lifePLUS Protect

Application and variation form

Before you start

Understand your cover

Read through the following key documents available at **csc.gov.au/pds**, and give us a call if you need more information.

- ADF Super Product Disclosure Statement (PDS) at **csc.gov.au/pds**
- Insurance and your ADF Super booklet at **csc.gov.au/pds**
- Target Market Determination (TMD) at **csc.gov.au/tmd**

Use LIFEapp to work out what you need

Log in to ADF Super Member Services Online at **csc.gov.au/log-in** or visit csc.gov.au/lifeapp and use our LIFEapp calculator to review your insurance needs and get a quote for your preferred level of cover.

Consider applying for or changing your cover online

To apply for or change your cover online, log in to ADF Super Member Services Online and use the LIFEapp tool. When you log in, some of the fields will be auto filled with information from your ADF Super account. It's quick and easy to use and, in some cases, your changes may occur within just a few minutes. And if you need help, call us on **1300 203 439**.

CSC — ADF Super Australian Defence Force Superannuation

Any financial product advice in this document is general advice only and has been prepared without taking account of your personal objectives, financial situation or needs. Before acting on any such general advice, you should consider the appropriateness of the advice, having regard to your own objectives, financial situation and needs. You may wish to consult a licensed financial advisor. You should obtain a copy of the ADF Super Product Disclosure Statement and consider its contents before making any decision regarding your super.

Commonwealth Superannuation Corporation (CSC) ABN: 48 882 817 243 AFSL: 238069 RSEL: L0001397
Trustee of the Australian Defence Force Superannuation Scheme (ADF Super) ABN: 90 302 247 344 RSE: R1077063

Completing this form

This form has two main sections, and what you fill in depends on whether you are increasing the insurance benefit to you or decreasing it.

1. **For all insurance applications or changes,** you must complete the relevant parts of the General information and declaration section.
2. **And, if your application increases the insurance benefit to you** (which in turn increases the insurer's risk), you must also complete the relevant parts of the Personal statement and declaration.

Use the checklist below as a guide to what you need to complete. If you need a hand, give us a call on **1300 203 439**.

What do you want to do today?

Update your Income (only if you have or are applying for Income Protection)

What you need to do

- ☐ Complete these subsections in the **General information and declaration** section:
  - ☐ 1. Your privacy
  - ☐ 2. Your personal details
  - ☐ 3. Update your salary for Income Protection
  - ☐ 6. General declaration
- ☐ Complete Parts A–F of the **Personal statement and declaration** section, including the relevant subsections (the form will guide you)

More information

If you have Income Protection cover and your Income changes, or you're applying for Income Protection, you'll need to let us know your Income amount.

If you are increasing your cover or applying for cover, you'll go through the full insurance application process for Income Protection cover. Your application will need to be approved by our insurer.

The maximum benefit you can apply for is $20 000 a month (which is approximately $282 000 a year).

Get new cover

What you need to do

- ☐ Complete these subsections in the **General information and declaration** section:
  - ☐ 1. Your privacy
  - ☐ 2. Your personal details
  - ☐ 3. Update your salary for Income Protection
  - ☐ 4. Apply for cover
  - ☐ 6. General declaration
- ☐ Complete Parts A–F of the **Personal statement and declaration** section, including the relevant subsections (the form will guide you)

More information

You can also apply online using our LIFEapp tool available at csc.gov.au/lifeapp.

New cover may include:

- applying for Income Protection
- applying for Death and TPD cover
- applying for Death only cover.

Change cover (more or less cover)

What you need to do

- ☐ Complete these subsections in the **General information and declaration** section:
  - ☐ 1. Your privacy
  - ☐ 2. Your personal details
  - ☐ 3. Update your salary for Income Protection
  - ☐ 5. Change cover
  - ☐ 6. General declaration
- ☐ If you are applying for more cover than you have now, complete Parts A–F of the **Personal statement and declaration** section, including the relevant subsections (the form will guide you)

More information

Applying for more cover may include:

- increasing your Death and TPD cover
- increasing your Income Protection benefit period
- shortening your Income Protection Waiting Period.

Reducing your cover may include:

- decreasing your Death and TPD cover
- fixing your current Death and TPD cover
- reducing your Income Protection benefit period
- increasing your Income Protection Waiting Period.

If you are reducing your Income, you don't need to complete the Personal statement and declaration.

Opt in to or out of cover

You don't need to complete this form.

More information

You can opt in to or out of Death and TPD cover. If opting in, do this within 60 days of receiving your welcome experience.

Opting in/out online: Click the link in your digital welcome experience or log in to ADF Super Member Services Online and use our LIFEapp tool.

Opting out using a form: Complete and return the **Cancellation of cover** form at csc.gov.au/forms.

Cancel some or all cover

You don't need to complete this form.

More information

Just log in to ADF Super Member Services Online and use our LIFEapp tool, or complete and return the **Cancellation of cover form** at csc.gov.au/forms.

General information and declaration

1 Your privacy

For everyone to read

Your privacy is important to us and to our insurer, AIA Australia. Please read through the two privacy statements that apply to your application. They explain how we and the insurer manage your privacy.

CSC's privacy statement

We're committed to protecting your privacy. We collect your personal information for the purposes of providing superannuation services to you (this includes the management of your insurance cover), improving our products and to keep you informed. We will only share your personal information where necessary for providing superannuation services to you. This may include disclosing your personal information to our scheme administrator, our insurer AIA Australia, our service providers or government or regulatory bodies. Your personal information may be accessed overseas by our service providers. Please see our privacy policy for full details.

Your personal information will not be otherwise used or disclosed unless required or permitted under law. A full copy of our privacy policy as well as the privacy complaint process is available at csc.gov.au/Members/Privacy-policy.

AIA Australia's privacy statement

Your privacy is important to AIA Australia. By becoming a member, or otherwise interacting or continuing your relationship with AIA Australia directly or via a representative or intermediary, you confirm that you agree and consent to the collection, use (including holding and storage), disclosure and handling of personal and sensitive information ("**Personal Information**") in the manner described in the AIA Australia Group Privacy Policy on AIA Australia's website as updated from time to time (AIA Australia Privacy Policy). AIA Australia's current Privacy Policy is available at www.aia.com.au or by calling 1800 333 613. In summary, for the purposes set out in AIA Australia's Privacy Policy (including for the purposes of administering, assessing or processing your insurance or any claim) AIA Australia may:

- collect Personal Information from you, including from application forms or other information submitted in respect of your insurance, or when interacting with you (including online)
- collect your Personal Information from, and provide to, third parties in Australia and overseas, such as your representatives (including your financial adviser), the trustee and administrator of a superannuation fund, employers, health professionals, reinsurers, government agencies, service providers and affiliates
- be required or authorised to collect your Personal Information under various laws including insurance, taxation, financial services and other laws set out in AIA Australia's Privacy Policy, and
- disclose Personal Information to third parties which may be located in Australia, South Africa, the US, the United Kingdom, Europe, Asia and other countries including those set out in AIA Australia's Privacy Policy.

If you do not provide the required Personal Information, AIA Australia may not be able to provide insurance or other services to you. Information about how to access or correct your Personal Information held by AIA Australia or lodge a privacy-related complaint is set out in AIA Australia's Privacy Policy.

The most recent version of the AIA Australia Privacy Policy at www.aia.com.au applies to and supersedes all previous Privacy Policies and/or Privacy Statements and privacy summaries that you may receive or access.

2 Your personal details

For everyone to complete

ADF Super member no.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other Specify

Surname

Given name(s)

Date of birth D D M M Y Y Y Y

Residential address
No. Street
Suburb State Postcode

Phone
Business hours After hours
Mobile number

Email

! We'll be in touch by email if you give us an email address. Otherwise, we'll send hardcopy mail to the residential address you've included.

3 Update your Income for Income Protection

Complete if you have Income Protection cover and your Income changes, or if you're applying for Income Protection

Your Income is the basic wage or income you earn. It does not include bonuses, overtime earnings, mandated super contributions, additional commissions and unearned income like investment or interest income.

If you own all or part of a business, your Income for insurance purposes is defined as:

- the gross amount earned by the business in the 12 months immediately prior to you becoming Disabled, and
- this gross amount was earned as a direct result of your personal exertion or activities, delivered through your usual occupation, after allowing for costs and expenses incurred in deriving that income.

Income from the business does not include investment income, profit distributions or similar payments that may continue in the event of Disability.

Log in to ADF Super Member Services Online if you need to check your cover type, or call us on **1300 203 439**.

! If you are responsible for reporting your Income for insurance purposes to CSC, you must do this as soon as possible after the change. This is because if you claim for Income Protection benefits, they are calculated on whichever of the following is less:

- your actual salary at the time of your Total Disability, or
- the salary you reported to us.

My annual salary for insurance is $ ☐☐☐☐☐☐☐☐

Please note: Your Income Protection cover must be underwritten through a full insurance application process, which must be approved by our insurer. Please also complete the Personal statement and declaration, including the relevant subsections (the form will guide you).

4 Apply for cover

For customers with no lifePLUS Protect cover who would like to apply for cover

Death and TPD cover

Death cover amount $ ☐☐☐☐☐☐☐☐

TPD cover amount $ ☐☐☐☐☐☐☐☐

Please note: If you have TPD cover you must also have Death cover. You can't hold TPD only cover. The TPD cover amount you choose can't be higher than your Death cover amount.

Income Protection cover

Waiting Period:

☐ 30 days ☐ 60 days ☐ 90 days

Benefit period:

☐ 2 years

Please note: All customers who apply for cover must also complete Parts A–F of the Personal statement and declaration section, including the relevant subsections (the form will guide you).

5 Change cover

For customers with lifePLUS Protect cover who would like change their cover—up or down

Complete this section, for example, if you want to:

- change your Death, TPD or Income Protection cover—up or down
- change your current level of Death and TPD cover to fixed cover.

I'd like to change my Death and TPD cover

☐ From my current level of Death and TPD cover to a fixed cover amount of

Death $ ☐☐☐☐☐☐☐☐ TPD $ ☐☐☐☐☐☐☐☐

☐ From my current level of Death only cover to a fixed cover amount of $ ☐☐☐☐☐☐☐☐

Please note: The TPD cover amount you choose can't be higher than your Death cover amount. If your current level of cover is lower than the amount of cover you're applying for, you'll also need to complete Parts A–F of the Personal statement and declaration section, including the relevant subsections (the form will guide you).

I'd like to change my Income Protection cover Waiting Period

Change it to ☐ 30 days ☐ 60 days ☐ 90 days

Please note: If you are shortening your Waiting Period, also complete Parts A–F of the Personal statement and declaration section, including the relevant subsections (the form will guide you).

Check point

Do you need to complete the Personal statement and declaration?

Yes If you're applying for cover that increases the insurance benefit to you (which in turn increases the insurer's risk), please also complete Parts A–F of the Personal statement and declaration section, including the relevant subsections (the form will guide you). When you're done, read through and sign the General declaration (below) before you lodge your application.

No Move on to reading and completing the General declaration, below.

6

General declaration

For everyone to read and complete

I declare:

- I have read and understood CSC's and AIA's privacy statements
- the information I have provided on this form is complete and correct
- I authorise the insurer, AIA Australia Limited, to change my insurance options as indicated on this form, but understand that this is at the insurer's discretion and I may be required to provide more information before my cover is changed
- I have fully considered the fees and other costs that may apply before taking action
- I have read and understood the **ADF Super PDS** and **Insurance and your ADF Super** booklet
- if reducing cover, I understand that I will need to reapply later if I wish to increase that cover again, and my application:
  - will be subject to underwriting by the insurer, and
  - may be declined or offered on modified terms and conditions
  - may require that I undertake medical testing before my cover will be accepted
- I have completed the attached Personal statement and declaration with this form if I am:
  - applying for new cover
  - increasing my Death and TPD cover
  - shortening my Waiting Period for Income Protection
  - advising of an increase to my Income for Income Protection.

Surname

Given name(s)

Signature

Date signed

D	D	M	M	Y	Y	Y	Y

What happens next?

Lodge your application

Post your completed form to **ADF Super Insurance, Locked Bag 20116, Melbourne Vic. 3001**
or scan and email it to us at formsandapplications@adfsuper.com.au.

When your cover changes

Generally, if you're applying for:

- a greater insurance benefit than you currently have, a full insurance application process applies. The insurer will assess your application and we'll let you know the outcome when they tell us. If your application to add or increase cover is successful, the new cover starts on the date the insurer accepts your application.
- less cover than you currently have, it's a straight-through process. Your reduced cover starts the day after we receive your application.

A few other conditions may apply. For example, if you're reducing your cover within 60 days of the date of receiving your welcome experience, we'll backdate your reduced cover to the date your cover started.

lifePLUS Protect

Personal statement and declaration

Group Life including Income Protection

About this application

The life insurance policy being applied for with this application is a consumer insurance contract within the meaning of the *Insurance Contracts Act 1984 (Cth)*.

When you apply for life insurance, AIA Australia conduct a process called underwriting. It's how AIA Australia decide whether they can cover you, and if so, on what terms and at what cost.

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

The duty to take reasonable care

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

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

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

If you do not meet your duty

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

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

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

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

Guidance for answering our questions

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

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

Changes before your cover starts

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.

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Commonwealth Superannuation Corporation (CSC) ABN: 48 882 817 243 AFSL: 238069 RSEL: L0001397
Trustee of the Australian Defence Force Superannuation Scheme (ADF Super) ABN: 90 302 247 344 RSE: R1077063

A PART A–Life insured (please provide current details)

ADF Super member no.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other Specify

Surname

Given name(s)

Gender ☐ Female ☐ Male

Date of birth D D M M Y Y Y Y Age last birthday

Residential address
No. Street
Suburb State Postcode

Postal address
No. Street
Suburb State Postcode

Phone
Business hours After hours
Mobile number

Email

Are you an Australian citizen or permanent resident of Australia (as approved by the Department of Home Affairs) or are you a New Zealand citizen living permanently in Australia? ☐ Yes ☐ No

If 'No', are you applying for, or intending to apply for, Permanent Residency in Australia? ☐ Yes ☐ No

Please advise what type of visa you hold and expiry date.

D D M M Y Y Y Y

1. (a) What is your usual occupation?

(b) Do you perform any manual work? If 'Yes', please describe duties and percentage of time spent in each ☐ Yes ☐ No

Type of work	% of time	Please describe your specific duties and where they are performed
Sedentary		
Light manual		
Heavy manual		

2. What is your annual income $

3. Hours currently working per week
☐ zero hours ☐ 1–14 hours ☐ 15–60 hours ☐ >60 hours Please provide number of hours if >60

B PART B–Personal history

1. (a) Do you have or are you applying for life, disability (including Total & Permanent Disablement or Salary Continuance cover) or trauma insurance on your life (including any pending applications held with any other insurer)? ☐ Yes ☐ No
If 'Yes', please complete policy details.

Policy number	Commencing date	Policy owner	Insurer	Type of cover	Amount of cover	Existing Income Protection: Waiting Period/ Benefit period	To be replaced 'Y' or 'N'

If you are intending to replace any existing cover that you hold as part of making this application, you should not cancel your existing cover until we have confirmed that we have accepted your application. If we don't accept this application, it could mean you have no cover.

The general risks of replacing life insurance cover may include but are not limited to:

- implications of any errors or omissions in your new application
- your existing policy containing differing terms, conditions, features and/or benefits to a new policy (e.g. waiting periods and qualifying periods restarting).

This information is general only and you should seek financial advice about the risks of replacing your policy to receive information that is specific to your circumstances.

(b) Have you **ever** been declined, deferred or accepted on special terms for life, disability or trauma insurance? ☐ Yes ☐ No

(c) Have you **ever** claimed benefits from any source (excluding unemployment), e.g. Accident, Sickness, Workers Compensation, Social Security, Disability Income Insurance or Pension? ☐ Yes ☐ No

If 'Yes' please give the name of the company, date, amount and reason for each claim below.

If you answered 'Yes' to any of the above questions 1(b) or 1(c), please give full details.

2. (a) In the last 12 months, have you smoked tobacco or any other substance such as cigarettes, cigars, pipes or used e-cigarettes or other nicotine products? ☐ Yes ☐ No

If 'Yes', please state substance and daily quantity (please note 'packet' is not sufficient detail):

(b) Do you drink alcohol? ☐ Yes ☐ No

If 'Yes', please state how many standard drinks you consume per week on average.....
(One standard drink = 30ml spirits (one nip), 100ml wine, 10oz/285ml beer.)

(c) Have you ever used recreational drugs or received advice, treatment or counselling for the use of alcohol or recreational drugs? (Examples of recreational drugs include marijuana, cocaine, methamphetamines, heroin, LSD or other non-prescribed drugs.) ☐ Yes ☐ No

If 'Yes', please provide details.

3. (a) What is your height? ☐☐☐ cm (b) What is your weight? ☐☐☐ kg

4. Do you have definite plans to travel or reside overseas? ☐ Yes ☐ No

If 'Yes', please state:

Cities/Countries	Duration of travel	Frequency of travel	Reason for travel	Date of departure

Note: If you are travelling and you have been fully vaccinated* with an Australian-approved COVID-19 vaccine, please 'tick' the box. ☐
*'Fully vaccinated' means you have received the recommended dosing regimen of a specific COVID-19 vaccine in accordance with the Australian Department of Health advice.

5. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes including touch football and oztag), long-distance sailing, hang gliding, scuba diving, motor racing, non-competitive off-road motorcycle sport (trail bike riding/dirt bike riding/motocross), parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? ☐ Yes ☐ No

If 'Yes', please fill in section **C. Aviation questionnaire** and/or section **D. Activities/Pursuits questionnaire**.

Family history

6. Have any of your immediate family (father, mother, brother, sister) prior to the age of 60 (alive or deceased), ever experienced heart disease, breast cancer, ovarian cancer, prostate cancer, colon (bowel) cancer, polycystic kidney disease, diabetes, stroke, Huntington's chorea, Alzheimer's disease, Dementia, Motor Neurone Disease, Multiple Sclerosis, Muscular Dystrophy, Parkinson's disease or any hereditary disease? ☐ Yes ☐ No

If 'Yes', please provide details in the table below.

Family member	Condition/Illness (for cancer or heart disease, please specify the type)	Age at onset (approx.)	Policy owner age at death (if applicable)
Father			
Mother			
Brother			
Sister			

Sexual health

7. (a) In the last 5 years, have you had sexual intercourse **without** a condom with the following persons?

(i) Someone who might have exposed you to the Human Immunodeficiency Virus (HIV) infection ☐ Yes ☐ No
(This may include unprotected sexual intercourse with someone other than your regular partner whose HIV status is unknown to you) ☐ Yes ☐ No

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

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

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

(v) Someone who is infected with Hepatitis B ☐ Yes ☐ No
(You may answer 'No' if you are vaccinated and have immunity for Hepatitis B)

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

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

PART C–Medical history

A. Medical and health history

(life insured to complete this section in full and complete relevant questionnaire)

1. Have you ever experienced symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?
   (a) High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke ☐ Yes ☐ No
   If 'Yes', please complete section **E. High blood pressure/High cholesterol questionnaire** OR section **G. Multi-purpose questionnaire**.
   (b) Asthma, chronic lung disease, sleep apnoea, COVID-19 (do not include a negative test result or if never diagnosed) or other respiratory disorder ☐ Yes ☐ No
   If 'Yes', please complete section **F. Asthma questionnaire** OR section **G. Multi-purpose questionnaire**.
   (c) Indigestion, gastric or duodenal ulcer or any bowel disorder ☐ Yes ☐ No
   If 'Yes', please complete section **G. Multi-purpose questionnaire**.
   (d) Depression, anxiety/stress state, fatigue (including chronic fatigue syndrome), panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder. This includes accessing EAP, or other mental health services, whether diagnosed with a condition or not ☐ Yes ☐ No
   If 'Yes', please complete section **H. Mental health questionnaire**.
   (e) Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness or recurrent headaches or any neurological disorder including multiple sclerosis ☐ Yes ☐ No
   If 'Yes', please complete section **G. Multi-purpose questionnaire**.
   (f) Arthritis, repetitive strain injury (RSI), fibromyalgia ☐ Yes ☐ No
   If 'Yes', please complete section **G. Multi-purpose questionnaire**.
   (g) Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles ☐ Yes ☐ No
   If 'Yes', please complete section **I. Spinal/Joints disorder questionnaire**.
   (h) Psoriasis or eczema, skin disorder, defect in hearing or sight ☐ Yes ☐ No
   If 'Yes', please complete section **G. Multi-purpose questionnaire**.
   (i) Diabetes, abnormal blood sugar, gout or thyroid disorder ☐ Yes ☐ No
   If 'Yes', please complete section **G. Multi-purpose questionnaire**.

   If you have answered 'Yes' to any of the above questions, please also complete a questionnaire for each condition (see Sections G to I).

   (j) Cancer, cyst, lump, tumour or growth of any kind including skin cancer such as melanoma, BCC, SCC (basal cell or squamous cell carcinoma) or skin lesions/moles that have changed in shape, colour or size ☐ Yes ☐ No
   (k) Liver disorder (including fatty liver), pancreas, prostate, kidney or bladder disorder, renal colic or stone ☐ Yes ☐ No
   (l) Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia ☐ Yes ☐ No
   (m) Hepatitis B or C (including carrier), Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS) ☐ Yes ☐ No
   (n) Are you pregnant? If 'Yes', please provide estimated date child is due. D D M M Y Y Y Y ☐ Yes ☐ No
   (o) Have you ever had or been advised to have treatment for:
      (i) Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound? ☐ Yes ☐ No
      (ii) An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries? ☐ Yes ☐ No
      (iii) Abnormal vaginal bleeding within the last 12 months or endometriosis? ☐ Yes ☐ No
2. Have you ever experienced symptoms of or had any other illness, disease or disorder? ☐ Yes ☐ No
3. During the last five (5) years have you:
   (a) Had any medical examinations, consultations, X-rays, pathology tests or procedures? ☐ Yes ☐ No
   (b) Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? ☐ Yes ☐ No
4. Are you currently under ongoing monitoring, consultation or review for any condition, complaint or finding? ☐ Yes ☐ No
5. Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? ☐ Yes ☐ No

For each 'Yes' answer in questions 1(j)–1(o), and 2–5 above, please provide full details in the table below.

Question reference	Illness, injury or tests	Date of illness/injury	Time off work	Degree of recovery (%)	Results of tests	Reason and type of treatment including date of last symptoms	Full name and address of doctor or hospital (if any)

C

B. Personal doctor's details

1. Please provide personal doctor details including name, date of last consultation, address and contact details. If no personal doctor, provide information about the last clinic or medical centre attended.

(a) Name

(b) What was the date of your last consultation? (Give approximate date if exact date unknown.)

D D M M Y Y Y Y

(c) Address

No.

Street

Suburb

State Postcode

(d) Contact details

Telephone

Facsimile

Email

2. (a) How long have you been attending the practice?

yrs mths

(b) If less than 12 months, please provide the name, address and contact details of your previous personal doctor or medical centre.

(i) Name

(ii) Address

No.

Street

Suburb

State Postcode

(iii) Contact details

Telephone

Facsimile

Email

C. Aviation questionnaire

1. Please state the number of hours flown where applicable:

(a) **Private flying**

Type of aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed wing				
Rotary				
Other (e.g. ultralight, microlight)				

(b) **Commercial flying**

Type of aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed wing				
Rotary				
Other (e.g. ultralight, microlight)				

(c) **Agricultural flying**

Type of aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed wing				
Rotary				
Other (e.g. ultralight, microlight)				

2. Are your flying activities:

☐ Recreational or ☐ Required for your occupation?

Please provide details.

3. (a) Name of aircrafts flown

(b) Make and model of the aircrafts

(c) If pilot only

(i) Age of aircrafts flown

(ii) Is the aircraft serviced and maintained in Australia?..... ☐ Yes ☐ No

If 'No', where is the aircraft serviced?

4. Do you fly or intend to fly outside Australia?..... ☐ Yes ☐ No

If 'Yes', please provide details

5. Do you participate in or intend to participate in any flying activities such as aerobics, stunt flying or exhibitions?..... ☐ Yes ☐ No

If 'Yes', please provide details

6. Have you ever been involved in any aviation accidents?..... ☐ Yes ☐ No

If 'Yes', please provide details

C

D. Activities/Pursuits questionnaire

1. Please describe the activity or pursuit

2. Please advise the number of times you engage in the activity per year

3. How many actual events/hours/trips/flights/dives/climbs/jumps/others, did you participate in over the last twelve months approximately?

4. What qualifications, certificates, licenses, associations and club memberships do you hold?

5. How long have you been involved in this activity?

6. Where do you engage in this activity and in what locations?

7. Do you ever engage in this activity alone, or are you always in a group? ☐ Alone ☐ Group

8. Do you compete in this activity? ☐ Yes ☐ No
   If 'Yes', please advise the level of competition and names of events

9. Do you receive any payments for your involvement in this activity? ☐ Yes ☐ No
   If 'Yes', please advise details

10. Please advise the maximum heights, speeds, depths the activity includes

11. Are any of the above likely to change over the next 2 years? ☐ Yes ☐ No
    If 'Yes', please provide full details

12. Are you involved in any record attempts? ☐ Yes ☐ No
    If 'Yes', please provide details

13. Are all recognised/standard safety measures and precautions followed? Please provide any additional details ☐ Yes ☐ No

14. Please provide details including engine size and model for any cars, boats, planes (state fixed wing or rotary) or other equipment used. For martial arts state whether contact or non-contact.

15. Have you ever been involved in any accident/mishap whilst participating in this activity? ☐ Yes ☐ No
    If 'Yes', please provide details

E. High blood pressure/ High cholesterol questionnaire

1. When was high blood pressure/high cholesterol first diagnosed?
   D D M M Y Y Y Y

2. What were the blood pressure/cholesterol readings (including total cholesterol, HDL, LDL and triglyceride) at time of diagnosis?

Reading	Results	Date diagnosed
Blood pressure		
Total cholesterol		
HDL		
LDL		
Triglycerides		

3. Please provide details of your past and current treatment. Include names of medication and dosage.

Date	Medication	Dosage

4. Are you still on treatment? ☐ Yes ☐ No
   If 'No', when was treatment discontinued and why?

5. Please give date(s) and result(s) of any electrocardiography (ECG), echocardiogram, X-ray, urine test or other investigations which may have been carried out.

Date	Procedure	Dosage

6. Regarding the monitoring of your condition:
   (a) Name of medical attendant:
   (b) How often do you attend for follow-up?
   (c) When was your last consultation? Please provide details of your blood pressure reading and/or cholesterol (including total cholesterol, HDL, LDL and Triglyceride) reading at that time.
   (d) Have you experienced any of the following conditions:
   (i) Eye disorder (other than short/long sightedness) ☐ Yes ☐ No
   (ii) Symptoms or disorder relating to heart or circulatory system ☐ Yes ☐ No
   (iii) Kidney disorder or protein in urine ☐ Yes ☐ No
   (iv) Dizziness, fainting episodes or stroke ☐ Yes ☐ No

   If you answered 'Yes' to any of the above, please provide details:

Date	Symptoms	Investigation	Results

   (e) How long has your blood pressure/cholesterol been well controlled?
   ☐ <6 months ☐ 6–12 months ☐ >12 months

7. Please provide any additional information on your condition which you feel will be helpful in processing your application.

8. Please attach copies of any reports or results (e.g. X-ray, pathology, ultrasound, etc.) you may have.

C

F. Asthma questionnaire

1. Date asthma first diagnosed.

D	D	M	M	Y	Y	Y	Y

2. How often do you experience symptoms? e.g. wheezing, breathlessness, chest tightness?
☐ Daily ☐ Weekly ☐ Monthly ☐ Other
3. When was your most recent episode of asthma?

D	D	M	M	Y	Y	Y	Y

4. Are you aware of any causes that trigger your symptoms? e.g. allergy, exercise.
5. Have you ever been off work due to asthma? ☐ Yes ☐ No
If 'Yes', please advise when, and for how long.
6. Name of medications
(a) Dosage
(b) Frequency
(c) When was the last time you received medication?
(d) What additional treatment do you use to control this condition?
7. Have you ever required steroid therapy (by tablet or syrup)? ☐ Yes ☐ No
If 'Yes', please provide details.
8. Have you ever been in hospital or received emergency treatment for asthma? ☐ Yes ☐ No
If 'Yes', please state when, for how long and where?
9. Have you ever undergone a lung function test? ☐ Yes ☐ No
If 'Yes', please advise dates and highest and lowest readings, if known.
10. Have you ever consulted a specialist for this condition? ☐ Yes ☐ No
If 'Yes', please state when, for how long and where?
11. Please provide details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

G. Multi-purpose questionnaire
(photocopy and complete for additional conditions)

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?
(b) Please state which side.
☐ Left ☐ Right ☐ Not applicable
3. What was the cause?
4. (a) Date symptoms commenced.

D	D	M	M	Y	Y	Y	Y

(b) How long have you been free of symptoms?
(c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? ☐ Yes ☐ No
If 'Yes', please state when, duration and reason/restriction.
6. Have you any residual, ongoing effects or restriction in your daily activities? ☐ Yes ☐ No
If 'Yes', please give details.
7. Have you taken regular or occasional medication for this condition? ☐ Yes ☐ No
If 'Yes', advise names of medication(s), dosage(s) and frequency.
Are you still taking this medication? ☐ Yes ☐ No
8. Have you had any other treatment for this condition (e.g. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No
9. Have you had any diagnostic investigations (e.g. scope, scan, X-rays, EEG, ECG etc.)? ☐ Yes ☐ No
10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No
11. Have you seen a doctor or other therapist for anything related to this condition ☐ Yes ☐ No
If 'Yes', please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

If you answered 'Yes' to questions 8–11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
If 'Yes', please give details.
13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
If 'Yes', please give details.

C

H. Mental health questionnaire

1. Please indicate the condition(s) you have had or received treatment for.
   - ☐ Anxiety including generalised anxiety, panic or phobic disorder
   - ☐ Eating disorder including anorexia nervosa, bulimia
   - ☐ Depression including major depression or mild depression
   - ☐ Manic depressive illness, bi-polar disorder
   - ☐ Alcohol or other substance abuse or addiction
   - ☐ Post traumatic stress
   - ☐ Schizophrenic or any other psychotic disorder
   - ☐ Stress, sleeplessness, chronic fatigue
   - ☐ Others (Please specify)

2. Describe your symptoms including the date started and how long they lasted.

Symptoms	Date from	Date to

3. Have you had any recurrences?..... ☐ Yes ☐ No
   If 'Yes', please provide details.

Symptoms	Date from	Date to

4. (a) Has any reason for your condition been identified, or are there any factors that trigger your condition?

   (b) Have you ever had any suicidal thoughts, attempted suicide, threatened to self-harm or engaged in self-harm? ☐ Yes ☐ No
   If 'Yes', please provide details.

5. (a) Please advise all treatments you have received and/or are receiving, including counselling, name(s) of medications, hospitalisation etc.

Type of treatment	Date commenced	Date ceased

   (b) Are you currently receiving treatment?..... ☐ Yes ☐ No
   If 'Yes', please provide details.

6. Please provide details of doctors or health professionals, including psychiatrists and psychologists, consulted for your condition.

Name and address	Date first consulted	Date last consulted

7. Have you ever been off work or your normal daily activities restricted in any way due to your condition?..... ☐ Yes ☐ No
   If 'Yes', when and how long?

8. Have you any ongoing effects or restriction to your activities of any kind due to your condition? ..... ☐ Yes ☐ No
   If 'Yes', please provide details.

I. Spinal/Joints disorder questionnaire

1. Area of spine (e.g. neck, upper or lower back) and/or joints affected (e.g. left knee, right hip, shoulders, elbows etc.)
2. Please state the precise diagnosis
3. When did symptoms first occur?
4. (a) What was the cause?

   (b) Please describe your symptoms.

   (c) Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? ..... ☐ Yes ☐ No

   (d) State frequency and severity of attacks/symptoms prior to treatment.

5. Are you still experiencing symptoms?..... ☐ Yes ☐ No
   (a) If 'No', date of last experienced symptoms.

   (b) If 'Yes', how frequently have symptoms occurred since commencing treatment?

6. (a) What is the nature of the treatment (e.g. medication, physiotherapy, exercise, etc.)?

   (b) Are you still receiving treatment?..... ☐ Yes ☐ No
   (i) If 'No', when did you cease treatment?
   D D M M Y Y Y Y

   (ii) If 'Yes', how often do you attend for follow-up and date of last consultation?

   (c) Name and address of doctor or therapist consulted.

7. Have you had any X-rays or other investigations or have you ever consulted a specialist for this condition? ..... ☐ Yes ☐ No
   If 'Yes', please provide date(s) and full details including type of investigations, results and name of doctor.

8. Have you had an operation for this condition or is an operation being considered?..... ☐ Yes ☐ No
   If 'Yes', please provide date(s) and full details including names of hospital and consultant/surgeon.

9. (a) Have you ever been off work due to your symptoms?
   If 'Yes', when and for how long? ..... ☐ Yes ☐ No

   (b) Are your occupation duties restricted in any way?
   If 'Yes', please provide details..... ☐ Yes ☐ No

   (c) Is it necessary to avoid lifting or to restrict your daily activities in any way?. ..... ☐ Yes ☐ No
   If 'Yes', please provide details

D

PART D–Further income details (complete only if Income Protection is required)

1. (a) Please state your monthly income from your current occupation (net of business expenses but before tax)?
Do not include investments and superannuation.

- **Self-employed:** If you are self-employed, a working director or partner in a partnership, your income is the income generated by the business or practice due to your personal exertion or activities, less your share of necessarily incurred business expenses. Note the benefit may be averaged in some circumstances based on the last 2 years' income.
- **Employed:** Your income is the total value or remuneration paid by your employer including salary, fees, regular commission, regular bonuses, regular overtime and fringe benefits but excluding mandated superannuation contributions.

Principal occupation:..... Current year $ p/m Previous year $ p/m

(b) How long have you been at your current occupation?..... yrs mths

(c) How much of the above income will continue if you are disabled?.....$

(i) For how long?..... yrs mths

(ii) State source of income (e.g. sick leave, directors fees, income protection insurance, profit share from the business)

2. If you become disabled, would you receive income from other sources? ..... Yes No

If 'Yes'

(a) How much? .....$ p/m (b) For how long? ..... yrs mths

(c) State source of income.....

3. Do you also perform another occupation? ..... Yes No

If 'Yes', describe the daily duties of this occupation (including manual work)

4. Do you receive any unearned income (e.g. from investments such as rental property or dividends)?..... Yes No

If 'Yes', how much? .....$ p/m

5. What was your previous occupation?

6. Are you self-employed or employed by your own company?..... Yes No

If 'Yes'

(a) Date your business started ..... D D M M Y Y Y Y

(b) How long have you been self-employed? ..... yrs mths

(c) What percentage of your work is: .....(i) Freelance? % (ii) Contract? %

7. Has your business or practice had a net operating loss in the last 2 years?..... Yes No

If 'Yes', please provide copies of Profit & Loss Statements for the last 2 years.

8. Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration?..... Yes No

If 'Yes', when..... D D M M Y Y Y Y Date of discharge D D M M Y Y Y Y

9. Do you earn commission or bonuses?..... Yes No

If 'Yes', state percentage of total income..... %

E

PART E–Personal statement declaration

- I declare that the above statements are true and correct (whether written in my hand or not) and that no information material to the insurance has been withheld.
- I agree that any personal statements made together with other relevant documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.
- I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy section of this form and the AIA Australia Privacy Policy available at www.aia.com.au as updated from time to time, including the exchange with third parties located in Australia and overseas. I agree that any personal and sensitive information AIA Australia holds will be governed by the most current Privacy Policy on AIA Australia's website.
- I consent to AIA Australia collecting sensitive information, that is, health information about me for the purposes of the performance of this contract.
- I agree that cover will not commence until the premium is paid and the proposal is accepted by AIA Australia.
- I have read the Duty to Take Reasonable Care notice and understand what is meant by that notice.
- I also understand that my duty continues after I have completed this application until AIA Australia has accepted the risk.
- I understand that AIA Australia does not currently send any Direct Marketing materials.

Signature

Signature of life insured

Date signed

D	D	M	M	Y	Y	Y	Y

F

PART F–Authority to release information about your health

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

How we collect and use your information

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)*.

For the full insurance application, we seek two authorities. Please read each one carefully and then sign confirming your consent.

Authority 1 explained

Release health information excluding consultation notes

Through this authority, you are consenting to any health provider releasing any health information about you in the form we ask for, excluding consultation notes held by your General Practitioner/Practice. 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 your General Practitioner/Practice has done, and/or
- releasing correspondence with other health providers.

In some cases, we may require access to your health consultation notes. We request access to this information through Authority 2.

Authority 2 explained

Release health information including consultation 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 four weeks, or
- the report they 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 Authority 2, we may not be able to process your application for cover or to claim.

F

Your authorisation

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.

As such, I agree to all of the following:

- **Authorisation 1:** 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. This authorisation excludes consultation notes held by any General Practitioner/Practice I have attended.
- **Authorisation 2:** 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.
- 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.

Surname

Given name(s)

Signature

Authority 1 signature

Date signed

D D M M Y Y Y Y

Authority 2 signature

Date signed

D D M M Y Y Y Y