



# Application to increase insurance cover

## SELECT PERSONAL SUPERANNUATION

## C-LIFE & PRU PRODUCTS

## PERSONAL SUPERANNUATION UMBRELLA INVESTMENT PLANS

### How to apply

1. Read the Duty of disclosure section carefully on page 2 of this application form.
2. Complete, sign and date all relevant sections of this Application Form.
3. Mail this Application Form to:

**Locked Bag 5075 Parramatta NSW 2124**

**Note:** To enable your insurance premiums to continue to be paid from your account you must ensure at the time each insurance premium is to be deducted that there are sufficient funds in your account for this purpose.

### Checklist for applicants

Personal Statement	Death, Total and Permanent Disablement (TPD) and Income Protection cover
Section A – Occupation and income details	<input type="checkbox"/>
Section B – Habits	<input type="checkbox"/>
Section C – Height and weight	<input type="checkbox"/>
Section D – Doctor's details	<input type="checkbox"/>
Section E – Insurance history details	<input type="checkbox"/>
Section F – Family history details	<input type="checkbox"/>
Section G – Medical history details	<input type="checkbox"/>
Section H – Additional medical details	<input type="checkbox"/>
Section I – Lifestyle	<input type="checkbox"/>
Section J – Residence and travel details	<input type="checkbox"/>
Section K – Pastimes and activities	<input type="checkbox"/>
Section L – General health questionnaire	<input type="checkbox"/>
Section M – Specific questionnaires	<input type="checkbox"/>
Section N – Pastimes and activities questionnaires	<input type="checkbox"/>
Section O – Active Account Election	

Declaration	Death, Total and Permanent Disablement (TPD) and Income Protection cover
Section P – General declaration	<input type="checkbox"/>

### Other requirements

- Read the Duty of disclosure (page 2)
- Read the Privacy Collection Statement (page 2)
- Sign the Consent for Accessing Health Information (page 4)
- Sign the Customer contact authority (page 25)

## Your duty of disclosure

When you apply for insurance cover within your superannuation plan, you are the life insured and the trustee of the superannuation plan is the owner of the life insurance contract.

Before a superannuation plan enters into, or increases cover under, a life insurance contract in respect of the life of a person (you), it has a duty to tell the insurer anything that it knows, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms.

The superannuation plan entering into the contract has this duty of disclosure until the insurance is provided.

The superannuation plan has the same duty before it extends, varies or reinstates the contract.

The superannuation plan does not need to tell the insurer anything that:

- reduces the risk of the insurance; or
- is common knowledge; or
- the insurer knows or should know as an insurer; or
- the insurer waives the duty to tell the insurer about.

**If you as the person whose life is to be insured under the superannuation plan do not tell the insurer something that you know, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms, this may be treated as a failure by the superannuation plan to comply with its duty of disclosure.**

### **If you or the superannuation plan do not tell the insurer something**

In exercising the following rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If the insurer does, it may apply the following rights separately to each type of cover.

If you or the superannuation plan do not tell the insurer anything they are required to, and the insurer would not have provided the insurance if it had been told, the insurer may avoid the contract within 3 years of entering into it.

If the insurer chooses not to avoid the contract, it may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if the you and the superannuation plan had told the insurer everything they should have. However, if the contract has a surrender value or provides cover on death, the insurer may only exercise this right within 3 years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount of insurance provided, it may, at any time, vary the contract in a way that places the insurer in the same position it would have been in if you and the superannuation plan had told the insurer everything they should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If the failure to comply with the duty of disclosure is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

## Privacy Collection Statement

Our privacy policy contains information on how we collect, use and disclose your personal information (including disclosure to overseas recipients). Visit [aia.com.au/privacy](https://www.aia.com.au/privacy) for a copy.

## Consent for Accessing Health Information

### 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.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

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.

### 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

Signature

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, 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

Signature

Date

## Personal Details

Life Insured

Policy / Account number

Title  Mr  Mrs  Miss  Ms  Other

Surname

Given name(s)

Postal address

State

Postcode

Home address (PO Box is not acceptable)

State

Postcode

Daytime phone number

Evening phone number

Mobile phone

Email address

Date of birth

Gender

 Male Female

## Increased insurance cover application details

Please complete sums insured for the appropriate cover desired.

Type of cover	Sum insured	
Death	\$	Minimum amount – \$50,000 Maximum amount – No maximum
Total and Permanent Disablement (TPD)	\$	Minimum amount – \$50,000 Maximum amount – \$1,000,000
Income Protection	\$	Maximum amount – \$10,000 per month

**Please note:** TPD cover can only be taken with Death cover and the amount of TPD cover cannot exceed the level of Death cover. You can apply for an increase to Death cover up to age 64, TPD cover up to age 54 and Income Protection cover up to age 54.

## Personal Statement

You need to complete all sections of this Personal Statement as indicated.

### Customer contact

Our underwriters are committed to assessing insurance applications as quickly as possible.

To do this, our underwriters or representatives may need to contact you directly to speed up the process.

Are you happy if we call/email you to clarify or gain further information?

Yes  **Please complete below**

No

Most convenient day to contact you:

Monday  Tuesday  Wednesday  Thursday  Friday  Any

Preferred method of contact	Preferred contact time (Monday to Friday 8 am to 6 pm)
Home phone number <input type="checkbox"/>	from am/pm to am/pm
Business phone number <input type="checkbox"/>	from am/pm to am/pm
Mobile phone number <input type="checkbox"/>	from am/pm to am/pm
Email address <input type="checkbox"/>	

## Section A - Occupation and income details

1. What is the main occupation 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)?  
  
 State  Postcode
4. Does your main occupation 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 fire arms  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.
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 questions below, otherwise go to Q6.**
- a. How long have you operated in this capacity?  
 Years  Months
- b. What are the number of hours you consistently work per week?
6. What is the nature of the work in your main occupation?  
**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 occupation is home duties) | %                                      |
| Manual work (e.g. cleaning, lifting over 5kg, carpentry, plumbing)       | %                                      |
| <b>Total</b>   | <b>= 100%</b>                          |
7. Do you work from home?  
 Yes  **Please complete below**  
 No  **Go to Q8**
- a. What percentage of your time is spent working from home?  
 %
- b. What weekly percentage of time are you in face-to-face contact (i.e. other than by phone, fax or email) with your clients/employer?  
 %
- c. Do you have the following in your business set-up?  
 Separate office  Yes  No  
 Separate entrance to place of residence  Yes  No  
 Separate business phone/fax  Yes  No
8. What is your current annual income\* earned through personal exertion (excluding superannuation) from your main occupation (less all business expenses), but before tax?  
 \$  p.a.

**\*Note:** current annual income excludes superannuation, but includes reportable fringe benefits you earned. If you are self-employed, current annual income also excludes all business expenses, but includes eligible payments to your spouse, share of depreciation, director's fees or share of profit from a trust or supporting service company.

**Section A - Occupation and income details (continued)**

**Additional income details – Only complete if you are applying for an increase to your Income Protection insurance cover.**

9. What is the percentage (%) of superannuation contribution (e.g. up to 15%)?

%

10. What was your annual income earned through personal exertion, from your main occupation, less all business expenses, but before tax, over the last two financial years?

	Period		Annual income earned
Last financial year	01/07/	– 30/06/	\$
Previous financial year	01/07/	– 30/06/	\$

11. 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 Q12**

Please provide details of other income from investments	Amount p.a.
Dividends and interest	\$
Net rental income	\$
Other source of income (please specify):	\$
<b>Total</b>	<b>\$</b>

12. If you became disabled, would any part of your income continue beyond 30 days?

Yes  **Please complete below**

No  **Go to Q13**

Source of income (e.g. sick pay, pension, company profit, salary continuance insurance)	Amount of income per month	How long would this continue?	
		Years	Months
	\$		
	\$		

13. Do you intend to change your occupation or duties, employment situation or take extended leave (e.g. sabbatical, maternity leave, paternity leave) in the next 12 months?

Yes  **Please complete below**

No  **Go to Q14**

Please provide details of change

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

Yes  **Please complete below**

No  **Go to Section B - Habits**

a. Have you been discharged?

Yes  **Please complete below**

No  **Go to Section B - Habits**

b. How long ago were you discharged?

Years       Months

## Section B – Habits

1. Have you smoked tobacco at any time during the last 12 months?

Yes  ► Please indicate type and amount smoked below

No  ► Go to Q2

Type smoked	Per day	Per week	Per month	Per year
Cigarettes <input type="checkbox"/>				
Cigars/Pipes <input type="checkbox"/>				

2. Do you drink alcohol?

Yes  ► Please indicate the average number of standard drinks\* in only ONE of the below

No  ► Go to Section C – Height and weight

Per day	Per week	Per month	Per year

\* A standard drink is equivalent to: one nip of spirits, one glass of wine, 250ml of beer.

## Section C – Height and weight

What is your current height and weight?

Height  cm OR  feet  inches

Weight  kg OR  stone  lbs

## Section D – Doctor's details

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

Doctor's name or medical centre

Address

<input type="text"/>	
<input type="text"/>	<input type="text"/>

Phone number

Fax number

2. Have you been a patient of this doctor or medical centre for less than 12 months?

Yes  ► Please provide the name and address of your previous doctor or medical centre below

No  ► Go to Section E – Insurance history details

Doctor's name or medical centre

Address

<input type="text"/>	
<input type="text"/>	<input type="text"/>

Phone number

Fax number

## Section E – Insurance history details

1. Other than this application, have you ever applied for, or are you currently applying for, any life, disability, trauma, accident or sickness insurance cover with AIA Australia 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)	Date policy commenced	To be replaced by this cover*?
		\$		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

2. Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?

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 (e.g. Worker's Compensation, Disability Pension, Veterans' Affairs) or any other insurance policy **providing accident or sickness benefits** (including but not limited to disability, trauma insurance, insurance provided by a superannuation scheme, credit card insurance or travel insurance)?

Yes  Please complete below

No  Go to Section F – Family history details

Benefit type/Source	Reason for claim	Date claim made	Total claim amount	Date claim finalised
		/ /	\$	/ / OR ongoing <input type="checkbox"/>
		/ /	\$	/ / OR ongoing <input type="checkbox"/>

## Section F – 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?

<ul style="list-style-type: none"> <li>Heart problems, cardiomyopathy, stroke, or sudden death</li> <li>Diabetes</li> <li>Any Dementia, Alzheimer's or Parkinson's disease</li> <li>Cancer of any type (specify type of cancer in table below e.g. breast or colon cancer)</li> <li>Motor Neurone Disease, Huntington's disease, Multiple sclerosis, Muscular Dystrophy or Polycystic kidney disease</li> <li>Any other condition which runs in your family</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If you answered 'Yes' please complete table below, otherwise go to Section G – 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.

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## Section G – Medical history details

1. Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following?
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. <b>Asthma (except childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. <b>Diabetes, gestational diabetes, insulin resistance or abnormal blood sugar</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. <b>Cysts, moles, sunspots, skin lesion or skin cancer</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. <b>Back, neck, shoulder, knee, elbow</b> complaints, sciatica, disc or spine complaints, injury or disorder of the joints, bones or muscles   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. <b>Depression or mental illness</b> (including but not limited to stress, anxiety, panic attacks, behavioural disorders [attention deficit disorder, Asperger's syndrome], nervous disorders or schizophrenia/bipolar disorder] | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. High blood pressure, raised cholesterol   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you have answered 'Yes' to any part of Q1 a to f above, please complete the **Specific questionnaire** on the related condition in **Section M – Specific questionnaires on page 16-21**.

2. Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following?
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Chest pains, heart complaint, cardiomyopathy, heart murmur, palpitations or rheumatic fever   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Stroke, paralysis, neurological disorder, multiple sclerosis, muscular dystrophy or blood vessel disorder   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Alzheimer's, Parkinson's, dementia or any other disorder of the brain   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Cancer, tumour or melanoma  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Thyroid, glandular, pituitary or pancreatic disorder  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Gastric or duodenal ulcer, persistent indigestion, gastro-oesophageal reflux disorder or Barrett's oesophagus   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Ulcerative colitis, Crohn's disease, colonic polyps, irritable bowel or any other bowel disorder  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Any disorder of the gall bladder or liver (including fatty liver/raised liver function tests)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Varicose veins, haemorrhoids or hernia  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Disorder of the kidney, bladder, blood in urine, kidney stones or prostate (including raised prostate specific antigen (PSA))   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Epilepsy, fits of any kind, fainting episodes, dizziness, vertigo, recurring headaches or migraines   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Lethargy, sleep apnoea or any sleeping disorder including insomnia  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Arthritis (including osteo, rheumatoid or psoriatic), gout or osteoporosis/osteopenia   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Chronic fatigue syndrome, ongoing tiredness, fibromyalgia, repetitive strain injury or any other chronic pain syndrome  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o. Psoriasis, eczema, dermatitis or any other skin disorder  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| p. Anaemia, leukaemia, haemophilia, deep vein thrombosis, pulmonary embolus, haemochromatosis or any other blood disorder (e.g. Factor V Leiden)                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| q. Any impairment of sight including blurred vision (other than short or long sightedness), hearing including tinnitus, deafness and high frequency hearing loss or speech | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| r. Any sexually transmitted diseases   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you have answered 'Yes' to any part of Q2 a to r above, please complete the **General health questionnaire(s)** in **Section L on page 14 for each of these conditions**.

## Section H – Additional medical details

1. In the last two years have you consulted a doctor or health professional for any other reason not already mentioned in Section G Q1 and 2 in this application (excluding minor ailments such as colds and flu and contraceptive medication)?

Yes  ► **Please complete below**

No  ► **Go to Q2**

- a. When was this consultation? (please tick (✓) the appropriate box)

In the last 3 months  3–6 months ago  6–12 months ago  12–24 months ago

- b. What was the condition/reason for the consultation?

- c. What was the result/outcome of the consultation? (please tick (✓) **ONLY ONE** of the below)

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

Tests conducted – results pending

Routine tests conducted – results all clear and normal

Not fully recovered yet

Referred to specialist/health professional

Ongoing treatment/surveillance/on-going monitoring

2. In the next two years are you considering or been advised to seek medical advice, treatment or tests (other than for routine general health check-ups) or surgery in the future?

Yes  ► **Please complete below**

No  ► **Go to Q3**

What is the reason for seeking advice, treatment, tests or surgery in the future?

3. Are you currently being tested for or have any signs or symptoms of ill health or disability not already mentioned in this application?

Yes  ► **Please complete below**

No  ► **Go to Q4**

Please provide details of tests being conducted or symptoms

4. In the last 5 years, due to injury or illness, have you been off work for more than 5 consecutive days for any condition not already mentioned in this application?

Yes  ► **Please complete below**

No  ► **Go to Q5**

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

5. Do you take or have you ever taken or been prescribed any medications on a regular or ongoing basis for any conditions not already mentioned in this application?

Yes  ► **Please complete below**

No  ► **Go to Q6**

Please provide details of the treatment or medication and the condition

6. Have you ever undergone screening for diseases or conditions such as, but not limited to, bowel cancer?

Yes  ► **Please complete 'a' below**

No  ► **Go to Q7**

- a. Were you advised to seek further medical follow-up or specific ongoing monitoring?

Yes  ► **Please complete below**

No  ► **Go to Q7**

Please provide details of the condition and follow up investigations

## Section H – Additional medical details (continued)

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 disablement cover (TPD) 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?

Yes  **Please complete below**

No  **Go to Q8 – females only. Otherwise proceed to Section I – Lifestyle**

**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 in the next 12 months intend to have a genetic test?

Yes  **Please complete 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

**Additional questions (for female life to be insured only).**

8. Have you had an abnormal pap smear?

Yes  **Please complete below**

No  **Go to Q9**

a. What type of abnormal pap smear did you have? (e.g. HPV CIN 1, CIN 2, CIN 3) (please tick (✓) the appropriate box)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Atypia cells                   | <input type="checkbox"/> CIN 1 (low grade abnormality) | <input type="checkbox"/> CIN 2 (high grade abnormality) |
| <input type="checkbox"/> CIN 3 (high grade abnormality) | <input type="checkbox"/> Human Papilloma Virus (HPV)   | <input type="checkbox"/> Not known                      |

b. How long ago was this? (please tick (✓) the appropriate box)

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

c. Have you successfully been treated for this condition? (e.g. colposcopy, cone biopsy, hysterectomy, laser or Lletz)

- Yes    No

d. Were your last three pap smears normal and at least six months apart?

Yes  **Go to Q9**

No  **Please provide details below**

9. Have you ever had a breast lump, cyst or any other type of breast abnormality (even if you have not consulted a doctor) or an abnormal breast ultrasound or mammogram test result?

Yes  **Please complete below**

No  **Go to Q10**

a. How long ago was this? (please tick (✓) the appropriate box)

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

b. Was this fully investigated by the following? (please tick (✓) the appropriate box)

- |  |   |                                    |   |
|--|---|------------------------------------|---|
| <input type="checkbox"/> Ultrasound              | <input type="checkbox"/> Fine needle aspiration | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Not investigated |
| <input type="checkbox"/> Other (please specify): | <input type="text"/>                            |                                    |   |

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

- |   |  |
|---|--|
| <input type="checkbox"/> Test conducted – results pending | <input type="checkbox"/> Test conducted – results all clear and normal |
| <input type="checkbox"/> Ongoing treatment/investigations | <input type="checkbox"/> Ongoing monitoring                            |

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

- Yes    No

10. Have you ever had or sought treatment for any condition of the ovaries, uterus, endometrium or perineum?

Yes  **Please complete below**

No  **Go to Q11**

## Section H – Additional medical details (continued)

11. Are you currently pregnant?

Yes  **Please complete below**

No  **Go to Section I – Lifestyle**

a. How many weeks pregnant are you?

b. Do you or have you ever had any complications with pregnancy or childbirth (e.g. diabetes, pre-eclampsia, post natal depression) excluding elective caesarean or miscarriage within the first 15 weeks of pregnancy?

Yes  **Please complete below**

No  **Go to C**

Please tick (✓) the appropriate box

Gestational diabetes  Pre-eclampsia (high blood pressure)  Post-natal depression

Other (please specify):

c. Will you be returning to work in the same capacity as your current occupation (e.g. back to the same or greater hours) within or at the end of 12 months from the date you commence maternity leave?

Yes  **Go to Section I – Lifestyle**

No  **Please complete below**

Please provide details of any intended change in working status, occupation, hours, etc.

## Section I – Lifestyle

1. In the last 10 years have you taken any illegal drugs?

Yes  **Please complete below**

No  **Go to Q2**

a. What type of drugs were they? (e.g. marijuana, ecstasy, speed, MDMA, GBH)

b. When did you start taking drugs?

c. When did you last take drugs?

2. In the last 10 years have you been advised to cease drinking alcohol or received counselling or treatment for alcohol or substance abuse?

Yes  **Please complete below**

No  **Go to Q3**

a. I received counselling and/or treatment for the use of alcohol  Yes  No

b. I received counselling and/or treatment for the use of drugs  Yes  No

c. When did you start receiving counselling/treatment for the use of drugs or alcohol? / /

d. When did you last use drugs or drink alcohol? / /

3. Have you ever been tested positive for HIV, Hepatitis B or Hepatitis C or are you awaiting the results of such a test?

Yes  **Please complete below**

No  **Go to Q4**

Please specify which condition you were tested positive for

4. In the last 5 years have you had:

a. Anal intercourse without a condom (except in a relationship between you and one other person only where neither of you had sex with anyone else for at least 5 years)?  Yes  No

b. Sex without a condom with someone you know or suspect to be HIV positive?  Yes  No

c. Sex without a condom with anyone who injects non-prescribed drugs?  Yes  No

d. Sex without a condom with a sex worker or as a sex worker?  Yes  No

If you have answered Yes to questions 4 a to d please provide details below. If you answered No to questions 4 a to d go to Section J.

  

**Note:** you may be asked to complete a confidential questionnaire.

## Section J – Residence and travel details

1. Are you a 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

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 plan to travel, live or work in another country?

Yes  ► **Please complete below**

No  ► **Go to Section K – Pastimes and activities**

a. What country/ies do you plan to travel to?

b. What is the reason for travelling? (please tick (✓) the appropriate box)

Holiday     Business     Residing

Visiting family/relatives     Studying     Emigrating

c. How often do you intend to travel to this country/ies in the next 12 months? (Please enter the number of times below)

d. What is the total duration of your trip/s? (Please advise the number of weeks)

 weeks

## Section K – Pastimes and activities

1. Do you currently engage or intend to engage, through your occupation(s) or pastimes, in any of the following sports or hazardous activities?

a. Flying (other than as a fare-paying passenger on a commercial airline) e.g. fixed wing, helicopter or ballooning  Yes  No

b. Underwater diving  Yes  No

c. Football of any code (excluding touch football and Oztag)  Yes  No

d. Motorised sports of any kind e.g. motorcross, rally driving or motorbike racing, etc.  Yes  No

e. Ocean racing, yachting, powerboat racing etc.  Yes  No

f. Trail bike, quad bike or three-wheeler bike riding (including off road and dirt bike)  Yes  No

g. Any other sport or hazardous activities e.g. body contact sports, parachuting, hang-gliding, competitive horse riding or cycling, abseiling, mountaineering or caving etc.  Yes  No

h. Any sport played in a professional or semi-professional capacity  Yes  No

**Note:** if you have answered 'Yes' to any part of Q1 a to h above, please complete the **Pastimes and activities Specific questionnaire(s)** on the related activity in **Section N on pages 22-24.**

## Section L – General health questionnaires

**General health questionnaire 1** (indicate the question you answered 'Yes' in Section G, Q2 a to r)

a. Illness/Injury/tests

b. Main symptoms or cause

c. Date commenced (please tick (✓) the appropriate box)

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

  

State

Postcode

Phone number

Fax number

**Section L – General health questionnaires (continued)**

**General health questionnaire 2** (indicate the question you answered 'Yes' in Section G, Q2 a to r)

a. Illness/Injury/tests

b. Main symptoms or cause

c. Date commenced (please tick (✓) the appropriate box)

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

  

State

Postcode

Phone number

( )

Fax number

( )

## Section M – Specific questionnaires

If you answered 'Yes' to:

**Section G Q1a on page 9**, then please complete **Asthma, bronchitis or any other lung complaint** questionnaire below

**Section G Q1b on page 9**, then please complete **Diabetes and abnormal blood sugar** questionnaire below

**Section G Q1c on page 9**, then please complete **Cysts/Moles/Sunspots/Skin lesions** questionnaire on page 17

**Section G Q1d on page 9**, then please complete **Joint/Musculoskeletal** questionnaire on page 18

**Section G Q1e on page 9**, then please complete **Mental health** questionnaire on page 19

**Section G Q1f on page 9**, then please complete **High blood pressure and raised cholesterol** questionnaire on page 21

### 1. Asthma, bronchitis or any other lung complaint questionnaire

a. Please tick (✓) the appropriate box

Asthma

Chronic bronchitis

Recurrent pneumonia

Emphysema

Other (please specify)

b. Frequency of symptoms in the last 2 years? (please tick (✓) the appropriate box)

Daily

None – childhood only

One-off episode

Occasionally

Weekly

c. Severity of symptoms? (please tick (✓) the appropriate box)

Mild – Infrequent attacks, exercise induced or seasonal

Moderate – Frequent symptoms, no specific triggers, occasional steroid therapy

Severe – Very frequent attacks with almost constant wheezing, restriction of work duties and frequent use of oral steroids

d. In the last two years have you required hospitalisation or emergency treatment?

Yes  No

e. In the last two years have you required more than three prescriptions for oral steroids?

Yes  No

f. In the last 12 months has this caused you to have time off work?

Yes  **Please complete below**

No

Total number of days you had off work in the last 12 months?

g. Is your treating doctor different from the last doctor you consulted?

Yes  **Please complete below**

No

Name of doctor

Doctor/medical centre/hospital address

State

Postcode

Phone number

Fax number

### 2. 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. Have your blood sugar levels returned to normal after the delivery of your baby?

Yes  No

c. At what age were you diagnosed with this condition?



**Section M – Specific questionnaires (continued)**

d. In the last 6 months, have you had an HbA1c (Glycosylated Haemoglobin) or Fasting Blood Sugar/glucose level test?

Yes  **Please complete below**

No

**HbA1c (Glycosylated Haemoglobin)** (please tick (✓) the appropriate box)

Up to 6.0%

6.1% to 8.0%

8.1% or more

Don't know

**Fasting blood sugar** (please tick (✓) the appropriate box)

Up to 6.6 mmol

6.7 to 8.0 mmol

8.1 mmol or above

Don't know

e. As a result of your condition, have you ever experienced complications such as eye problems, numbness or tingling in your legs or feet, a diabetic or insulin coma?

Yes  **Please complete below**

No

Please specify the complication and the date this occurred


f. Is your treating doctor different from the last doctor you consulted?

Yes  **Please complete below**

No

Name of doctor

--

Doctor/medical centre/hospital address

State
Postcode

Phone number

( )
-----

Fax number

( )
-----

**3. Cysts/Moles/Sunspots/Skin lesions questionnaire**

a. Please tick (✓) the appropriate box

Cyst/Mole

BCC (Basal Cell Carcinoma)

Dysplastic naevi

Sunspot

SCC (Squamous Cell Carcinoma)

Melanoma

Other

--

b. Location of growth(s) e.g. face, back, right arm

--

c. Date of treatment(s)

/ /
-----

/ /
-----

d. Have you been advised that your growth(s) or skin lesion(s) were cancerous or malignant?

Yes  No

e. How many growth(s) or skin lesion(s) did you have?

--

f. Have all your growth(s) or skin lesion(s) 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 growth(s) or skin lesion(s) removed surgically, cut out or scraped off?

Yes

No  **Please complete below**

(i) How many?

--

## Section M – Specific questionnaires (continued)

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

  

State

Postcode

Phone number

 ( ) 

Fax number

 ( ) 

### 4. Joint/Musculoskeletal questionnaire

a. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone, dislocated shoulder

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, degenerative or a disc problem?

Yes  No

d. Has this condition occurred more than once?

Yes  **Please complete below**

No

How often has condition occurred?

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

Within the last 3 months

2-5 years ago

12-24 months ago

6-12 months ago

3-6 months 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

2-5 years ago

12-24 months ago

6-12 months ago

3-6 months ago

more than 5 years ago

**Section M – Specific questionnaires (continued)**

**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

	State	Postcode
--	-------	----------

Phone number

Fax number

**5. 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 diagnosis)

**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 below**

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 Question h**

No  **Go to Question i**

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

Yes  **Please complete below**

No

Provide details including dates

	/	/
	/	/

**Section M – Specific questionnaires (continued)**

i. Have you had any recurrences of these symptoms?

Yes  **Please complete below**

No

Provide details including dates

	/	/
	/	/

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

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. 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 below**

No

  


l. Does your usual doctor have knowledge of this condition?

Yes  **Please complete below**

No

Name of doctor

Doctor/medical centre/hospital address

  


Phone number

 ( ) 

Fax number

 ( ) 

State

Postcode

**Section M – Specific questionnaires (continued)**

**6. High blood pressure and raised cholesterol questionnaire**

a. Please tick (✓) the appropriate box(es)

- High blood pressure\*
- Raised cholesterol#

b. When were you first diagnosed with this condition? (please tick (✓) the appropriate box)

- Within the last 12 months
- More than 12 months ago

c. Do you have any problems or complications resulting from this condition? (e.g. heart disease, kidney disorder)

- Yes  No

d. Are you taking regular medication for this condition?

- Yes  No

**\*Additional questions for high blood pressure**

e. Is your blood pressure being monitored by your doctor and considered to be well controlled? (e.g. less than 140/90)

- Yes  No

f. Is your treating doctor different from the last doctor you consulted?

Yes  **Please complete below**

No

Name of doctor

Doctor/medical centre/hospital address

	State	Postcode

Phone number

Fax number

**#Additional questions for raised cholesterol**

g. When was your last cholesterol reading? Please tick (✓) the appropriate box(es)

- Within the last 12 months
- More than 12 months ago

h. When was your last cholesterol reading? Please tick (✓) the appropriate box(es)

- 2.0 to 6.5 mmol
- 6.6 to 7.5 mmol
- 7.6 mmol or above
- Don't know

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

	State	Postcode

Phone number

Fax number

## Section N – Pastimes and activities questionnaires

If you answered 'Yes' to:

**Section K a on page 13**, then please complete **Flying** questionnaire below

**Section K b on page 13**, then please complete **Underwater diving** questionnaire on page 23

**Section K c on page 13**, then please complete **Football of any code** questionnaire on page 23

**Section K d on page 13**, then please complete **Motor sports of any kind** questionnaire on page 23

**Section K e to h on page 13**, then please complete **Other sports or hazardous activities** questionnaire on page 24

### 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)	<input type="checkbox"/>		
Helicopter (Private/recreational/commuter travel)	<input type="checkbox"/>		
Fixed wing (Charter flying)	<input type="checkbox"/>		
Helicopter (Charter flying)	<input type="checkbox"/>		
Fixed wing and Helicopter (Agriculture/crop/mustering)	<input type="checkbox"/>		
Helicopter, fixed wing – occupation i.e aerial surveyor, photographer etc.	<input type="checkbox"/>		
Ballooning	<input type="checkbox"/>		
Gliding	<input type="checkbox"/>		
Ultra-light/gyroplane	<input type="checkbox"/>		
Aerobatics/stunts	<input type="checkbox"/>		

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

## Section N – Pastimes and activities questionnaires (continued)

### 2. Underwater diving questionnaire

a. At what level do you participate? (please tick (✓) the appropriate box)

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

b. How many times per year do you participate in this activity?

c. Do you ever dive:

alone? e.g. without a buddy

Yes  No

over 40 meters in depth?

Yes  No

in wrecks, caves or potholes?

Yes  No

**If 'Yes' to any above, please provide details**

  

d. What type of qualification do you hold? (please tick (✓) the appropriate box)

- No qualification  
 NAUI

- PADI  
 Other (please specify)

BSAC

### 3. Football of any code questionnaire

a. What type of football code do you participate in? (please tick (✓) the appropriate box)

- Rugby League  Australian Rules  American football  
 Rugby Union  Touch football/Oztag  Soccer

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

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

c. In the last two years have you had a sporting injury to your shoulder, leg, knee or ankle that required any time off work?

Yes  **Please complete below**

No

Please provide details

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?

\$

### 4. Motor sports of any kind questionnaire

a. What type of vehicle or motor activity do you engage in?

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

- Recreational only (non-competitor)  Semi-professional/professional  
 Recreational only (with competition)  Record attempts or prototype testing

c. Have you ever been involved in any accidents whilst practising, testing or racing?

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

d. Do you hold a CAMS license and/or are you a member of a motor racing club or organisation?

Yes  **Please complete below**

No

Please provide details

## Section N – Pastimes and activities questionnaires (continued)

e. Which events do you race in? (e.g. circuit racing, drag racing) Please provide details including class of racing event

  

f. Please advise the following details

Number of times per year that you participate in this activity

Vehicle type including make

Engine size

What maximum speed is reached?

## 5. Other sport or hazardous activity 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-competitor)    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 O – Active Account Election

If your superannuation account is, or becomes, inactive for a continuous period of 16 months then under superannuation legislation we are required to cancel your insurance cover unless you provide an election. If you do not want your insurance cover to cease please tick the box below.

- I elect that all insurance cover already applying, or to be provided, for me under

(‘My insurance’) is to continue to apply for me even if my account in the product is, or becomes, inactive for a continuous period of 16 months under superannuation legislation

## Section P – General declaration

The following declarations apply to all policy owner(s):

- I understand that the insurance applied for will not become effective unless and until the Application is accepted by AIA Australia and AIA Australia is under no liability until acceptance is effected.
- I acknowledge that the AIA Company Limited and its subsidiaries (other than AIA Australia to the extent provided for in this document) do not guarantee the obligations or performance of AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia) or the products it offers.
- 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).
- I have read and understood my Duty of disclosure as set out in this application and 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.
- I have read and understood the Privacy Collection Statement on page 2 of this application form.
- I hereby authorise Equity Trustees Superannuation Limited and AIA Australia Limited to deduct premiums for this cover from my account and acknowledge that any benefits or other moneys payable by AIA Australia with respect to this cover will be credited to that account.

Name of life insured

Signature of life insured

Date



## Customer contact authority

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

**Only complete this section if you are happy to be contacted by a representative of AIA Australia Limited for more information in order to speed up the assessment process.**

Name of life insured

I,

agree that AIA Australia or an authorised representative may contact me in respect of my insurance application or policy.

Signature of life insured

Date