Personal Statement
Application for Insurance

NATIONWIDE SUPER

CommInsure

You are applying to enter into a contract of insurance.

As such, you have a duty to disclose all relevant information. Failing to provide the insurer with full and accurate information could result in your insurance cover being cancelled and any claim for benefits could be denied, so it is vital you answer all questions fully and accurately.

Although we ask you specific questions via a personal statement, you should also tell us about any other information that will impact on the insurer's decision to offer you insurance cover, regardless of whether you deem it to be material or important. This includes current medical issues that require investigation, medication or treatment, even if a diagnosis has not been made.

This obligation applies to all insurance cover relating to this application, including amounts transferred from another fund or insurance arrangement. This means you could be placed in a position where you have no insurance cover if we later find you have not answered all questions fully and accurately.

Your Duty of Disclosure continues until you receive written confirmation your application has been accepted. You must contact the insurer if there is any change in your health or circumstances that are relevant to the insurer's decision on your application.

The full Duty of Disclosure is contained within this document and it is important you read it carefully. Having read the above, I declare the information I am about to provide is honest, true and complete.

Signed ✗

Dated DD/MM/YYYY

Section A – Your details

Nationwide Super Member ID

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Miss Other

Surname

Full given name(s)

Residential address

State Postcode

Email address

Date of birth DD/MM/YYYY

What industry do you work in?

Occupation

What is your gross annual salary?

Are you a permanent resident of Australia? ☐ Yes ☐ No

What is your: **Height** cm **or** ft/in **Weight** kg **or** st/lb

Have you smoked tobacco, e-cigarettes or any other substance in the last 12 months?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate what you smoke

What is your average? per day per week **or** per year

Do you drink alcohol? No ☐ Yes ☐ ▸ If **'yes'**, please provide the average number of standard drinks consumed:

per day per week **or** per year

If you want to apply to have your insurance cover rated under either the White Collar or Professional occupation rating, please complete this section.

Eligibility for White Collar rating	**Please tick (✔) appropriate box**
Are the duties of your occupation limited to professional, managerial, administrative, clerical, secretarial or similar 'white collar' tasks which do not involve manual work and are undertaken entirely (or at least 80%) within an office environment (excluding travel time from one office environment to another)? ▸ If you were able to answer the above question with a 'Yes' you are eligible for cover under the White Collar occupation rating.	No ☐ Yes ☐
Eligibility for Professional rating In addition to being able to answer the eligibility question for White Collar:	**Please tick (✔) appropriate box**
Are you earning in excess of $100,000 per annum?	No ☐ Yes ☐
Do you hold a tertiary qualification and are you a member of a professional institute or registered by a government body? '**Or**'	No ☐ Yes ☐
Are you a member of your company's executive leadership team with more than 10 years' experience in your industry?	No ☐ Yes ☐

If you were able to answer the above questions with a 'Yes' you are eligible for cover under the Professional occupation rating.

- Eligibility for White Collar or Professional cover is subject to acceptance by the insurer
- If accepted, all cover held with Nationwide Super will be subject to the appropriate rate – White Collar or Professional.
- If the insurer does not accept your application for the White Collar or Professional occupation rating, you will be advised of the premium scales which apply to your cover with Nationwide Super.

Please indicate which insurance option and the type and level of cover you require.

Employer Sponsored members may choose only one option (Unitised Cover or Fixed Cover). Personal members can only choose fixed cover.

Option 1 – Unitised Cover

Please indicate the number of units you require in total including your existing cover (Employer Sponsored members only):

Death cover: ☐ Units TPD cover: ☐ Units

Option 2 – Fixed Cover

Please indicate the total level of cover you require (in multiples of $10,000) including your existing cover:

Death cover: $ ☐ TPD cover: $ ☐

Do you work more than 15 hours per week? No ☐ Yes ☐ ▸ If 'No' then you are not eligible for Income Protection cover.

How much Income Protection cover would you like?

☐ 75% salary + 10% Super Contribution

☐ 75% salary only

☐ Other amount – please advise sum insured required: $ ☐ per month

What Waiting Period would you like? ☐ 30 days ☐ 60 days ☐ 90 days

What Benefit Period would you like? ☐ 2 years ☐ age 65

- Maximum Death cover is $10 million.
- Maximum TPD cover is $3 million.
- Maximum Income Protection cover is 85% salary up to $30,000 per month.
- Any cover or increase in cover is subject to your application being accepted.
- If the insurer does not accept your application you will retain your current level of cover.
- If the insurer accepts your application, this new cover will replace the level of cover you currently have with Nationwide Super. As such, you should apply for the total number of units or total amount of cover you require. If we exclude on an increase, that exclusion doesn't apply to the existing cover.

Section B – Personal statement

1. Do you engage in any hazardous pastimes or pursuits such as, but not limited to, football (other than touch or Oztag), motorised sports, parachuting, hang-gliding, abseiling, mountaineering activities, aviation (other than as a fare paying passenger), scuba diving or any sport(s) in a professional capacity?	No ☐ Yes ☐	A
2. Have you:		
a) Recently applied for or do you have a policy for life, total and permanent disability, trauma or salary continuance (excluding this application)?	No ☐ Yes ☐	B
b) Ever had an application for life, disability, trauma, accident or sickness insurance on your life declined, deferred or accepted with a loading, exclusion or special terms?	No ☐ Yes ☐	B
c) Ever claimed a lump sum or accident or sickness benefit from any insurance policy, including but not limited to superannuation, workers' compensation, disability pension or Veterans Affairs?	No ☐ Yes ☐	B
3. Have you ever experienced symptoms, received medical advice, been treated for or diagnosed with any back, neck, hip, shoulder, knee or elbow complaints, sciatica, disc or spine complaints, or an injury, complaint or disorder of any joint, bones or muscle, including arthritis, gout or repetitive strain injury (RSI)?	No ☐ Yes ☐	C
4. Have you ever received medical advice, been treated for or diagnosed with depression or a mental illness, including but not limited to stress, anxiety, chronic tiredness or lethargy, panic attacks, post traumatic stress, behavioural or nervous disorder, attention deficit disorder or aspergers syndrome, myalgia or fibromyalgia or Chronic Fatigue Syndrome?	No ☐ Yes ☐	D
5. Have you received medical advice, undergone any treatment, investigation or operation for, or had:		
a) High blood pressure or raised cholesterol?	No ☐ Yes ☐	E
b) Cyst, mole, sunspots, skin lesions, skin cancer or melanoma?	No ☐ Yes ☐	F
c) Asthma (other than childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint?	No ☐ Yes ☐	G
d) Chest pain, heart complaint, cardiomyopathy, stroke, neurological disorder, multiple sclerosis, muscular dystrophy or blood disorder?	No ☐ Yes ☐	G
e) Cancer, leukaemia, diabetes or chronic kidney complaint?	No ☐ Yes ☐	G
6. Have you:		
a) Taken any illegal or non prescribed drugs (other than over the counter medications) in the last 10 years?	No ☐ Yes* ☐	
b) Ever been advised to cease drinking alcohol or received counselling or treatment for alcohol or substance abuse?	No ☐ Yes* ☐	
c) Ever been infected with or tested positive for HIV/AIDS, Hepatitis B and/or C or are you awaiting the results of such a test?	No ☐ Yes* ☐	
d) In the last five years, ever engaged in unprotected anal intercourse (except in a relationship between you and one other person only where that person is not known or suspected to be HIV positive and/or injects non-prescribed drugs) or worked as or engaged the services of a prostitute?	No ☐ Yes* ☐	
7. Apart from anything already stated:		
a) Are you considering seeking medical advice, treatment, tests or surgery in the future?	No ☐ Yes ☐	G
b) Have you, in the last five years, received any medical advice, any medical treatment, investigation or had any operation not mentioned above (apart from colds, flu, contraceptive advice)?	No ☐ Yes ☐	G
8. To the best of your knowledge, have any of your natural parents, brothers or sisters suffered from or been diagnosed with:		
a) Heart or circulatory problems, stroke, diabetes?	No ☐ Yes ☐	H
b) Depression or any other mental illness?	No ☐ Yes ☐	H
c) Cancer of any type?	No ☐ Yes ☐	H
d) Huntington's disease, muscular dystrophy, multiple sclerosis, polycystic kidney disease or any other hereditary disease?	No ☐ Yes ☐	H
9. a) In the next 12 months do you plan to travel, to another country?	No ☐ Yes ☐	
b) In the last 6 months have you been in another country?	No ☐ Yes ☐	

If yes to either or both question(s), please provide details below:

Country/ destination	Date of departure from Australia (if applicable)	Date of return/arrival in Australia	Reason for travel
	DD/MM/YYYY	DD/MM/YYYY	
	DD/MM/YYYY	DD/MM/YYYY	
	DD/MM/YYYY	DD/MM/YYYY	

Have you answered 'yes' to any questions (1 to 5) or (7 and 8) in Section B?

No ☐ ▸ **Go straight to Section E on page 10. Do not complete Section C or D.**

Yes ☐ ▸ **For each 'yes' answer you must complete a corresponding questionnaire, as noted in the column beside your 'yes' answer above. Proceed to relevant questionnaire in Section C.**

*If you have answered 'yes' to question 6, a confidential questionnaire will be sent to you.

Section C – Questionnaire A – Pastimes questionnaire

Only complete if you answered **'yes'** to **question 1** of **Section B – Personal statement**

1. Do you engage in any of the following hazardous pastimes or pursuits?	
a) Flying? (other than as a fare paying passenger on a commercial airline)	No ☐ Yes ☐
b) Underwater diving (scuba)	No ☐ Yes ☐
If **'yes'** (i) do you dive more than 40 metres in depth?	No ☐ Yes ☐
(ii) do you dive alone?	No ☐ Yes ☐
c) Football of any code (other than touch or Oztag)	No ☐ Yes ☐
d) Motorised sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing	No ☐ Yes ☐
e) Trail bike or quad bike riding (including off road and dirt bike)	No ☐ Yes ☐
f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, para-gliding, competitive water sports, horse riding or recreations involving heights?	No ☐ Yes ☐

If you have answered 'yes' to any of the above questions, please answer the following questions:

What are the activity(ies) you engage in?

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

Recreational only (non competition) ☐

Recreational with competition ☐

Semi-professional/professional ☐

Number of times you participate on average in this activity(ies) per annum, e.g. hours flown, number of dives, events?

Do you receive income from participating in this activity(ies)?

No ☐ Yes ☐

Questionnaire B – Insurance history questionnaire

Only complete if you answered **'yes'** to any part of **question 2** of **Section B – Personal statement**

1. Other than this application, do you have or have you recently applied for life, total and permanent disability, trauma, or salary continuance on your life with CommInsure, or any other insurance company? No ☐ Yes ☐

If **'yes'**, please provide details below:

Insurance company	Type of cover	Insurance benefit	To be replaced?	Date commenced
		$	No ☐ Yes ☐	
		$	No ☐ Yes ☐	
		$	No ☐ Yes ☐	

2. Has an application for life, total and permanent disability, trauma, or salary continuance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? No ☐ Yes ☐

If **'yes'**, please provide details below:

Insurance company	When was the decision made on the application?	Terms offered and reason

3. Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit, Workers' Compensation, Disability Pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits? No ☐ Yes ☐

If **'yes'**, please provide details below:

Benefit type/source/reason for claim	Date commenced	Claim amount	Date finalised
		$	
		$	
		$	

Questionnaire C – Joint/musculoskeletal questionnaire

Only complete if you answered **'yes'** to **question 3** of **Section B – Personal statement**

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

2. Location of complaint, e.g. lower back, right knee, sciatic nerve.

3. When did symptoms first begin?

4. Cause of condition, e.g. lifting, car accident, fall in workplace, unknown.

5. Was an x-ray or scan taken?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Date of most recent test

Details of results of tests taken:

6. Is the nature of the condition degenerative or a disc problem?

No ☐ Yes ☐

7. Are you still undergoing treatment or experiencing symptoms?

No ☐ ▸ If **'no'**, please complete the details below:

Yes ☐

Date symptoms ceased DD/MM/YYYY

Date treatment ceased DD/MM/YYYY

8. Have you been off work as a result of this complaint or been unable to perform your normal day to day activities?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) off work:

9. Do you have any residual, ongoing effects or restrictions as a result of this condition?

No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details:

10. Is your treating doctor different from your usual doctor?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire D – Mental health questionnaire

Only complete if you answered **'yes'** to **question 4** of **Section B – Personal statement**

1. Please provide details of the condition (doctor's diagnosis):

2. Please indicate the reason or cause by ticking the appropriate box(es):

Bereavement/family illness ☐

Marital problems ☐

Post natal ☐

Work related ☐

Other (please specify) ☐

3. Date symptoms first commenced:

4. Have the symptoms ceased?

No ☐ Yes ☐ ▸ If **'yes'**, please provide the date symptoms ceased:

5. Have you taken or are you taking medication?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details

Type of medication	Dosage	Date ceased (if not ongoing)

6. Have you attempted suicide or had suicidal thoughts?

No ☐ Yes ☐

7. Have you ever been hospitalised?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) hospitalised:

8. Did the condition ever cause you to take time off work?

No ☐ Yes ☐ ▸ If **'yes'**, please indicate period(s) off work

9. Has your ability to perform daily activities been restricted in any way?

No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details:

10. Is your treating doctor different from your usual doctor?

No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire E – High blood pressure/ Raised cholesterol questionnaire

Only complete if you answered **'yes'** to **question 5a** of **Section B – Personal statement**

1. Name of condition
High blood pressure ☐ Raised cholesterol ☐

2. When were you first diagnosed with this condition?

3. Do you have any problems or complications resulting from this condition? e.g. heart disease, chest pain?
No ☐ Yes ☐ ▸ If **'yes'**, please provide details:

4. Are you taking regular medication for this condition?
No ☐
Yes ☐ ▸ If **'yes'**, please provide details, including dosage:

5. Blood pressure

When was your last blood pressure reading?
DD/MM/YYYY

Was it considered to be well controlled, e.g. less than 140/90?
No ☐ Yes ☐
Don't know ☐

Cholesterol

When was your last cholesterol reading?
DD/MM/YYYY

What was the result of your last cholesterol reading?
2.0 to 6.5 mmol ☐
6.6 to 7.5 mmol ☐
7.6 or above ☐
Don't know ☐

6. Is your treating doctor different from your usual doctor?
No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Questionnaire F – Cysts, moles, sunspots or skin lesion questionnaire

Only complete if you answered **'yes'** to **question 5b** of **Section B – Personal statement**

1. Please provide type:
Cyst ☐ Mole ☐ Sunspot ☐ Skin lesion ☐
Melanoma ☐ Basal cell carcinoma ☐
Other ☐ ▸ please specify:

2. Location of growth(s)
Face/head ☐ Back/shoulder ☐ Chest/front ☐
Arm/leg ☐

3. When was this?

4. Was/were the growth(s) removed?
No ☐ Yes ☐ ▸ If **'yes'**, please complete below:
When was it removed?
DD/MM/YYYY
How many growths were removed?
Method of removal:
Frozen/burnt off ☐ Surgical/cut out ☐

5. Was/were the growth(s) reported as cancerous (malignant)?
No ☐ Yes ☐ ▸ If **'yes'**, were any further tests, investigations, treatments, follow up or re-excision required?
No ☐ Yes ☐ ▸ If **'yes'**, please provide dates and details of further tests, investigations, treatments, follow up or re-excision:

6. Is your treating doctor different from your usual doctor?
No ☐ Yes ☐ ▸ If **'yes'**, please complete the details below:
Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Only complete if you answered **'yes'** to any part of **question 5 C, D & E and/or 7** of **Section B – Personal statement**

1. When did you last consult a doctor?

Within the last month ☐ 1 to 3 months ago ☐ 3 to 6 months ago ☐

6 to 12 months ago ☐ 12 months to 2 years ago ☐ Over 2 years ago ☐

a) What was the reason for this consultation?

b) What was the result/outcome from your last consultation? **(tick (✔) the appropriate box)**

Referral to specialist/health professional ☐ Tests conducted – results pending ☐

Ongoing treatment e.g. Ventolin inhaler ☐ Routine tests conducted – results all clear/normal ☐

All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication) ☐ Not fully recovered yet ☐

c) Was the doctor/medical centre consulted, your usual doctor/medical centre?

No ☐ Yes ☐

If you have been a patient of this doctor for less than 12 months, please provide details of your previous doctor/medical centres:

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

2. This question is for females only, otherwise please continue to question 3.

a) Are you currently pregnant?

No ☐ Yes ☐ ▸ If **'yes'**, what is the due date for your baby?

b) 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 your 12 month maternity leave

No ☐ Yes ☐

c) Have you ever had any complications with pregnancy or childbirth? (e.g. diabetes, ectopic pregnancy, pre-eclampsia & excluding elective caesarian or miscarriage in the first 15 weeks)

No ☐ Yes ☐ ▸ If **'yes'**, please provide details and dates below

d) Have you ever had an abnormal result for any of the following tests?

i) Pap smear No ☐ Yes ☐

ii) Breast ultrasound No ☐ Yes ☐

iii) Mammogram No ☐ Yes ☐

If **'yes'**, please provide details and dates below

e) Have you ever had a breast lump or breast cyst or any other type of breast abnormality (even if you have not consulted a doctor)?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details including dates and results of treatments.

f) Have you ever sought treatment for any condition of the ovary, uterus, endometrium or perineum?

No ☐ Yes ☐ ▸ If **'yes'**, please provide details including dates and results of treatments.

▸ Please continue to question 3 overpage...

Questionnaire G – Personal and medical details questionnaire (continued)

3. Have you ever had, or sought advice or treatment, experienced symptoms or suffered from any of the following:

a)	Asthma (other than childhood), chronic bronchitis, emphysema, recurrent pneumonia or any other lung complaint?	No ☐ Yes ☐
b)	Chest pains, heart complaint, cardiomyopathy, heart murmur, palpitations or rheumatic fever	No ☐ Yes ☐
c)	Stroke, paralysis, neurological disorder, multiple sclerosis , muscular dystrophy or blood vessel disorder	No ☐ Yes ☐
d)	Alzheimer's, Parkinson's dementia or any other disorder of the brain	No ☐ Yes ☐
e)	Cancer, tumour or melanoma	No ☐ Yes ☐
f)	Thyroid, glandular, pituitary or pancreatic disorder	No ☐ Yes ☐
g)	Gastric or duodenal ulcer, persistent indigestion, gastro oesophageal reflux disease, Barrett's oesophagitis irritable bowel or other bowel disorder (eg: polyps, ulcerative colitis or Crohn's disease)	No ☐ Yes ☐
h)	Diabetes, gestational diabetes, insulin resistance or abnormal blood sugar	No ☐ Yes ☐
i)	Any disorder of the gall bladder or liver, including hepatitis B, C or fatty liver/raised liver function	No ☐ Yes ☐
j)	Varicose veins, haemorrhoids or hernia	No ☐ Yes ☐
k)	Disorder of the kidney, bladder or prostate (including raised PSA), blood in urine or kidney stones	No ☐ Yes ☐
l)	Epilepsy, fits of any kind, fainting episodes, dizziness or vertigo or recurring headaches or migraines	No ☐ Yes ☐
m)	Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder including insomnia	No ☐ Yes ☐
n)	Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome	No ☐ Yes ☐
o)	Eczema, dermatitis, psoriasis or any other skin disorder	No ☐ Yes ☐
p)	Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder, embolism, thrombosis (DVT) or Factor V Leiden	No ☐ Yes ☐
q)	Any impairment of sight (other than short or long sightedness) or blurred vision	No ☐ Yes ☐
r)	Any impairment of hearing (including tinnitus, deafness, high frequency hearing loss) or speech	No ☐ Yes ☐
s)	Any sexually transmitted diseases	No ☐ Yes ☐
t)	Any other illness, injury, disease or disorder not mentioned above	No ☐ Yes ☐
u)	Other than those conditions mentioned above, are you taking any regular prescribed medication	No ☐ Yes ☐
v)	Have you undergone screening for diseases or conditions such as, but not limited to, bowel cancer or have you had a genetic test?	No ☐ Yes ☐
w)	Within the last three years, have you had an ECG, X-ray (excluding broken bones or joint strains), any abnormal blood test results, a genetic test or an ultrasound (other than for pregnancy)?	No ☐ Yes ☐
x)	Are you considering seeking medical advice, treatment, tests or surgery in the future?	No ☐ Yes ☐

If you have answered **'yes'** to any **of the above questions**, please provide full details of each **'yes'** answer in **Section D – General health questionnaire on page 9.**

Questionnaire H – Family history questionnaire

Only complete if you answered **'yes'** to any part **question 8** of **Section B – Personal statement**

1. Please complete the table below:

Family member	Condition – if cancer please state type	Age diagnosed

2. Have you had or do you intend on having a genetic test?

No ☐ Yes ☐

3. What was the result of the genetic test? (please mark the appropriate box)?

Have not been tested yet ☐ Positive (I have the gene) ☐ Negative (I do not have the gene) ☐ Unsure ☐

Section D – General health questionnaire

If you have answered **'yes'** to any part of **question 3 a to x** in **questionnaire G**, please complete the table below:

Details for question number:	Question ( )	Question ( )	Question ( )
1. Name of injury, illness, condition or tests?			
2. Date symptoms first started?			
3. Date symptoms ceased (if applicable)?			
4. Are these symptoms singular, recurrent or ongoing?			
5. How often do/did you have symptoms? Please choose one of the following: **daily, weekly, monthly, quarterly, half yearly, one off, other (please specify).**			
6. Severity of symptoms? Please choose one of the following: **mild, moderate, severe, never had symptoms, symptoms ceased.**			
7. Did you take medication or have any other treatment for this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'** please give details of the medication/treatment.			
8. Are you still on treatment, including medication?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
9. Have you ever been off work as a result of this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'**, please indicate the total time off work.			
10. Do you have or have you had any residual, ongoing effects or restrictions as a result of this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
11. Have you ever had an x-ray, scan or blood test for this condition?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
12. Is your treating doctor different from your usual doctor?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If **'yes'**, please provide the doctor's name and contact details.			

Section E – Duty of disclosure

Duty of disclosure

Before a person enters into a life insurance contract in respect of their life or the life of another person, they have a duty to tell the insurer anything that they know, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms.

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

The person who has entered into the contract has the same duty before they extend, vary or reinstate the contract.

The person entering into the contract 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 the insurance is for the life of another person and that person does not tell the insurer something that they 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 person entering into the contract to comply with their duty of disclosure.

If the person entering into the contract does not tell us 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 the person entering into the contract does not tell the insurer anything they are required to, and the insurer would not have provided the insurance if they 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 person entering the contract 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 the person entering the contract 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.

Section F – Privacy of your personal information

CommInsure's Privacy Policy can be found at **commbank.com.au** or upon request at any Commonwealth Bank Australia (CBA) branch. It describes their handling practices, information on how to make a complaint and how they deal with your complaint.

These sections must be completed in all circumstances

Section G – Telephone underwriting

The telephone underwriting facility reduces the need for follow-up information and medical reports, resulting in faster completion. I permit the insurer (CommInsure) to call me (the life to be insured) to clarify or gain further information regarding any matter pertaining to the assessment and processing of this application. I understand that the call will form part of my duty of disclosure as described in Section E.

No ☐ Yes ☐ ▸ If **'yes'**, I am contactable on the following number ( )

between the hours of ____ am ☐ pm ☐ and ____ am ☐ pm ☐

(note they must be usual business hours eastern standard time)

Section H – Doctor's details

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

Name of doctor

Doctor's address

State Postcode

Phone number ( )

Fax number ( )

Section I – Declaration

I have read the duty of disclosure in this Personal statement and I am aware of the consequences of non-disclosure.

I understand that the duty of disclosure continues after I have completed this statement until my application for cover has been accepted by The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers).
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me.
- any hospital, doctor or other person who has treated or examined me to give to CMLA any information on my illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical reports.

I agree to provide further medical authorities if requested.

I declare that:

- the answers to all the questions and the declarations in this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect CMLA's decision to provide insurance
- I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.
- I have read and understood the "Privacy of your personal information" in Section F. I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section.
- I have read and understand the obligations outlined in the "Duty of disclosure" in Section E.

I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Full name

Signature of life to be insured

X

Date of signature

DD/MM/YYYY

Please ensure that you initial any amendments or changes made throughout this form