Personal statement

APPLICATION FOR INSURANCE

NATIONWIDE SUPER

You are applying to enter into a contract of insurance.
As such, you have a duty to take reasonable care to not make a misrepresentation to the insurer. 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 to take reasonable care 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 to take reasonable care 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 ✗ Date / /

Section A – Your details

Member number | Name of super fund

Given name(s) | Surname | Date of birth

Employer | What is your job? | Salary or yearly income

Postal address (PO Box is not acceptable)

State Postcode

Email address | Phone number | Mobile number

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

2. 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 the average you smoke? per day **or** per week **or** per year

3. Do you drink alcohol? No ☐ Yes ☐ ▶ If 'Yes', please provide the average number of standard drinks consumed:

per day **or** per week **or** per year

A standard drink is 375ml of mid strength beer, 100ml of wine or 30 ml of spirits.

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 ☐

Section A – Your details (continued)

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 high risk sports or activities such as, but not limited to, trail bike, quad bike or off-road riding, football (other than touch or Oztag), motorised sports, parachuting, hang-gliding, abseiling, mountaineering activities, aviation (other than a fare paying passenger), scuba diving or are you paid or sponsored to play any sports?	No ☐ Yes ☐	**A**
2. The next three questions are about life insurance*. You may have this cover as part of your super or you may have bought it separately.		
a) Apart from this application, do you have or are you applying for any other life insurance*?	No ☐ Yes ☐	**B**
b) Have you ever had an application for life insurance* turned down, been asked to pay higher premiums or had exclusions or special terms applied?	No ☐ Yes ☐	**B**
c) Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit, from any superannuation fund, Workers Compensation, Disability Pension, Veterans Affairs, TAC (Transport Accident Commission) or any other insurance policy providing accident or sickness benefits?	No ☐ Yes ☐	**B**
*Life insurance includes cover which pays out if you die (Life cover), or if you get sick or seriously injured (Trauma, Total and Permanent Disability (TPD), Salary Continuance or Income Protection cover).		
3. Have you ever had symptoms of or obtained advice or treatment for any of the following?		
a) Any injury, disease, restriction of movement or problem of any joints, bones, ligaments or muscles? *Examples include back or neck pain, hip, knee or shoulder pain, arthritis of any kind, osteoporosis, RSI (repetitive strain injury) or gout*	No ☐ Yes ☐	**C**
b) Depression, stress, anxiety, panic attacks, eating or behavioural disorders, post-traumatic stress or any other mental health condition?	No ☐ Yes ☐	**D**
c) High blood pressure or raised cholesterol?	No ☐ Yes ☐	**E**
d) Cyst, mole, sunspots, skin lesions or skin cancer?	No ☐ Yes ☐	**F**
e) Chronic fatigue syndrome, fibromyalgia or any other disorder causing ongoing symptoms of pain or tiredness?	No ☐ Yes ☐	**G,I**
f) Asthma, bronchitis, pneumonia or any other breathing difficulties or lung complaint?	No ☐ Yes ☐	**G,I**
g) Heart attack, chest pain or any other heart problem, stroke, MS (multiple sclerosis) or any other brain, blood vessel or nervous system disorder?	No ☐ Yes ☐	**G,I**
h) Cancer, tumour, leukaemia, diabetes or abnormal blood sugar, liver or kidney complaint?	No ☐ Yes ☐	**G,I**
4. a) In the last ten years have you taken any illegal drugs or drugs that weren't prescribed for you?	No ☐ Yes^ ☐	
b) Has a doctor or healthcare provider told you to reduce or stop drinking alcohol, or have you received counselling or treatment for alcohol, substance or drug use?	No ☐ Yes^ ☐	
c) Have you ever tested positive for HIV, Hepatitis B and/or C or are you awaiting the results of such a test?	No ☐ Yes^ ☐	
d) Have you been exposed to the risk of HIV infection? This would include sex without a condom with someone you know or suspect to be infected by HIV, Hepatitis B or C, someone who injects non-prescribed drugs, with or as a sex worker?	No ☐ Yes^ ☐	
5. Other than what you have already told us:		
a) Are you currently being tested for or have signs or symptoms of ill health or disability, whether or not you have seen a medical professional?	No ☐ Yes ☐	**G,I**
b) Have you, in the last five years, received any medical advice or treatment, had any tests or investigations or had any operation (apart from colds, flu, contraceptive advice)?	No ☐ Yes ☐	**G,I**
6. This question is about your family's medical history. As far as you know, has your mother, father, sisters or brothers had any of the following? • Heart problems, cardiomyopathy, stroke, or sudden death • Diabetes • Any Dementia, Alzheimer's or Parkinson's disease • Cancer of any type • Motor Neurone Disease, Huntington's disease, Multiple sclerosis, Muscular Dystrophy or Polycystic kidney disease • Any other condition which runs in your family	No ☐ Yes ☐	**H,I**
7. Have you travelled in the last six months, or do you intend to travel in the next 12 months, to a country that is rated by the Department of Foreign Affairs as 'Reconsider your need to travel' or 'Do not travel'? Before answering these questions you may wish to check the Smart Traveller website: www.smartraveller.gov.au **If 'Yes' please provide details below:**	No ☐ Yes ☐	

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

Have you answered 'Yes' to any questions (1 to 3) or (5 to 6) in Section B?

No ☐ ▶ **Go straight to Section E on page 11. 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 questionnaires in Section C.**

^If you have answered 'Yes' to question 4, a confidential questionnaire will be sent to you.

Section C – Questionnaire A - Pastimes

Only complete if you answered 'Yes' to **question 1** of **Section B – Personal Statement**

1.	Do you engage in any high risk sports or activities:	
	a) Aviation (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 at more than 40 meters, or engage in cave, nitrox or wreck diving?	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, abseiling, mountaineering 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 ☐

If 'Yes', please provide full details

Section C – Questionnaire B - Insurance history

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

1. Apart from this application, do you have or have you recently applied for life, total and permanent disability, trauma, income protection or salary continuance on your life with AIA Australia 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. Have you ever had an application for life, total and permanent disability, trauma, or salary continuance on your life turned down, been asked to pay higher premiums or had exclusions or special terms applied? 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, TAC (Transport Accident Commission) 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
	/ /	$	/ /
	/ /	$	/ /
	/ /	$	/ /

Section C – Questionnaire C - Joint/musculoskeletal

Only complete if you answered 'Yes' to **question 3a** 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 your symptoms first begin?

4. Cause of the 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 your most recent test / /

Details of results of tests taken:

6. Is the nature of your 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 your symptoms ceased / /

Date your treatment ceased / /

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

Section C – Questionnaire D - Mental health

Only complete if you answered 'Yes' to **question 3b** of **Section B – Personal Statement**

1. Please provide details of your 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 your 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

Section C – Questionnaire E - High blood pressure/ raised cholesterol

Only complete if you answered 'Yes' to **question 3c** 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. **High blood pressure**
When was your last blood pressure reading?
/ /
Was it considered to be well controlled, e.g. less than 140/90?
No ☐ Yes ☐
Don't know ☐

Raised cholesterol
When was your last cholesterol reading?
/ /
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

Section C – Questionnaire F - Cysts, moles, sunspots or sun lesion

Only complete if you answered 'Yes' to **question 3d** 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?
/ /
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

Section C – Questionnaire G - Personal and medical details

Only complete if you answered 'Yes' to any part of **question 3e to h and/or 5** 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 the consultation?

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

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 pregnant?

No ☐ ▶ If 'No', go to **2d)** 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 and excluding elective caesarean 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.

Section C – Questionnaire G - Personal and medical details (continued)

3. Have you ever had symptoms of or obtained advice or treatment for any of the following:

a)	Asthma, bronchitis, pneumonia or any other breathing difficulties or lung complaint?	No ☐ Yes ☐
b)	Heart attack, chest pain, heart murmur, rhythm or valve disorder, palpitations, rheumatic fever, heart surgery, enlarged heart or any other heart problem?	No ☐ Yes ☐
c)	Stroke, Paralysis, MS (multiple sclerosis), muscle weakness or spasms, numbness or tingling?	No ☐ Yes ☐
d)	Alzheimer's, Parkinson's, dementia or any other disorder of the brain?	No ☐ Yes ☐
e)	Cancer, leukaemia, tumour or melanoma?	No ☐ Yes ☐
f)	Thyroid, pituitary, pancreas or any other glandular disorder?	No ☐ Yes ☐
g)	Stomach ulcer, reflux, irritable bowel or any other bowel or stomach disorder?	No ☐ Yes ☐
h)	Diabetes, gestational diabetes, insulin resistance or abnormal blood sugar?	No ☐ Yes ☐
i)	Fatty liver, raised liver function tests, or any disorder of the liver (including Hepatitis B or C) or gall bladder?	No ☐ Yes ☐
j)	Varicose veins, haemorrhoids or hernia?	No ☐ Yes ☐
k)	Kidney stones, blood in the urine, or any other kidney, bladder, urinary or prostate problem?	No ☐ Yes ☐
l)	Epilepsy, fits of any kind, fainting episodes, recurring headaches or migraines?	No ☐ Yes ☐
m)	Sleep apnoea or any sleeping disorder including insomnia?	No ☐ Yes ☐
n)	Chronic fatigue syndrome, fibromyalgia or any other disorder causing ongoing symptoms of pain or tiredness?	No ☐ Yes ☐
o)	Arthritis, gout or osteoporosis?	No ☐ Yes ☐
p)	Eczema, dermatitis, psoriasis or any other skin disorder?	No ☐ Yes ☐
q)	Anaemia, bleeding disorder, blood clots, haemochromatosis or any other blood disorder?	No ☐ Yes ☐
r)	Any problem or disease of the eyes or sight, other than long or short sightedness? *Examples include blurred vision, cataracts, glaucoma, uveitis, macular degeneration or keratoconus*	No ☐ Yes ☐
s)	Any problems with speech, or any problems or disease of the ears or hearing, such as hearing loss, balance problems or ringing in the ears?	No ☐ Yes ☐
t)	Any sexually transmitted infection (STI)?	No ☐ Yes ☐
Other than what you've already told us:		
u)	Have you in the last five years sought any medical advice or treatment, had any tests or investigations, or had an operation?	No ☐ Yes ☐
v)	Are you currently being tested for or have signs or symptoms of ill health or disability, whether or not you have seen a medical professional?	No ☐ Yes ☐
w)	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 10.**

Section C – Questionnaire H - Family history

Only complete if you answered 'Yes' to question 6 of Section B – Personal Statement

Please complete the table below:

Family member	Condition – if cancer please state type (e.g. breast or colon cancer)	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 C – Questionnaire I - Additional medical details

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 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, salary continuance and business overheads cover?

Yes ☐ ▸ **Please complete below**
No ☐ ▸ **Go to Section E**

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

Yes ☐ **Please complete below**

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.

No ☐ **Go to Section E**

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?

Test has not been done yet ☐

Section D – General health

If you have answered 'Yes' to any part of **question 3 a to w** in **Section C 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 to take reasonable care

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 investgate 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

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.*

Section F – Privacy of your personal information

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** for a copy.

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 (AIA Australia) 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 to take reasonable care 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 – 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 to take reasonable care 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.

Full name

Signature of life to be insured

X

Date of signature

/ /

Section I – Consent for accessing health information

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.

Full name

Signature of life to be insured

✗

Date of signature

/ /

Section J – Active account election

If your superannuation 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 pelase 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 K – Declaration

I have read the duty to take reasonable care in this Personal statement and I am aware of the consequences of misrepresentation.

I understand that the duty to take reasonable care continues after I have completed this statement until my application for cover has been accepted by AIA Australia Limited ABN 79 004 837 861 AFSL 230043 (AIA Australia) 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.

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 AIA Australia'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 to take reasonable care" 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

✗

Date of signature

/ /

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