigue, or degenerative musculoskeletal disorders Yes ☐ No ☐

Yes ▶ **Please complete a 'General health questionnaire' in Section K for each of these condition(s) on pages 30-31 Then go to Section L – Alcohol and Drug Use on page 32**

No ▶ **Go to Section L – Alcohol and Drug Use on page 32**

Section K – General health questionnaire

General health questionnaire 1

Question number

a Illness/Injury/tests

b Main symptoms or cause

c Date commenced (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

d Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates

e How long ago did the symptoms cease? (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

f Did you require time off work for this condition?

Yes ☐ No ☐

g If **'Yes'** how long have you had off work?

☐ Days ☐ Weeks ☐ Months

h What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i Have you made a full recovery?

Yes ☐

No ☐ ▶ **Please provide details below**

j Do you have any residual ongoing limitations?

Yes ☐ ▶ **Please complete below**

No ☐

k Does your usual GP have details of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

General health questionnaire 2

Question number

a Illness/Injury/tests

b Main symptoms or cause

c Date commenced (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

d Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates

e How long ago did the symptoms cease? (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

f Did you require time off work for this condition?

Yes ☐ No ☐

g If **'Yes'** how long have you had off work?

☐ Days ☐ Weeks ☐ Months

h What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i Have you made a full recovery?

Yes ☐

No ☐ ▶ **Please provide details below**

j Do you have any residual ongoing limitations?

Yes ☐ ▶ **Please complete below**

No ☐

k Does your usual GP have details of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

General health questionnaire 3

Question number

a Illness/Injury/tests

b Main symptoms or cause

c Date commenced (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

d Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates

e How long ago did the symptoms cease? (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

f Did you require time off work for this condition?

Yes ☐ No ☐

g If **'Yes'** how long have you had off work?

☐ Days ☐ Weeks ☐ Months

h What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i Have you made a full recovery?

Yes ☐

No ☐ ▶ **Please provide details below**

j Do you have any residual ongoing limitations?

Yes ☐ ▶ **Please complete below**

No ☐

k Does your usual GP have details of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

General health questionnaire 4

Question number

a Illness/Injury/tests

b Main symptoms or cause

c Date commenced (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

d Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates

e How long ago did the symptoms cease? (please tick (✔) the appropriate box)

- ☐ Within the last 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

f Did you require time off work for this condition?

Yes ☐ No ☐

g If **'Yes'** how long have you had off work?

☐ Days ☐ Weeks ☐ Months

h What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i Have you made a full recovery?

Yes ☐

No ☐ ▶ **Please provide details below**

j Do you have any residual ongoing limitations?

Yes ☐ ▶ **Please complete below**

No ☐

k Does your usual GP have details of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

Section L – Alcohol and drug use

ESS

1 Have you ever been advised to reduce or stop your alcohol consumption by a doctor, nurse or other medical professional?
Note: This includes a referral for specialist support such as an alcohol dependence unit or Alcoholics Anonymous.

Yes ☐ ▶ **Please complete below**
No ☐ ▶ **Go to Q4**

Date of advice
/ /

Reason for advice

What advice were you provided?

Who provided you with the advice?

2 What was the maximum amount of standard drinks that you were drinking a week when you were advised to reduce your consumption?

3 Did you cease/reduce drinking alcohol and when?

Yes ☐ ▶ **Please complete below**
No ☐ ▶ **Go to Q4**

Date drinking ceased/reduced
/ /

4 Have any of the following applied to you in the last 5 years? (please tick (✔) all applicable)

☐ Have had blood tests to determine if my liver is functioning correctly
☐ Have been convicted of driving while under the influence of alcohol
☐ Have been seen in an emergency care unit whilst intoxicated
☐ Have been admitted to hospital due to alcohol use
☐ Have been unable to work or required time off work or alcohol has affected your ability to complete your work
☐ None of the above

5 In the last 10 years have you taken any illegal drugs or used drugs that were prescribed to another person?

Yes ☐ ▶ **Complete Section O Q10 - Drug questionnaire on page 40 - then go to Section M - Residence and travel details**
No ☐ ▶ **Go to Section M - Residence and travel details**

Section M – Residence and travel

ESS AD

1 Are you a Citizen or permanent resident of Australia or New Zealand?

Yes ☐ ▶ **Go to Q2**
No ☐ ▶ **Please complete below**

a What country did you migrate from?

b What type of visa do you hold? (please tick (✔) the appropriate box)

☐ 457 (Temporary work (skilled) visa) ☐ Spouse's visa ☐ 418 (Education or Student visa)
☐ 419 (Visiting academic visa) ☐ Tourist visa ☐ 426 or 427 (Domestic staff visa)
☐ Other (please specify)

c When will your visa expire? (please tick (✔) the appropriate box)

☐ Within 12 months ☐ 12-24 months ☐ More than 2 years

d Will you be applying for permanent residency in Australia before your visa expires?

Yes ☐

No ☐

2 Have you lived in Australia for more than 2 years?

Yes ☐ ▶ **Go to Q3**

No ☐ ▶ **Please complete below**

Please provide details of the type of visa or status held previously (e.g. bridging visa, spouse visa, refugee status) and the country you migrated from

3 In the next 12 months, do you have definite plans to travel, live or work in another country?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q4**

Reason for travelling eg. Holiday, live, emigrating, work, visiting family/relatives, studying)	**Destination (city/country)**	**Date of departure (if known)**	**Duration of trip (weeks)**	**If you are temporarily working abroad, please advise the duration of the contract and the expected date of return to Australia**
		/ /		
		/ /		

☐ Note: If you are travelling, and you have been fully vaccinated by an Australian approved COVID-19 vaccine, please tick the box

(Fully vaccinated means you have received the recommended dosing regimen of a specific COVID-19 vaccine in accordance to the Australia Department of Health advice)

4 Do you plan to leave Australia permanently? **ESS** **AD**

Yes ☐

No ☐

Section N – Pastimes and activities

1 Do you take part, or plan to take part, in any of the following?
Note: You do not need to tell us about flying only as a fare-paying passenger, a one-off parachute jump or a one-off scuba dive.

a Private flying, gliding, hang gliding, parachuting or ballooning Yes ☐ No ☐

b Underwater diving Yes ☐ No ☐

c Football of any code such as football, soccer or rugby Yes ☐ No ☐

d Motor car or motorcycle sport including rally driving, karting and drag racing Yes ☐ No ☐

e Trail bike, quad bike, or three wheeler bike riding including off road and dirt bike Yes ☐ No ☐

f Sailing at sea or powerboat racing Yes ☐ No ☐

g Combat sports such as martial arts or boxing Yes ☐ No ☐

h Any other sport or hazardous activities such as competitive horse riding or cycling, abseiling, mountaineering, climbing, caving, rafting, or winter sports Yes ☐ No ☐

i Are you paid or sponsored to play any sports if **'Yes'**, please complete below Yes ☐ No ☐

Type of sport	**Name of team/sponsor**	**Are you paid or sponsored**	**Amount of money/ sponsorship you receive per annum**
			$
			$

Note: if you have answered **'Yes' to any part of Q1 a to h above**, please complete the **Pastimes and activities questionnaire(s)** on the related activity in **Section P on pages 41-42.**

Section O – Specific questionnaires

If you answered **'Yes'** to:

Section H Q1a on page 23, then please complete **Asthma, Lung and breathing disorder** questionnaire below or if **Sleep Apnoea**, then please complete **Sleep Apnoea** questionnaire below

Section H Q1b on page 23, then please complete **Diabetes and abnormal blood sugar** questionnaire on page **35**

Section H Q1c or d on page 23, then please complete **Cysts, Moles and Skin lesions** questionnaire on page **36**

Section H Q1e on page 23, then please complete **Back, Neck and Spine** questionnaire on page **36**

Section H Q1f on page 23, then please complete **Joint/Musculoskeletal** questionnaire on page **37**

Section H Q1g or h on page 23, then please complete **Mental health** questionnaire on page **37**

Section H Q1i on page 23 re High blood pressure, then please complete **High blood pressure** questionnaire on page **38**

Section H Q1i on page 23 re Raised Cholesterol, then please complete **Raised Cholesterol** questionnaire on page **39**

Section L Q5 on page 32, then please complete **Drug** questionnaire on page **40**

1 Asthma, lung and breathing disorder questionnaire

a Please tick (✔) the appropriate box

☐ Asthma ☐ Chronic bronchitis

☐ Emphysema ☐ Recurrent pneumonia

☐ Shortness of breath

☐ Chronic obstructive pulmonary disease (COPD)

☐ Other (please specify)

b When did your symptoms begin?

/ /

c Do any of the following apply to your condition? (please tick (✔) the appropriate box)

☐ Claimed benefits due to work absence

☐ Taken early retirement

☐ Required oxygen treatment at home

☐ None of the above

d Is your condition made worse by your job?

Yes ☐

No ☐

e Have you stayed overnight in hospital due to your condition?

Yes ☐ ▶ **Please provide full details below**

No ☐

f How many times have you been in hospital or attended the emergency department in the last 3 years due to your condition?

g How often do you have symptoms?

☐ Continuous symptoms

☐ More than once a day

☐ Daily

☐ More than 2 days a week but not daily

☐ 2 or less days per week

☐ Never have symptoms

h How many days have you taken steroid tablets in the last 2 years?

i Unless already provided, please give details of when you first suffered from this condition, details of symptoms, tests or investigations, treatment, time off work, when you last had symptoms or treatment and whether you are fully recovered.

j Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

2 Sleep Apnoea questionnaire

a Are you undergoing or awaiting hospital referral, tests, investigations, the results of any tests or investigations or surgery for this condition?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

b Has this condition been fully investigated?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

c Has the condition been diagnosed as obstructive sleep apnoea?

Yes ☐

No ☐ ▶ **Please complete below**

Please provide details

d What was the date of the diagnosis?

/ /

e Have you been using a CPAP machine every night for 3 months or more?

Yes ☐

No ☐ ▶ **Please complete below**

Please provide details including any other treatment used

f Do you suffer from excessive daytime tiredness? This means you're likely to fall asleep or feel the urge to sleep when sitting inactive in a public place (e.g. in a theatre or a meeting), watching TV, as a passenger in a car or sitting and talking to someone?

Yes ☐ No ☐

g Is your condition fully controlled? (this means that your symptoms have not gotten worse or more frequent, and your treatment hasn't changed, for at least 6 months)

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

h Does this condition limit your ability to work or carry out your normal daily activities?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

i Unless already provided, please give details of when you first suffered from this condition, details of symptoms, tests or investigations, treatment, time off work, when you last had symptoms or treatment and whether you are fully recovered.

Please provide details

j Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

3 Diabetes and abnormal blood sugar questionnaire

a Please tick (✔) the appropriate box

Gestational diabetes ☐ ▶ **Go to b**

Diabetes Type 1 – insulin dependent ☐ ▶ **Go to c**

Diabetes Type 2 – diet controlled, oral medication ☐ ▶ **Go to c**

Abnormal blood sugar ☐ ▶ **Go to c**

Insulin resistance ☐ ▶ **Go to c**

b Were your sugar levels found to be high during a current pregnancy or a previous pregnancy?

☐ Current ☐ Previous ☐ Both

(i) Were you treated with insulin?
Please tick (✔) the appropriate box

☐ Yes but not on insulin now

☐ Yes and still on insulin

☐ No

(ii) Has the sugar level in your blood or urine been checked since you gave birth?

☐ Yes ☐ No ☐ Currently pregnant

☐ Awaiting my 6 week postnatal check

If **'Yes'**, was the result normal?

☐ Yes ☐ No ☐ Don't Know

c On what date were you diagnosed?

/ /

d Do any of the following apply to you?
Please tick (✔) the appropriate box(es)

☐ I have had tingling, numbness or loss of sensation in my fingers, toes or feet

☐ My diabetes has affected my eyes but I have not needed any treatment

☐ My diabetes has affected my eyes and I have needed laser or other treatment

☐ I have or have had foot ulcers

☐ None of the above

e Except when first diagnosed have you been admitted to hospital as a result of your diabetes?

Yes ☐ ▶ **Please complete below**

No ☐

When were you last admitted to hospital as a result of your diabetes?

/ /

f When was your last diabetic review?

/ /

g Do you know the result of your last HbA1c test?

Yes ☐ ▶ **Go to h**

No ☐ ▶ **Go to i**

h What was your last HbA1c?

Note: HbA1c (or glycosylated haemoglobin) is a blood test that shows average blood glucose levels over a period of time, the reading has usually been expressed as a number with 1 decimal place in the format 8.0% but recently maybe expressed in mmol/mol such as 64.

%

mmol/mol

☐ Don't know

i At your last diabetes review what did your doctor or nurse tell you about the control of your diabetes?
Please tick (✔) the appropriate box

☐ Diabetic control is very good

☐ Diabetic control is satisfactory

☐ Diabetic control could be improved

☐ Diabetic control is not good enough

j Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

4 Cysts, Moles and Skin lesions questionnaire

a What was the diagnosis? Please tick (✔) the appropriate box

☐ Cyst/Mole
☐ Dysplastic naevi
☐ Sunspot
☐ Melanoma
☐ BCC (Basal Cell Carcinoma)
☐ SCC (Squamous Cell Carcinoma)
☐ Other

b Location of growths e.g. face, back, right arm

c Date of treatment(s)

/ / / /

d Have you been advised that your growths or skin lesions were cancerous or malignant?

Yes ☐ No ☐

e How many growths or skin lesions did you have?

f Have all your growths or skin lesions been removed or treated?

Yes ☐

No ☐ ▶ **Please complete below**

(i) How many were treated?

(ii) Why were they not all removed or treated?

g Were any of your growths or skin lesions removed surgically, cut out or scraped off?

Yes ☐ ▶ **Please complete below**

No ☐

(i) How many?

h Were any further tests, investigations, treatments, wider excisions or follow-ups recommended?

Yes ☐ ▶ **Please provide details below**

No ☐

i What was the date of your last skin check?

/ /

j What was the result of your last skin check?

k Does your usual doctor have knowledge of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

5 Back, Neck and Spine questionnaire

Was your back problem related to any of the following? Please tick (✔) the appropriate box

☐ Ankylosing spondylitis
☐ Osteoporosis
☐ Scoliosis, lordosis or kyphosis (spinal curvature)
☐ Tumour/cancer
☐ Rheumatoid or psoriatic arthritis
☐ Fracture
☐ None of the above

a Are you undergoing or awaiting hospital referral, tests, investigation, surgery or the results of any investigations or tests for this condition? Please tick (✔) the appropriate box

☐ Yes undergoing or awaiting referral to hospital
☐ Yes undergoing or awaiting investigations
☐ Yes undergoing or awaiting surgery
☐ None of the above

b Are you currently or have you in the last 12 months used prescription medication such as Steroids, Endone, Tramadol, or Oxycontin?

Yes ☐ No ☐

c Has a medical professional assessed your condition? Please tick (✔) the appropriate box

☐ No, have not seen a medical professional for these symptoms
☐ Yes, I have seen a medical professional and a diagnosis has been made
☐ Yes, I have seen a medical professional but no diagnosis has been made

(i) If 'Yes', when did you first consult your GP?

/ /

(ii) What diagnosis was made for your back pain? Please tick (✔) the appropriate box

☐ Muscle pain or sprain
☐ Disc related problem
☐ Don't know the cause

d How many days off your normal work or daily activities have you had for this condition?

e On how many separate occasions have you experienced symptoms of this condition? Please tick (✔) the appropriate box

☐ Once only
☐ Twice
☐ More than twice or continuously

f When did you last experience symptoms or take treatment for this condition?

/ /

g Where did you suffer pain?

☐ Neck (cervical) ☐ Lower back (lumbar sacral)

☐ Upper back (thoracic) ☐ More than one area

h Have you had surgery for this condition?

Yes ☐ No ☐

i Did you experience any of the following due to your back condition?

☐ Bowel or bladder problems

☐ Persistent symptoms in both legs such as pins and needles, weakness or numbness

☐ None of the above

j Unless already provided please give details of when you first suffered from this condition, details of symptoms, tests or investigations, treatment, time off work, when you last had symptoms or treatment and whether you are fully recovered.

l Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( ) Fax number ( )

6 Joint/Musculoskeletal questionnaire

a What was the cause of the complaint (doctor's diagnosis)? (e.g. arthritis, RSI, broken bone/fracture, carpal tunnel, osteoporosis, gout, accident)

b What part of the body was affected? (e.g. lower back, neck, left or right limb)

c Is the nature of the condition arthritic or degenerative?

Yes ☐

No ☐

d Has this condition occurred more than once?

Yes ☐ ▶ **Please complete below**

No ☐

How often has this condition occurred?

e When did your symptoms first occur? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ 3-6 months ago

☐ 6-12 months ago ☐ 12-24 months ago

☐ 2-5 years ago ☐ more than 5 years ago

f Has this condition caused you to lose time off work?

Yes ☐ ▶ **Please complete below**

No ☐

Total number of days you have had off work

g Are you experiencing symptoms or have any residual restrictions or limitations to your work duties?

Yes ☐ ▶ **Please complete (i) below**

No ☐ ▶ **Please complete (ii) below**

(i) Please provide details of any symptoms, residual restrictions or limitations to your work duties

(ii) When did your symptoms cease? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ 3-6 months ago

☐ 6-12 months ago ☐ 12-24 months ago

☐ 2-5 years ago ☐ more than 5 years ago

h Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( ) Fax number ( )

7 Mental health questionnaire

a Are you currently suffering from, or have you previously experienced symptoms of or sought advice or treatment for any of the following:

Single episode of depression including adjustment disorder, postnatal depression or grief reactions Yes ☐ No ☐

Chronic or recurrent depression Yes ☐ No ☐

Stress including acute stress reaction, work-related stress or adjustment disorder Yes ☐ No ☐

Anxiety disorder(s) including generalised anxiety, obsessive compulsive, phobic/ panic anxiety, or Post Traumatic Stress Yes ☐ No ☐

Bipolar I or II disorder, or Cyclothymia Yes ☐ No ☐

Schizophrenia or other psychotic disorder(s) including drug-induced delusional disorder Yes ☐ No ☐

Eating disorder(s) including Anorexia nervosa or Bulimia Yes ☐ No ☐

Attention Deficit Disorder including ADD/ADHD Yes ☐ No ☐

Other (please specify)

b Have any reasons or causes for the condition been identified?

Yes ☐ ▶ **Please complete below**

No ☐

If **'Yes'** advise details including cause, and if the cause is still persisting

c When were you first diagnosed with the condition?

/ /

d Are there any physical/other medical conditions contributing to or associated with your condition? such as chronic pain

Yes ☐ ▶ **Please provide details**

No ☐

e Please describe your symptoms, including the date they started

/ /

f When did you last experience these symptoms? (Or specify if ongoing)

/ / ☐ Ongoing

g Did your symptoms include suicidal thoughts or ideation?

Yes ☐ ▶ **Go to h**

No ☐ ▶ **Go to i**

h If **'Yes'**, have you ever attempted suicide?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details including dates

	Date / /
	Date / /

i Have you had any recurrences of these symptoms?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details including dates

	Date / /
	Date / /

j Please complete the table below with details of all treatments prescribed, recommended or received for your condition including medications, counselling and alternative/complementary therapies

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received

/ /

Date treatment ceased (or specify if ongoing)

/ / ☐ Ongoing

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received

/ /

Date treatment ceased (or specify if ongoing)

/ / ☐ Ongoing

k Did you comply with treatment(s) and/or advice from your treating doctor/health care professional?

Yes ☐

No ☐ ▶ **Please provide details**

l Has your condition ever caused you to take time off work?

Yes ☐ ▶ **Please provide details including dates**

No ☐

Date from / / Date to / /

Date from / / Date to / /

Date from / / Date to / /

m Are you limited in your ability to work or perform your activities of daily living as a result of this condition?

Yes ☐ ▶ **Please provide details**

No ☐

n Does your usual doctor have knowledge of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

8 High blood pressure questionnaire

a Are you awaiting a hospital referral or investigations for this condition?

Yes ☐ No ☐

b Have you had any of the following? (Please tick (✔) all that apply)

☐ Kidney problems, kidney stones or protein in your urine

☐ Angina, a heart attack, a stroke, a TIA or blocked or narrowed arteries in your legs

☐ An ECG or heart test that was abnormal or needed further investigation

☐ Chest pain that required attendance at an Accident and Emergency Department or any clinic or hospital

☐ Eye problems as a result of your condition

☐ None of the above

c Are you currently on prescribed treatment to control your blood pressure?

Yes ☐

No ☐ ▶ **Please complete below**

(i) Have you ever stopped treatment without your doctors approval?

Yes ☐ No ☐

d When was your blood pressure first noticed to be raised?

/ /

e Do you know the result of your last blood pressure reading?

Yes ☐ ▶ **go to (i)**

No ☐ ▶ **go to (ii)**

(i) If **'Yes'**,what was your last blood pressure reading? (e.g. 140/80)

(ii) If **'No'**, did your doctor or nurse tell you whether your last blood pressure reading was high, normal or low?

☐ High and needs to be reduced

☐ Satisfactory but slightly raised

☐ Normal

☐ Low

☐ Don't know

f What was the outcome of your last review of your blood pressure?

☐ Advised to start or increase treatment

☐ Treatment remained the same or has been decreased

☐ Treatment was stopped

☐ Advised to attend a review in less than 6 months

☐ Advised to attend a review in 6 months time or later

☐ Discharged from follow-up

☐ Referred to a specialist

g Unless already provided please give details of when you first suffered from this condition, details of symptoms, tests or investigations, treatment, time off work, when you last had symptoms or treatment and whether you are fully recovered?

h Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

9 Raised cholesterol questionnaire

a Are you awaiting a hospital referral or investigations for this condition?

Yes ☐ No ☐

b Have you had any of the following? (Please tick (✔) all that apply)

☐ Kidney problems, kidney stones or protein in your urine

☐ Angina, a heart attack, a stroke, a TIA or blocked or narrowed arteries in your legs

☐ An ECG or heart test that was abnormal or needed further investigation

☐ Chest pain that required attendance at an Accident and Emergency Department or any clinic or hospital

☐ Eye problems as a result of your condition

☐ None of the above

c Are you currently on prescribed treatment to control your cholesterol?

Yes ☐

No ☐ ▶ **Please complete below**

(i) Have you ever stopped treatment without your doctors approval?

Yes ☐ No ☐

d When was your cholesterol first noticed to be raised?

/ /

e Do you know the result of your last cholesterol reading?

Yes ☐ ▶ **go to (i)**

No ☐ ▶ **go to (iii)**

(i) If **'Yes'**,what was your last total cholesterol reading? (e.g. 5.5)

(ii) If **known**, what was your last HDL reading? (e.g. 1.0)

Unknown ☐

(iii) If **'No'**, did your doctor or nurse tell you whether your last cholesterol reading was high, normal or low?

☐ High and needs to be reduced

☐ Satisfactory but slightly raised

☐ Normal

☐ Low

☐ Don't know

f What was the outcome of your last review of your cholesterol? (Please tick (✔) all that apply)

☐ Advised to start or increase treatment

☐ Treatment remained the same or has been decreased

☐ Treatment was stopped

☐ Advised to attend a review in less than 6 months

☐ Advised to attend a review in 6 months time or later

☐ Discharged from follow-up

☐ Referred to a specialist

g How regularly is your doctor or nurse checking your cholesterol?

☐ Less often than yearly

☐ Yearly

☐ More often than yearly

h Unless already provided please give details of when you first suffered from this condition, details of symptoms, tests or investigations, treatment, time off work, when you last had symptoms or treatment and whether you are fully recovered?

i Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

10 Drug questionnaire

a Have you ever sought advice, treatment or counselling due to drug use?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details including dates

	Date / /
	Date / /

b Please provide details of all illegal drugs you have used in the table below

Name of substance	
Date first used	/ /
Date last used	/ /
Frequency of use	

Name of substance	
Date first used	/ /
Date last used	/ /
Frequency of use	

Name of substance	
Date first used	/ /
Date last used	/ /
Frequency of use	

c Have you ever injected or used drugs intravenously?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details including dates

	Date / /
	Date / /

d Have you ever been hospitalised due to, or treated for a drug overdose?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details including dates

	Date / /
	Date / /

e Have you ever been convicted of a criminal offence relating to drug use?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details including dates

	Date / /
	Date / /

f Has your drug use ever affected your ability to complete your work duties or required time off work?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details including dates

	Date / /
	Date / /

g Does your usual doctor have knowledge of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

Suburb	State	Postcode

Phone number ( )

Fax number ( )

Section P – Pastimes and activities questionnaires

ESS AD

If you answered **'Yes'** to:

Section N a on page 33, then please complete **Flying** questionnaire below

Section N b on page 33, then please complete **Underwater diving** questionnaire on **page 42**

Section N c on page 33, then please complete **Football of any code** questionnaire on **page 42**

Section N d or e on page 33, then please complete **Motor sports of any kind** questionnaire on **page 42**

Section N f to h on page 33, then please complete **Other sports and activities** questionnaire on **page 42**

1 Flying questionnaire

a What type of aerial device/aircraft do you fly? (please tick (✔) the appropriate aircraft(s))

	✔	Number of hours flown in the last 12 months	Number of hours in the next 12 months
Fixed wing (Private/recreational/commuter travel)	☐		
Helicopter (Private/recreational/commuter travel)	☐		
Fixed wing (Charter flying)	☐		
Helicopter (Charter flying)	☐		
Fixed wing and Helicopter (Agriculture/crop/mustering)	☐		
Helicopter, fixed wing – job i.e aerial surveyor, photographer etc.	☐		
Ballooning	☐		
Gliding	☐		
Ultra-light/gyroplane	☐		
Aerobatics/stunts	☐		

b Do you hold any licence that allows you to fly any aircraft (but not including Remotely Piloted Aircraft) e.g. recreational pilot licence, private pilot licence, commercial pilot licence, air transport pilot licence, etc.?

Yes ☐

No ☐

c Do you intend to change the scope of your present licence?

Yes ☐ ▶ **Please complete below**

No ☐

Please state the change in scope of your present licence

d Have you ever had an accident or been charged with violating civil aviation regulations?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

e Do you intend to engage in any form of aviation other than already mentioned?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details on the other form of aviation

f Do you ever use unauthorised landing areas?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

g Please advise the make and model of the aircraft that you fly/pilot

Make | Model

Continued overleaf

2 Underwater diving questionnaire

Please tell us more about your diving.

a Which of the following diving activities do you participate in?
(please tick (✔) all that apply)

- ☐ Snorkelling
- ☐ Scuba diving
- ☐ Scuba "try dives" only when on holiday
- ☐ Free diving (without breathing apparatus)

b What level of diving certification do you hold?

- ☐ Level 1/Basic/Introductory level
- ☐ Open water level or above
- ☐ Try dives or discover scuba diving only
- ☐ No formal training

c Are you a current BSAC, PADI or SSI member (or equivalent)?

Yes ☐
No ☐

d What is the maximum depth to which you usually dive? (in metres)

e Do you always dive with a buddy?

Yes ☐
No ☐

f Do you participate in any of the following activities in association with your diving? (please tick (✔) all that apply)

- ☐ Cave or pot hole diving
- ☐ Internal exploration of wrecks
- ☐ Mixed air diving
- ☐ Ice diving
- ☐ Record attempts or expeditions
- ☐ Diving for treasure
- ☐ Using diving bells
- ☐ Diving for profit or reward
- ☐ None of the above

e Please give details of the number of years of experience and any accidents or injuries suffered as a result of diving

3 Football of any code questionnaire

Please tell us more about your football.

a What type of football do you play?
(please tick (✔) all that apply)

- ☐ Australian Rules
- ☐ Rugby League
- ☐ Rugby Union
- ☐ Football (Soccer)
- ☐ Oztag
- ☐ Touch
- ☐ Gaelic Football
- ☐ American Football

b At what level do you participate?
(please tick (✔) the appropriate box)

- ☐ Recreational only (non-competition)
- ☐ Competitive – organised matches or as part of a club
- ☐ Semi-professional competitor
- ☐ Professional competitor

4 Motor sports of any kind questionnaire

a What type of vehicle or motor activity/event do you engage in? (eg. trail/quad bike riding, rally driving, karting, drag racing, circuit racing etc.)

b Vehicle type including make/model

Engine size

What maximum speed is reached?

c How often do you participate per year?

Last 12 months	
Next 12 months (expected)	

d At what level do you participate?
(please tick (✔)all that apply)

- ☐ Recreational only (non-competition)
- ☐ Recreational only (with competition)
- ☐ Job use (e.g. farming)
- ☐ Semi-professional/professional
- ☐ Record attempts or prototype testing

e Do you hold a CAMS licence and/or are you a member of a motor racing club or organisation?

Yes ☐ ▶ **Please complete below**
No ☐

Please provide details

f Have you ever been involved in any accidents whilst practising, testing, racing or riding/driving?

Yes ☐ ▶ **Please complete below**
No ☐

Provide details of when this occurred and whether you have any restrictions of your work duties or activities as a result

5 Other sport and activities questionnaire

a What type of activity do you engage in?

b At what level do you participate?
(please tick (✔) the appropriate box)

- ☐ Recreational only (non-competition)
- ☐ Recreational only (with competition)
- ☐ Semi-professional/professional

c How many times per month do you play, jump/launch or participate in this activity?

d Do you receive an income from participating in this activity?

Yes ☐ ▶ **Please complete below**
No ☐

How much do you earn from this activity per year?

$

Section Q – Child's personal details

Complete **Q1** to **Q7** if you have selected the Child Cover Option, otherwise go to **Section R – General declaration**

Child life to be insured 1

Surname | Date of birth

Given name(s)

Gender _____ Male ☐ Female ☐

1 What is the relationship between you (i.e. the applicant) and your child? (please tick (✔) the appropriate box)

☐ Mother/Father ☐ Legal guardian

2 Have you cared for your child continuously since birth?

Yes ☐

No ☐ ▶ **Please complete below**

How long have you cared for the child?

☐ Less than 12 months ☐ More than 12 months

3 Has your child suffered from severe asthma, requiring continuous oral steroid medication or hospitalisation in the last 2 years?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide dates and details on diagnosis and treatment

4 Other than for asthma, has your child ever been admitted to hospital (other than for minor ailments, e.g. broken bones, tonsillitis) or does your child suffer from any other medical condition or disability?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

5 Is your child currently undergoing medical tests, or being considered for an operation?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

6 Have any of your child's natural family (i.e. parents, brothers or sisters) ever had:

- Heart problems, stroke, diabetes, cancer?
- Cystic fibrosis, or any other hereditary disorder?

Yes ☐ ▶ **Please complete below**

No ☐

Family member	Condition	Approximate age diagnosed

7 Name of your child's usual doctor or medical centre

Doctor's address

Suburb | State | Postcode

Phone number ( ) | Fax number ( )

Child life to be insured 2

Surname | Date of birth

Given name(s)

Gender _____ Male ☐ Female ☐

1 What is the relationship between you (i.e. the applicant) and your child? (please tick (✔) the appropriate box)

☐ Mother/Father ☐ Legal guardian

2 Have you cared for your child continuously since birth?

Yes ☐

No ☐ ▶ **Please complete below**

How long have you cared for the child?

☐ Less than 12 months ☐ More than 12 months

3 Has your child suffered from severe asthma, requiring continuous oral steroid medication or hospitalisation in the last 2 years?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide dates and details on diagnosis and treatment

4 Other than for asthma, has your child ever been admitted to hospital (other than for minor ailments, e.g. broken bones, tonsillitis) or does your child suffer from any other medical condition or disability?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

5 Is your child currently undergoing medical tests, or being considered for an operation?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

6 Have any of your child's natural family (i.e. parents, brothers or sisters) ever had:

- Heart problems, stroke, diabetes, cancer?
- Cystic fibrosis, or any other hereditary disorder?

Yes ☐ ▶ **Please complete below**

No ☐

Family member	Condition	Approximate age diagnosed

7 Name of your child's usual doctor or medical centre

Doctor's address

Suburb | State | Postcode

Phone number ( ) | Fax number ( )

Section Q – Child's personal details (continued)

Complete **Q1** to **Q7** if you have selected the Child Cover Option, otherwise go to **Section R – General declaration**

Child life to be insured 3

Surname | Date of birth (/ /)

Given name(s)

Gender _____ Male ☐ Female ☐

1 What is the relationship between you (i.e. the applicant) and your child? (please tick (✔) the appropriate box)

☐ Mother/Father ☐ Legal guardian

2 Have you cared for your child continuously since birth?

Yes ☐

No ☐ ▶ **Please complete below**

How long have you cared for the child?

☐ Less than 12 months ☐ More than 12 months

3 Has your child suffered from severe asthma, requiring continuous oral steroid medication or hospitalisation in the last 2 years?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide dates and details on diagnosis and treatment

4 Other than for asthma, has your child ever been admitted to hospital (other than for minor ailments, e.g. broken bones, tonsillitis) or does your child suffer from any other medical condition or disability?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

5 Is your child currently undergoing medical tests, or being considered for an operation?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

6 Have any of your child's natural family (i.e. parents, brothers or sisters) ever had:

- Heart problems, stroke, diabetes, cancer?
- Cystic fibrosis, or any other hereditary disorder?

Yes ☐ ▶ **Please complete below**

No ☐

Family member	Condition	Approximate age diagnosed

7 Name of your child's usual doctor or medical centre

Doctor's address

Suburb	State	Postcode

Phone number ( ) | Fax number ( )

Child life to be insured 4

Surname | Date of birth (/ /)

Given name(s)

Gender _____ Male ☐ Female ☐

1 What is the relationship between you (i.e. the applicant) and your child? (please tick (✔) the appropriate box)

☐ Mother/Father ☐ Legal guardian

2 Have you cared for your child continuously since birth?

Yes ☐

No ☐ ▶ **Please complete below**

How long have you cared for the child?

☐ Less than 12 months ☐ More than 12 months

3 Has your child suffered from severe asthma, requiring continuous oral steroid medication or hospitalisation in the last 2 years?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide dates and details on diagnosis and treatment

4 Other than for asthma, has your child ever been admitted to hospital (other than for minor ailments, e.g. broken bones, tonsillitis) or does your child suffer from any other medical condition or disability?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

5 Is your child currently undergoing medical tests, or being considered for an operation?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details of the condition, date diagnosed, treatment and whether fully recovered

6 Have any of your child's natural family (i.e. parents, brothers or sisters) ever had:

- Heart problems, stroke, diabetes, cancer?
- Cystic fibrosis, or any other hereditary disorder?

Yes ☐ ▶ **Please complete below**

No ☐

Family member	Condition	Approximate age diagnosed

7 Name of your child's usual doctor or medical centre

Doctor's address

Suburb	State	Postcode

Phone number ( ) | Fax number ( )

Section R – General declaration and application for policy/membership

The following declarations apply to all policy owner(s) and also apply to a Total Care Plan Super life insured.

1 I have read and understood the Quotation attached to this application. I acknowledge that the quotation forms part of this application and apply to AIA Australia for the life insurance policy(ies) shown on the quotation or, for Total Care Plan Super, to the trustee of the FirstChoice Trust for the benefits shown on the quotation.

2 I have read and understood the **Product Disclosure Statement (PDS) and Policy** I was issued. My decision to apply for this insurance cover is based on the information in the PDS.

3 I understand that insurance cover will not commence until AIA Australia accepts the insurance proposed in writing or receives a signed acceptance of such alternative conditions as may be offered, and the first premium is received.

The following declarations apply to all policy owner(s) and lives insured.

4 I confirm that the declarations and answers to all questions in this application are true and correct including those not in my own handwriting. (For a life insured, this confirmation relates to answers and declarations about them.)

5 I have read and understood the section **Privacy of personal information** in the PDS. I acknowledge and consent to the use and disclosure of my personal information as detailed in that section. **If the life insured is different to the policy owner:** I, the life insured, acknowledge and consent to the insurer disclosing to the policy owner and the policy owner's financial adviser, the personal, medical and financial information used for the purpose of assessing the application for insurance. I understand this information may also include any "sensitive information", as defined in the Privacy Act.

The following additional declarations apply to the policy owner(s) under a SMSF plan.

I, the trustee(s) of the superannuation fund named in this application:

6 Confirm that the superannuation fund of which I am the trustee is a complying superannuation fund within the meaning of the Superannuation Industry (Supervision) Act 1993 (SIS Act) and Income Tax Assessment Act 1997 (Tax Act).

7 Undertake to advise AIA Australia immediately if the superannuation fund at any time ceases to be a complying fund as defined in the SIS Act and/or the Tax Act.

8 Confirm that I have the power under the trust deed governing the superannuation fund to apply for the policy(ies) the subject of this application.

9 Confirm that the life insured named in this application is a member of the superannuation fund named in this application.

The following additional declarations apply to the Total Care Plan Super life insured.

10 I understand that AIA Australia will pay any insurance benefits to the trustee of the FirstChoice Trust as the policy owner and the benefits will only be released in accordance with the Fund trust deed and the 'conditions of release' provided by the relevant superannuation legislation.

11 I apply to the trustee of the FirstChoice Trust for admission as a member of the Protection Category of membership in the Fund. I also undertake to notify the trustee of the FirstChoice Trust in writing immediately if at any time:

- I cease to be eligible to contribute to the Fund, or
- my employer makes Award or Superannuation Guarantee contributions to the Fund on my behalf.

By ticking the box beside my signature below, I indicate that I do not want to receive marketing information. To be completed by all lives insured and policy owners (including individual and corporate trustees and company directors/secretaries).

Name of signatory 1

Signature of signatory 1 ✗ Date / /

I do not wish to receive marketing information ☐

Name of signatory 2

Signature of signatory 2 ✗ Date / /

I do not wish to receive marketing information ☐

Name of signatory 3

Signature of signatory 3 ✗ Date / /

I do not wish to receive marketing information ☐

Name of signatory 4

Signature of signatory 4 ✗ Date / /

I do not wish to receive marketing information ☐

To be completed if the policy owner is a company, including a corporate trustee.

Executed by (name of company)

in accordance with section 127 of the Corporations Act 2001 (Cth)

Relationship to policy (please tick)	Signatory 1	Signatory 2	Signatory 3	Signatory 4
Life insured	☐	☐	☐	☐
Policy owner(s)	☐	☐	☐	☐
If the owner is a company including a corporate trustee				
Director (of company)	☐	☐	☐	☐
Sole Director (of company)	☐	☐	☐	☐
Secretary (of company)	☐	☐	☐	☐

Medical authority

AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia)

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, AIA Australia, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Medical authority

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to AIA Australia, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form AIA Australia asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- AIA Australia can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while AIA Australia is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name of life to be insured

Previous surname (if applicable)

AND/OR

Name of child life to be insured 1

Name of child life to be insured 2

Name of child life to be insured 3

Name of child life to be insured 4

Signature of life to be insured

✗

Date

/ /

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/ Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to AIA Australia, or to third parties they engage, only if AIA Australia has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- AIA Australia can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while AIA Australia is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name of life to be insured

Previous surname (if applicable)

AND/OR

Name of child life to be insured 1

Name of child life to be insured 2

Name of child life to be insured 3

Name of child life to be insured 4

Signature of life to be insured

✗

Date

/ /

Financial authority

AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia).

Only complete this section if you want your accountant or financial adviser to release financial information to AIA Australia.

Name of life to be insured

I, _____

authorise my accountant/financial adviser to release all information which AIA Australia and/or an authorised person requests for the purpose of assessing my Application for insurance. A photocopy of this authorisation is as effective and valid as the original.

Signature of life to be insured

✗

Date

/ /

Pathology request

Important information relating to AIDS (HIV)

What is AIDS?

AIDS (Acquired Immune Deficiency Syndrome) is the name given to a condition in which the immune system is attacked by the Human Immunodeficiency Virus (HIV). AIDS is a viral disease which destroys white blood cells in the body. The white blood cells help protect the body against infections and cancers.

How do people contract AIDS?

HIV can be transmitted by:

- unprotected sex with a partner who has the virus
- receiving blood, semen or organs which have been infected with HIV
- people who inject drugs
- people who share needles and syringes, or
- mother to child during pregnancy or breastfeeding.

Is there a cure?

The most recent evidence suggests that the virus will persist in the body indefinitely. As yet, there is no known cure for AIDS.

Why do people need an AIDS test for insurance?

As there is no known cure for AIDS, it is essential that AIA Australia protects the interests of existing policy owners. It must also ensure long-term viability for the benefit of not only current but also future policy owners. AIDS has become a critical risk factor as are heart disease, cancers, dangerous jobs, hazardous activities and the like. Accordingly, a lifestyle declaration has been introduced as part of the Personal Statement. Additionally, a blood test will be required.

What are your options?

You may choose not to have the test or you may wish to have further information first. If so, we recommend you discuss this with your own doctor or specialist counsellor. If you choose not to have the test, AIA Australia may not be able to proceed with the application for insurance.

What does a negative result mean?

If you receive a negative result, it means that you have not been infected with HIV or that you may have been infected recently but your body has not produced the antibodies signalling the presence of the virus. The body can take between seven and twelve weeks to manufacture the antibodies for HIV.

What does a positive result mean?

If the result is positive, it means that you have been infected with the virus and thus the infection is permanent. Please be aware of how the infection is transmitted so that you do not pass it on. People who have been infected with HIV may develop AIDS at some stage and the long-term outlook is uncertain. For this reason, insurance may not be available to these people.

Where do the results go?

Everyone undergoing an HIV test must sign a release form.

All results will be sent under confidential cover to AIA Australia to preserve your privacy.

Important information relating to Hepatitis B and C

What is Hepatitis B?

Hepatitis B is liver inflammation caused by the Hepatitis B Virus (HBV). Many people who get Hepatitis B either don't become ill or recover completely and the virus disappears from the blood. However, between 5 percent and 10 percent of people who are infected remain infectious and can infect other people. Chronic Hepatitis B infection can lead to cirrhosis of the liver and/or liver cancer.

What does a positive Hepatitis B test result mean?

If the result of the Hepatitis B test is positive, this means you have been infected by the Hepatitis B Virus and you can pass this infection to:

- any unprotected sexual partner
- anyone receiving your blood, donated organs or semen
- a person that injects drugs by sharing a needle, or
- a newborn baby from a Hepatitis B positive mother.

What is Hepatitis C?

Hepatitis C is liver inflammation caused by the Hepatitis C Virus (HCV). Many people have no symptoms. Some people may feel tired, have mild abdominal discomfort, or feel nauseous. The Hepatitis C Virus is usually spread by blood-to-blood contact with someone who is already infected. People infected with the Hepatitis C Virus will either clear the virus from their body or develop chronic hepatitis with or without symptoms. About 50 percent of people with Hepatitis C will develop chronic hepatitis. Some people with chronic hepatitis will develop cirrhosis of the liver and/or liver cancer.

What does a positive Hepatitis C test result mean?

A positive Hepatitis C test result means that you have Hepatitis C antibodies in your blood indicating present or past infection and you can pass this infection to:

- a person that injects drugs by sharing a needle, or
- anyone receiving your blood or donated organs.

Note: if you test positive for Hepatitis B or C, the laboratory that tests your blood is required by law to inform the state health department. This information is treated confidentially and used only for statistical purposes. People with Hepatitis B or C are not necessarily refused life insurance but may expect to pay higher annual premiums.

Pathology Request for insurance purposes

AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia).

Please complete pages 50 and 51.

It is essential to present this consent form to your doctor/pathologist if you need to undergo any pathology test(s).

Adviser instructions

1 With the life to be insured, complete the following sections on this page: Adviser details, Life to be insured details, Tests requested, Current doctor and Pathologist.

2 Give your client this Pathology Request and confirm the 'Life to be insured instructions' section with them.

Life to be insured instructions

1 Please complete this form but do not sign the client consent prior to attending the pathologist appointment.

2 Telephone the pathology branch for an appointment and ask if any special instructions apply.

3 If a Multiple Biochemical Analysis (MBA20) is required, you should fast overnight for a minimum ten hours before the test.

4 If an HIV test and/or Hepatitis B and C test are required, please ensure you have read the sections 'Important information relating to AIDS (HIV)' and 'Important information relating to Hepatitis B and C' on page 49.

Adviser details

Name(s)

Agency number

Application number

Phone number ( )

Fax number ( )

Life to be insured details

Given name(s)

Surname

Gender _____ Male ☐ Female ☐

Date of birth / /

Referral date / /

Tests requested

Other than a positive HIV and Hepatitis B and C test result, I request and authorise the pathologist mentioned in this form to forward a copy of my blood test results to my current doctor in addition to AIA Australia and its authorised person.

Consent

No ☐

Yes ☐

Tests

Please tick (✔) the appropriate test(s)

☐ Multiple Biochemical Analysis (MBA20) (including HDL and LDL cholesterol)

☐ Hepatitis B and C serologies (please read the section 'Important information relating to Hepatitis B and C')

☐ HIV antibodies (please read the section 'Important information relating to AIDS (HIV)')

☐ Cotinine test

☐ Full blood count and ESR

☐ Prostate Specific Antigen (PSA)

☐ Resting ECG

☐ Exercise ECG

☐ Microscopic urinalysis

☐ Other (please specify):

Current doctor

Name(s)

Address

Suburb | State | Postcode

Phone number ( )

Pathologist

Name(s)

Address

Suburb | State | Postcode

Phone number ( )

▶ Continued overleaf

Results and accounts for all applications should be sent to AIA Australia:

BY MAIL:
AIA Australia
Underwriting Department
PO Box 319
Silverwater NSW 2128

OR

EMAIL: Au.LNBReturnedCorro@aia.com

Please indicate client's full name and date of birth on the results and accounts.

Please forward the blood test results to the appropriate person and AIA Australia as indicated in this form by the life to be insured (refer to 'Tests requested' section).

Life to be insured consent

I,

- request and authorise the pathologist mentioned above to perform the tests requested by AIA Australia and authorised person in connection with my application for insurance and to forward such report to AIA Australia's Chief Medical Officer
- consent to have my blood tested for the presence of antibodies to the AIDS virus and Hepatitis B and C where requested by AIA Australia. I have read the information provided on page 49 regarding the implications of AIA Australia's AIDS test and understand its significance.

Please tick (✔) the box below:

☐ I request in the event of a test for HIV antibodies and/or Hepatitis B and C serologies being positive AIA Australia's Chief Medical Officer to communicate the result to my current doctor or to the doctor nominated below for communication to me in person

Doctor's full name

Doctor's address

Suburb	State	Postcode

Doctor's phone number

( )

Signature of life to be insured

✗

Date

/ /

Direct debit request

AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia).
Note: We will treat payments made by direct debit to Total Care Plan Super policies (if applicable) as personal contributions.

Policy number (if known) and/or Product type

Policy owner/Member name(s)

Payer details

Surname

Given name(s)

or Company/Business name(s) giving direct debit request

Account holder 1

ABN

Account holder 2

ABN

Payer – Postal address

Suburb	State	Postcode

I/We, as payer authorise and request
AIA Australia - User ID 000115 (APCA User ID) until further notice in writing to arrange for funds to be debited from my/our account, at the Financial Institution identified and as described in The Schedule below, any amounts which AIA Australia may debit or charge me/us through the Bulk Electronic Clearing System (BECS).

The Schedule

Name of account to be debited

Details of financial institution at which your account is held

Account details

BSB

Account number

Name of financial institution

Address

Suburb	State	Postcode

Direct debit request authorisation
I/We have read the Direct Debit Service Agreement on page 54 and 55 of this Application and acknowledge and agree with its terms and conditions. I/We request this arrangement to remain in force in accordance with details set out in The Schedule described above and in compliance with the Direct Debit Service Agreement.

Customer 1 name

Customer 1 signature

Date / /

✗

Customer 2 name

Customer 2 signature

Date / /

✗

Credit card authority

AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia).
Note: We will treat payments made by direct debit to Total Care Plan Super policies (if applicable) as personal contributions.

Policy number (if known) and/or Product type

Policy owner/Member name(s)

Please tick (✔) the appropriate box and complete all details.

☐ MasterCard ☐ Visa

Please charge my credit card the amount of $

(or adjusted amount as advised to me from time to time) until this ongoing authority is cancelled.

Cardholder's name

Cardholder's number

Expiry date /

(Note: if submitting this form online, a Card Verification Value (CVV) will also be required)

Address

Suburb | State | Postcode

Cardholder's signature

✗

Date / /

Direct debit request service agreement

This is your Direct Debit Request Service Agreement with AIA Australia Limited (APCA ID 000115, ABN 79 004 837 861, AFSL 230043). It explains what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your Direct Debit provider.

Please keep this agreement for future reference. It forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR authorisation.

Definitions

Account means the account held at your financial institution from which we are authorised to arrange for funds to be debited.

Agreement means this Direct Debit Request Service Agreement between you and us.

Business day means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.

Debit day means the day that payment by you to us is due.

Debit payment means a particular transaction where a debit is made.

Direct debit request or **DDR** means the Direct Debit Request between us and you.

Us or **we** means AIA Australia – Direct Debit User ID 000115, the Debit User you have authorised by requesting a DDR.

You means the customer who has signed or authorised by other means the DDR.

Your financial institution means the financial institution nominated by you on the DDR at which the account is maintained.

1. Debiting your account

1.1 By signing a DDR or by providing us with a valid instruction, you have authorised us to arrange for funds to be debited from your account. You should refer to the DDR and this agreement for the terms of the arrangement between us and you.

1.2 We will only arrange for funds to be debited from your account as authorised in the DDR, or we will only arrange for funds to be debited from your account if we have sent to the address nominated by you in the DDR, a billing advice which specifies the amount payable by you to us and when it is due. We will do this except where we have agreed to a temporary variation in accordance with your instructions under Clause 3 of this agreement, or where a credit tribunal or other legal tribunal has instructed us to vary the arrangement.

1.3 If the debit day falls on a day that is not a business day, we may direct your financial institution to debit your account on the following business day. If you are unsure about which day your account has or will be debited you should ask your financial institution.

2. Amendments by us

2.1 We may vary any details of this agreement or a DDR at any time by giving you at least 14 days written notice.

2.2 We reserve the right to cancel this agreement if the first debit from your account is returned unpaid or two or more debit attempts are returned unpaid by your financial institution.

3. Amendments by you

You may change*, stop or defer a debit payment, or terminate this agreement by providing us with at least 14 days notification by contacting us in writing at AIA Australia Underwriting Department, PO Box 319, Silverwater NSW 2128, or by phone on 13 1056 between 8am and 6pm (AEST/AEDT), Monday to Friday. You can also arrange any change through your financial institution, which is required to act promptly on your instructions.

*In relation to the reference to 'change', your financial institution may change your debit payment only to the extent of advising us of your new account details.

4. Your obligations

4.1 It is your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the DDR and this agreement.

4.2 If there are insufficient clear funds in your account to meet a debit payment:

a) you may be charged a fee and/or interest by your financial institution

b) you may also incur fees or charges imposed or incurred by us, and

c) you must arrange for the debit payment to be made by another method or arrange for sufficient clear funds to be in your account by an agreed time so that we can process the debit payment.

4.3 You should check your account statement to verify that the amounts debited from your account are correct.

5. Dispute

5.1 If you believe that there has been an error in debiting your account, you should notify us directly on 13 1056 and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly. Alternatively, you can take it up directly with your financial institution.

5.2 If as a result of our investigations, we conclude that your account has been incorrectly debited we will respond to your query by arranging for your financial institution to adjust your account (including interest and charges) accordingly. We will also notify you in writing of the amount by which your account has been adjusted.

5.3 If as a result of our investigations, we conclude that your account has not been incorrectly debited we will respond to your query by providing you with reasons and any evidence for this finding in writing.

5.4 Any queries you may have about an error made in debiting your account should be directed to us in the first instance and, if we are unable to resolve the matter, you can refer such queries to your financial institution which will obtain details from you of the disputed transaction and may lodge a claim on your behalf.

6. Accounts

6.1 Before completing the DDR you should check with your financial institution whether direct debiting is available from your account, as direct debiting is not available through BECS on all accounts offered by financial institutions.

6.2 You should confirm that the account details you provide to us are correct by checking them against a recent account statement.

6.3 If you have any questions about how to complete the DDR, you should contact your financial institution.

7. Confidentiality

7.1 Subject to Clause 7.2, we will keep any information (including your account details) collected as part of your DDR confidential. We will make reasonable efforts to keep any such information that we have about you secure and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

7.2 We will only disclose information about you that we have collected as part of your DDR:

a) to the extent specifically required or permitted by law or under our Privacy Policy or procedures, or

b) for the purposes of this agreement, including disclosing information in connection with any query or claim.

8. Notice

8.1 If you wish to notify us about anything relating to this agreement, you can write to us at AIA Australia Underwriting Department, PO Box 319, Silverwater NSW 2128.

8.2 We will notify you by sending a notice in the ordinary post or via email to the address you have given us in the DDR.

8.3 Any notice will be deemed to have been received on the third business day after posting.

Superannuation payment authority form

Total Care Plan Super

Total Care Plan Super is a superannuation product within the Colonial First State FirstChoice Superannuation Trust ABN 26 458 298 557 (FirstChoice Trust). Colonial First State Investments Limited ABN 98 002 348 352 AFSL 232468 is the Trustee of the FirstChoice Trust. AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia) is responsible for the administration of the Total Care Plan Super and provides insurance benefits to the Trust.

Authority for AIA Australia to request transfers or rollovers to Total Care Plan Super

Completing this form authorises AIA Australia to request a transfer or rollover on your behalf to Total Care Plan Super from your Nominated Super Fund Account stated at Section 2 or 3 for the amount of insurance premiums plus other taxes, fees and costs payable under Total Care Plan Super.

Fees

Your superannuation provider may charge you withdrawal or other fees for making a rollover or transfer to Total Care Plan Super. If you are not already aware of the fees your superannuation provider may charge, you should contact them for further information before completing this form.

Proof of identity

Please note your superannuation fund may require you to provide proof of identity, eg a certified copy of your Birth Certificate, Passport or Drivers Licence. Speak with your fund administrator to confirm what (if any) identification requirements they need before allowing the partial rollover and whether this is required once only or for each subsequent rollover.

Section 1 – Total Care Plan Super member details

My Total Care Plan Super policy number/s (if known)

Unique Superannuation Identifier (USI): **26 458 298 557 008**

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:

Surname

Full given name(s)

Date of birth / /

Occupation (if retired, state retired)

Main country of residence, if not Australia

Residential address (PO Box is not acceptable)

Suburb | State | Postcode

Postal address (if different to above)

Suburb | State | Postcode

Work phone number ( )

Home phone number ( )

Mobile phone number

Fax number ( )

Email address

Section 2 – Your nominated CFS FirstChoice super fund account (if applicable)

Super Fund name

Colonial First State FirstChoice Superannuation Trust

Product and account details

	Product name	Unique Superannuation Identifier (USI)	Account Number
☐	**CFS FirstChoice Personal Super**	**FSF0217AU**	**001 010**
☐	**CFS FirstChoice Wholesale Personal Super**	**FSF0511AU**	**001 011**
☐	**CFS FirstChoice Employer Super**	**FSF0361AU**	**001 065**

Colonial First State, Reply Paid 27, Sydney, NSW, 2001.

Super Fund email address: **contactus@colonialfirststate.com.au** Super Fund phone number: **13 13 36**

Section 3 – Your nominated super fund account

You should make sure that your account balance is sufficient each year to pay the premium plus the taxes, fees and costs payable under Total Care Plan Super, as well as continuing to meet the minimum balance requirements of the transferring fund.

Super Fund name

Product names

ABN

Unique Superannuation Identifier (USI)

Account number

Postal address

Suburb

State

Postcode

Super Fund email address

Super Fund phone number

Section 4 – Transfer or rollover authorisation

I authorise:

- AIA Australia from time to time to request, on my behalf, that the trustee ('trustee') of the superannuation fund nominated in Section 2 or 3 of this form transfer or rollover from my account an amount nominated by AIA Australia to Total Care Plan Super for the payment of insurance premiums plus other taxes, fees and costs payable under Total Care Plan Super. I understand and agree that the amount transferred or rolled over may be net of any withdrawal or other fees charged under the transferring fund.
- AIA Australia to do all acts and execute such documents on my behalf as are necessary to complete the requested transfer or rollover.
- AIA Australia is authorised to transfer or rollover from my account in accordance with the default arrangements set by the trustee of the transferring fund for transfers or rollovers.

This authority continues until the earliest of the following:

- it is revoked in writing by me;
- AIA Australia receives a replacement authority signed by me;
- I cease to hold my Total Care Plan Super policy; or
- I die.

Section 5 – Declaration

I declare that:

- my account is my superannuation account and I have authority to transact on it;
- the details provided in this form are true and correct;
- the authority in Section 4 includes an authority for any other person authorised by AIA Australia to do the things authorised in this form and that the request for a transfer or rollover may be made in any form agreed between AIA Australia and the trustee.
- I am aware that my superannuation provider can provide me with information about the effect this transfer will have on my benefits, including information about any fees and charges that may apply. I have already obtained this information or decided not to obtain it.
- I acknowledge and agree that I'm responsible for ensuring there are sufficient funds in my superannuation account to pay the premium, fees and any other amounts payable under Total Care Plan Super as they fall due, as well as ensuring the minimum balance requirements of my superannuation account are met.
- I am aware and agree that any refund of monies transferred or rolled over to Total Care Plan Super under this Authority will be repaid to the superannuation account I have nominated in this form.

Print name

Your signature

✗

Date

/ /

Employer payment instructions form

Important - Employees please complete this form and give it to your employer

If you are an employer please read 'Making super contributions to your employee's Total Care Plan Super (TCPS) Policy.

Employer to read

Making super contributions to your employee's Total Care Plan Super (TCPS) Policy

As you'll be aware, under SuperStream legislation all employers are obliged to send a **Contribution Transaction Request (CTR)** and electronic payment to Superannuation providers. Your employee, named below, has recently indicated that they wish to contribute to their TCPS policy through this method.

Below are the details you'll need to make payments to AIA Australia using SuperStream.

Employee to complete

Total Care Plan Super USI

26 458 298 557 008

Your Total Care Plan Super policy number

Initial Premium Amount

$

Type of contribution

The contribution type(s) you and/or your employee wish to make is included in the Contribution Transaction Request (CTR). This must accompany your payment made via Direct Credit or BPAY.

Employee details

Employee ID (if applicable)

Surname

Full given name(s)

Date of birth

/ /

Residential address

Suburb	State	Postcode

More Information

Find out more about SuperStream at www.ato.gov.au/SuperStream

Issued by Colonial First State Investments Limited ABN 98 002 348 352 AFSL 232468, the Trustee of Colonial First State FirstChoice Superannuation Trust ABN 26 458 298 55 (Trustee). Total Care Plan Super is administered by AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia) on behalf of the Trustee.

Authority to cancel existing policy/ies

Section 1 – Existing policy details

Policy number/s

Life insured 1

Policy type

Life insured 2

Policy owner/trustee (if superannuation fund)

I/We request AIA Australia or the trustee (if applicable) to cancel the above mentioned policy on acceptance by AIA Australia or the trustee of this application.

Signature of existing policy owner 1 ✗

Date / /

Signature of existing policy owner 2 ✗

Date / /

If you have a second policy and the life insureds and/or policy owners/trustees are different from above, please ensure the below section is also completed and signed.

Policy number/s

Life insured 1

Policy type

Life insured 2

Policy owner/trustee (if superannuation fund)

I/We request AIA Australia or the trustee (if applicable) to cancel the above mentioned policy on acceptance by AIA Australia or the trustee of this application.

Signature of existing policy owner 1 ✗

Date / /

Signature of existing policy owner 2 ✗

Date / /

Where there is more than one policy owner all owners must sign and date.

Note: this authority only provides for the cancellation of a existing CommInsure policy.

Adviser details

For adviser use only (must be submitted with the application)

AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia).

Replacement policy

1. Option to convert	☐
2. Splitting or consolidating policies	☐
3. Adding or removing cover options	☐
4. Premium structure change (stepped to level premiums OR level to stepped premiums)	☐
5. Increase of cover on an existing policy	☐
6. Continuation option to Ordinary	☐
7. Cover structure change	☐
8. Child Cover Continuation Option	☐

Policy number

Staff policy ☐ Staff employee ID

Concurrent applications

Are you submitting any life or disability insurance applications for this customer(s) through Colonial First State*. If 'Yes', please include

Product name (e.g. FirstChoice) **Proposal/Policy Number**

English literacy

Can the proposed policy owner(s) and/or life/lives insured read and understand English?

Yes ☐ ▶

No ☐ ▶ **Please complete below**

What language was used to explain the policy?

Please indicate by ticking (✔) the applicable box, which state or territory you are from

☐ NSW or ACT ☐ QLD or SA

☐ VIC or TAS ☐ NT or WA

Adviser 1 name

Agency number

Phone number ( ) Fax number ( )

Adviser 1 remuneration split

Adviser 2 name

Agency number

Phone number ( ) Fax number ( )

Adviser 2 remuneration split

Adviser declaration

I certify that the applicant has the relevant Product Disclosure Statement (PDS) and Policy as outlined on Page 4 of this application.

Signature of adviser 1 ✗ Date / /

Signature of adviser 2 ✗ Date / /

* Colonial First State Investments Limited ABN 98 002 348 352. AFS Licence 232468.

Notes