AMP Group Insurance personal statement

Information sheet

Note: If you are unsure of anything in the statement, please ask your financial adviser or AMP to explain it.

If you require more room to provide your answers than has been allocated on this form, please provide a separate signed and dated page(s) and attach this page(s) to your application.

Your duty of disclosure

Read this if you are applying for insurance as the policy owner, or if you will be an insured person under a policy owned by someone else.

What you need to tell us

When you apply for insurance, and up until the insurer accepts your application, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect the insurer's decision to insure you and the terms of your insurance.

This includes answering all the questions in the application honestly, making sure you include all the information we ask for.

You have the same duty if anything changes, or you remember more information, while we're processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same duty at that time to tell us anything that may affect the insurer's decision to insure you and the terms of your insurance.

Where a policy owned by one person covers the life of another person, it's important that the other person also gives us all the information that is required under the duty. If he or she doesn't, then it can be treated as a failure by the owner of the policy to tell us something that the owner must tell us. Therefore you must give us all the required information – whether you're the owner of the policy or a person insured under it.

If you don't tell us something

If you don't give all the required information, and the missing information would've affected the insurer's decision to insure you or the terms of your insurance, the insurer may:

- **treat the contract (or your cover) as if it never existed** – the insurer can only do this within three years of your cover starting.
- **reduce the amount you've been insured for** – to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would've had to pay if you'd told us everything you should've. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.
- **vary your cover** – to take into account the information you didn't tell us and put the insurer in the same position as it would've been if you'd told us. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.

Your total insurance cover forms one insurance contract. If you don't give us all the required information, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

It's fraudulent to deliberately leave out required information or give us incorrect information. In these situations the insurer may refuse to pay a claim and treat the contract (or your cover) as if it never existed.

What you don't need to tell us

You don't need to tell us anything:

- that reduces the insurer's risk, or
- that's common knowledge, or
- the insurer knows or should know as an insurer, or
- we've told you that you don't need to tell us.

Privacy Information

The privacy of your personal information is important to us. We may collect personal information directly from you or from anyone you have authorised. We may also collect personal information if it is required or authorised by law, including the *Superannuation Industry (Supervision) Act 1993*, the *Corporations Act 2001* and the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006* (AML/CTF). We will only collect information about you and your immediate family background that is necessary for the purposes of assessing your application for insurance, any claim you may make under the policy, and for managing the policy (including Group Insurance plans). Necessary information includes details about health, financial situation, occupation and lifestyle.

Issue date: 3 April 2017

Issued by AMP Superannuation Limited ABN 31 008 414 104, AFSL No. 233060

If the information you give us is not complete or accurate we may not be able to provide you with the insurances you have applied for.

We may also use this information for related purposes—for example, providing you with ongoing information about financial services that may be useful for your financial needs through direct marketing. These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services that may be made available by us, other members of the AMP group, or by your financial adviser. Please contact us if you do not want your personal information used for direct marketing.

In assessing your cover or any claim you may make (including under Group Insurance plans), AMP may need to disclose your personal information to other parties who may be located in Australia or overseas, such as re-insurers, claims assessors, medical professionals, policy intermediaries/advisers, the policy owner, judicial or dispute resolution bodies, and AMP group companies. A list of countries where these parties are likely to be located can be accessed via our privacy policy.

If health information is collected in relation to this financial product, then additional restrictions apply. AMP Life may collect health information using a third party provider. The primary purpose for obtaining this health information is for the insurer, AMP Life, to assess your application for new or additional insurance. AMP Life may also use this information for directly related purposes—for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims. AMP Life may disclose this type of health information to:

- the financial adviser or broker responsible for the plan
- the trustee
- the owner of your personal insurance plan (if applicable)
- AMP Life's reinsurers
- medical practitioners
- any person AMP Life considers necessary to help either assess claims or resolve complaints
- anyone you have authorised or if required by law.

If you are an insured person, aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

Under the AMP privacy policy you may access personal information about you held by the AMP group. The AMP privacy policy sets out the AMP group's policies on management of personal information, including information about how you can access your personal information, seek to have any corrections made on inaccurate, incomplete or out-of-date information, how you can make a complaint about privacy and information about how AMP deals with such complaints. For AMP's privacy policy, please visit **amp.com.au**.

HIV antibodies test information

For AMP Life to consider your insurance application, you may need to have a blood test for Human Immunodeficiency Virus (HIV) antibodies. Depending on the type of insurance you have applied for, the blood sample may also be used to determine other matters like your serum, cholesterol, and kidney and liver functions.

AIDS—Acquired Immune Deficiency Syndrome is the final stage of the illness caused by HIV. HIV destroys some of the defence mechanisms which protect us against infections and cancers. As a result, people infected with HIV may suffer severe infections and cancer as well as organ damage.

The most recent evidence suggests that the virus stays in the body indefinitely and causes progressive damage. There is still no cure or vaccine for AIDS but in many cases those infected may survive 10 or more years.

A positive HIV antibody test can have major social, medical, psychological and legal consequences which you should consider before having this test done. These include:

- Possible ill-informed discrimination.
- Possible lawful exclusion from employment if you work in one of a very limited range of occupations where there is a risk of transmitting HIV.
- HIV and AIDS are notifiable to government authorities, but your identity would not be reported.
- As HIV positive people will develop AIDS and long-term outlook is uncertain, life and disability insurance is not normally available to people with HIV.
- Some countries restrict the entry of people with HIV.
- It is an offence to knowingly transmit HIV or to put other people at risk of infection.

You may choose to not have the test done. If you decide not to have the test, AMP can't consider your application for insurance. You may choose to arrange your own HIV antibody test and have the results sent to AMP.

If you choose to have AMP arrange the test, the results will be sent under confidential cover to the AMP's medical officer/ chief underwriter to protect your privacy. In the event of a positive result, this will be communicated to you via the doctor you have specified in your authority for an HIV test. Otherwise, acceptance of your insurance application will indicate that your HIV antibody test was negative.

Please retain this information sheet for your records.
Do not return it with your completed form(s).

NS7580 01/17

AMP Group Insurance personal statement

Please print in CAPITAL LETTERS and place a cross ☒ in any applicable boxes.

1. Details

Plan number

Member number (if applicable)

Plan name

Employer's name

Title

Surname

Given name(s)

Date of birth D D M M Y Y Y Y

Gender ☐ Male ☐ Female

Address

Suburb

State

Postcode

May we phone or email you if we need to clarify any details contained in this statement? ☐ No ☐ Yes

If **'yes'**, please provide preferred contact details:

Phone number

Preferred contact time ☐ am ☐ pm ☐ Any

Preferred contact day ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Any

Email address

2. Residence

a. Are you an Australian citizen or a permanent resident of Australia?

☐ Yes › go to question **2c**

☐ No › proceed to question **2b**

b. Are you a New Zealand citizen?

☐ Yes › proceed to **2c**.

☐ No ›

i. Which country has issued your current passport?

ii. How long have you lived in Australia? years months

iii. What type of visa do you hold?

iv. Have you applied for an Australian permanent residency visa? ☐ No ☐ Yes

If **'no'** do you intend applying for an Australian permanent residency? ☐ No ☐ Yes

If you do, please advise the date you can make that application. D D M M Y Y Y Y

If applicable, do you have your family residing with you in Australia? ☐ No ☐ Yes

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

2. Residence (continued)

c. In the next 12 months, do you intend to leave Australia to go and live in another country? ☐ No ☐ Yes

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

Where	Duration

3. Travel

a. Do you have any definite plans to travel overseas, other than New Zealand in the next 12 months? ☐ No ☐ Yes

If **'yes'**:

i. What countries will you travel to?

ii. What is the purpose of travel?

iii. When is the planned departure and duration?

4. Occupation details

a. What is your current occupation?

b. How many hours per week do you work in your main occupation? hours

c. How many weeks per year do you work in your main occupation? weeks

d. Name of your business or employer

e. Address of your business or employer

f. Do you hold any professional/trade qualifications? ☐ No ☐ Yes

If **'yes'**, give details:

Type	Institution

g. What are the main duties of your occupation?

Duties (eg office work, sales, supervision, manual work, explosives handling)	% of time
	0 %

Main location (eg office, on-site, driving, underground, offshore, underwater, at heights or at home)	% of time
	0 %

h. Do you have any other occupation? ☐ No ☐ Yes

If **'yes'**, please provide details (including type of occupation, duties, number of hours worked per week and the income earned in the last 12 months):

i. Do you have any definite plans to change your occupation? ☐ No ☐ Yes

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

4. Occupation details (continued)

j. i. Have you ever been bankrupt or entered into a personal insolvency arrangement? ☐ No ☐ Yes

If **'yes'**, please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable:

ii. Has any business that you have, or have had ownership of, ever been liquidated or been placed under administration? ☐ No ☐ Yes

If **'yes'**, please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable:

k. What is your current annual income? (income earned through personal exertion, less any expenses incurred whilst earning that income)? $

5. Additional occupation and income details

Complete this section only if you are applying for TSC cover.

Note: Members in an employer plan can only apply for TSC as a result of a salary increase, causing the total monthly benefit to exceed the AAL limits on your plan. Members **cannot** voluntarily increase cover.

a. Has your main occupation and/or employment status changed in the last three years? ☐ No ☐ Yes

If **'yes'**, please provide details of your previous occupation, duties and dates of change:

Occupation	Employment status	Date from	Date to
		/ /	/ /
		/ /	/ /
		/ /	/ /

b. Do you have any definite plans to take extended leave (eg parental or study leave) in the near future? ☐ No ☐ Yes

If **'yes'**, please provide full details including type and length of leave and your intentions on returning to work:

c. Do you have definite plans to change your working arrangements to part-time, casual or self-employed? ☐ No ☐ Yes

If **'yes'**, please provide full details including current and future employment status:

d. Are you self-employed (including sole trader, in a partnership or employee of your own company or trust)? ☐ No ☐ Yes

If **'yes'**, please complete the questions for **self-employed (e to i)**
If **'no'**, please complete the questions for **employee (j to l)**

Self-employed: sole trader, partnership, employee of own company or trust

e. How long have you been self-employed? years months

f. Please select which of the following applies:

☐ sole trader ☐ in a partnership ☐ employee of your own company or trust

g. What is the percentage of the business that you own and how many employees do you have? % employee(s)

h. Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If **'yes'**, please provide for how long, and the source (eg salary, investment income, company profits) and if this is for an investment property, please advise if the property is positively or negatively geared:

i. Please indicate your share of the business income/expenses, etc for the last two financial years for which tax returns, assessment notices and accounts are available.

Tax year ending	Gross income ($) A	Expenses incurred ($) B	Net profit or loss before tax ($) A–B=C	Any salaries, wages, director's fees, superannuation ($) D	Your total income C+D=E
30 / 06 /			0.00		$ 0.00
30 / 06 /			0.00		$ 0.00

5. Additional occupation and income details (continued)

Employee – with no ownership interest in your employer's business

j. What is your base annual salary from your main occupation (including salary packaged items, but excluding compulsory government superannuation contributions)?

Current financial year	Previous financial year 30/06/20
$	$

k. Do you receive any commission, bonuses or regular overtime? ☐ No ☐ Yes

	Current financial year ($)	Previous financial year ($) 30/06/20
Commissions		
Bonuses		
Regular overtime		

l. Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If **'yes'**, please provide for how long, and the source (eg salary, investment income, company profits) and if this is for an investment property, please advise if the property is positively or negatively geared:

6. Sports activities

Have you in the last 12 months, do you currently, or do you intend to take part in any of the following activities?

a. **Aviation (other than a fare paying passenger on a licensed public service)** ☐ No ☐ Yes

b. **Motor racing (including car, bike and boat)** ☐ No ☐ Yes

c. **Underwater diving** ☐ No ☐ Yes

d. Football ☐ No ☐ Yes

e. Motor bike riding, including quad bike riding, trail bike riding and commuting (please specify below) ☐ No ☐ Yes

f. Any other hazardous activity, pursuit or sport not previously disclosed (including, but not limited to: rock climbing, hang-gliding, ocean racing, martial arts, horse riding, or any other motor sports) ☐ No ☐ Yes

If **'yes'**, please complete one of the supplementary questionnaires in section **14**.

7. Doctor information

a. Name and address of your usual doctor (if you do not have a usual doctor, then the last doctor that you saw)

Name	Address	Phone number

If you have known your doctor for less than two years, please provide details of the previous doctor.

Name	Address	Phone number

b. Date of last consultation with any doctor

D D M M Y Y Y Y

c. Name of doctor that you saw (if same as above, write 'as above')

d. Please advise reason for your last consultation

e. Please advise results/outcome of your last consultation

f. Were you referred for further tests, investigations or referred to a specialist? ☐ No ☐ Yes

If **'yes'**, please provide full details

8. Insurance details

a. Has any insurer ever indicated that they would not offer you insurance, or would apply loadings, restrictions or exclusions? ☐ No ☐ Yes

If **'yes'**, please provide full details

b. Have you ever made a claim or received benefits in regard to any illness, injury, or condition? ☐ No ☐ Yes

If **'yes'**, please provide full details (eg type of claims and condition claimed for):

c. Has the claim been finalised? ☐ No ☐ Yes

If **'yes'**, please specify the date the claim was finalised

D D M M Y Y Y Y

9. Habits

a. Have you smoked tobacco or any other substance or used e-cigarettes or nicotine replacement products in the last 12 months? ☐ No ☐ Yes

If **'yes'**, please advise the type of product:

Quantity per: day week month

b. Do you consume alcohol? ☐ No ☐ Yes

If **'yes'**, please advise number of standard drinks[1] per:

day week month

c. Have you ever used cocaine, marijuana, ecstasy, heroin or any other recreational drugs, or drugs not prescribed by a doctor? (You do not need to tell us about any paracetamol, anti-histamines or any other over-the-counter medication). ☐ No ☐ Yes

If **'yes'**, please advise details including type, frequency and date(s) of usage:

d. Have you ever received treatment or been recommended for treatment by a doctor or other medical facility for the use of drugs or alcohol? ☐ No ☐ Yes

If **'yes'**, please advise details including date(s) of treatment:

10. Medical history

Height

cm or ft ins

Weight

kg or st lbs

Has your weight varied in the last 12 months? ☐ No ☐ Yes

If **'yes'**, please advise which of the following and provide the amount and reason:

☐ Gain ☐ Loss Amount

Reason

1 A standard drink = 1 x nip/30ml spirits, 1 x 100ml glass of wine, 1 x sherry glass of port/sherry, 1 x 250ml glass of beer.

10. Medical history (continued)

Have you ever had symptoms of, been told you had, or received advice from any health professionals including but not limited to doctors, specialists, counsellors or chiropractors for any of the following:

a. **High blood pressure**, **chest pain**, **high cholesterol**, **stroke** or any **heart or vascular disorder**? ☐ No ☐ Yes

b. **Asthma, bronchitis** or **any other lung disorder**? ☐ No ☐ Yes

c. **Epilepsy**, seizure disorder, multiple sclerosis, paralysis, migraine, dizziness, neuritis or any other neurological disorder? ☐ No ☐ Yes

d. **Kidney stones**, nephritis, passing blood in the urine or any other kidney or bladder disorder? ☐ No ☐ Yes

e. Hepatitis, cirrhosis or any liver or gall bladder disorder? ☐ No ☐ Yes

f. **Diabetes**, sugar in urine, thyroid or pancreatic disorder? ☐ No ☐ Yes

g. Indigestion, reflux, **ulcer or hernia**? ☐ No ☐ Yes

h. Colitis, passing blood from the bowel, any change to your usual bowel habits or any other bowel disorder? ☐ No ☐ Yes

i. Anaemia, leukaemia, haemophilia, received a blood transfusion or any other blood disorder? ☐ No ☐ Yes

j. Cancer, tumour, **lump**, **cyst** or **skin lesion** of any kind? ☐ No ☐ Yes

k. **Back** or **neck pain**, **injury** or **disorder including slipped disc**, **sciatica**, **whiplash** or any other **condition of the neck**, **middle** or **lower back**? ☐ No ☐ Yes

l. **Repetitive strain injury**, chronic fatigue syndrome, fibromyalgia, or muscle strain? ☐ No ☐ Yes

m. **Disorder**, **pain** or **injury of the wrist**, **elbow**, **shoulder**, **hip**, **knee**, **ankle** or any other **joints**, or **arthritis** or **gout**? ☐ No ☐ Yes

n. **Depression, adjustment disorder, post-traumatic stress disorder, post natal depression, major depression**? ☐ No ☐ Yes

o. **Anxiety, attention deficit disorder, eating disorder, obsessive compulsive disorder** or any other **anxiety disorder**? ☐ No ☐ Yes

p. **Schizophrenia, psychotic or personality disorder, manic or bipolar disorder** or any other **mental health disorder**? ☐ No ☐ Yes

q. **Stress, fatigue, insomnia** or **sleeplessness**? ☐ No ☐ Yes

r. **Psoriasis**, **eczema**, **dermatitis** or any other **skin condition**? ☐ No ☐ Yes

s. Sleep apnoea or any other sleep disorder? ☐ No ☐ Yes

t. Any impairment of sight not corrected by glasses or contact lenses? ☐ No ☐ Yes

u. Any ear disorder such as hearing loss or tinnitus? ☐ No ☐ Yes

v. Have you ever had an **occupational needle stick injury**? ☐ No ☐ Yes

w. i. Have you, or do you intend to participate in any activity that increases your chances of contracting the HIV virus? This would include things such as working or engaging in sexual intercourse with a sex worker or intravenous drug user or someone you suspect or know to be HIV positive, or engaging in anal sexual intercourse. ☐ No ☐ Yes

ii. Are you suffering from AIDS, or infected with HIV, or are you carrying antibodies to the HIV virus? ☐ No ☐ Yes

Note: If you have answered **'yes'** to either of these questions, AMP will contact you for further information.

x. Have you had any other disorder or impairment, taken any medication or undergone any medical tests or surgery either in Australia or overseas not mentioned above? ☐ No ☐ Yes

y. Do you intend to seek any medical advice, undergo any tests or investigations or surgery either in Australia or overseas in the future? ☐ No ☐ Yes

z. Have you ever had, are you currently waiting for a result of, or are you considering having a genetic test? ☐ No ☐ Yes
Note: You do not have to provide a result if you were or are taking part in a medical research project or trial and have not been or will not be provided with your individual result.

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

Males only

aa. Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine, increase in night urination? ☐ No ☐ Yes

Females only

ab. Have you had an **abnormal pap smear** or any gynaecological condition? ☐ No ☐ Yes

i. Have you ever had a breast ultrasound or mammogram? ☐ No ☐ Yes

ii. Have you ever had a **breast lump thickening, unexplained pain or change in the breast or nipples** (even if you have not seen a doctor about it)? ☐ No ☐ Yes

iii. Are you currently pregnant? ☐ No ☐ Yes

If **'yes'**, expected date of delivery? D D M M Y Y Y Y

iv. Have you ever had a complication with a past or current pregnancy? ☐ No ☐ Yes

10. Medical history (continued)

If you answered **'yes'** to any of the items on the previous page, please provide details in the table below, **except** for any condition in bold text above, for which you should also complete the relevant Health questionnaire in section **13**.

Additional information (required if 'yes' answered for conditions not in bold)

Question letter	Condition/ test/reason	Date first started	Date of last symptoms	Have you completely recovered?	Full details of treatment	Full name and address of doctor or hospital
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

11. Family history

Section **11** must be completed in all circumstances.

a. Has any first degree blood related family member (father, mother, brother, sister) had diabetes, stroke, a heart condition, familial polyposis, breast, ovarian, colon, bowel, or any other cancer, polycystic kidney disease, Huntington's chorea, Alzheimer's disease, multiple sclerosis, motor neurone disease, muscular dystrophy or any other hereditary or any other condition that runs in families? ☐ No ☐ Yes

Note: You are only required to disclose family information relating to first degree blood related family members—living or deceased (mother, father, sisters and brothers).

If **'yes'**, please complete the tables and questions below:

Direct family member (please state their relationship to you but not their name)	Condition/illness (for cancer or heart disease, please specify the type)	Age at onset (approx)	Age at death (if applicable)

11. Family history (continued)

b. Are you required to have any regular screening due to your family history? ☐ No ☐ Yes

If **'yes'**, please complete the table below:

Type of regular screening eg mammogram, Prostate Specific antigen, colonoscopy	How often is this screening performed?	Date of last test	Results including any abnormality	Doctor seen
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

Are any tests or investigations pending? ☐ No ☐ Yes

If **'yes'**, please give details of which tests are pending and when these will be performed.

12. Agreement and declaration

I, the insured person, agree and declare that:

a. I have read my duty of disclosure. I have kept my duty of disclosure in mind when completing my Personal Statement, and I understand any cover issued by AMP will be based on information I give in my Personal Statement, any additional questionnaire(s), form(s), and statement(s), as well as telephone underwriting (if applicable)

b. I understand I must tell AMP of any change in my health, occupation or pastimes and of any other thing that happens to me which may in any way affect the risk of insuring me, where this change occurs after I have completed this Personal Statement right up to the time that AMP issues cover

c. all the information provided in my Personal Statement is complete and correct. If any information has been written by someone else, I have reviewed this information and confirm it is complete and correct. I understand that if I do not comply with my duty to disclose all information completely and accurately, the insurance might be cancelled or the terms may be altered by AMP

d. I authorise any doctor, hospital or other health service provider that I have or may attend to release details of my personal and family medical history, including referrals to or treatment by other practitioners, to AMP. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. I understand that, under Government Privacy legislation, I may access a copy of these reports from AMP. I have been advised by AMP of the ways this information may be used, and to whom it may be disclosed, and approve those purposes

e. I have read the privacy information in the information sheet and I agree to the various uses and exchanges of my personal information as set out in that section

f. I have read the HIV Antibodies test information in the information sheet and I agree that if an HIV test is required to assess my application for insurance, that I consent to such a test being performed and that I will provide advice at the time of blood collection as to whom I wish to be notified in the event of a positive HIV antibody result.

g. Where I hold other policies or plans within the AMP group, I authorise the use of any information obtained under this authority in connection with those policies or plans.

By completing this Personal Statement, I acknowledge that AMP may agree to provide the insurance cover I apply for, but subject to any exclusion, loading or condition that AMP determines and notifies me of. I agree that I will be taken to have accepted the insurance cover subject to any such exclusion, loading or condition unless I tell AMP otherwise in writing within 30 days of receiving notice of it.

The premium for the new cover will be payable from the date AMP agrees to provide the cover. However, AMP will refund this premium from inception provided your written notification is received within 30 days of the date AMP notifies you of the new cover.

If you are under 18

You should speak to your parent or guardian about your application for additional insurance cover before signing this form, and understand that by signing this form you give up any claims against the trustee in relation to the additional insurance cover in this form arising out of or in connection with your being a minor.

If I am under age 18, I declare that I will not commence any action against the trustee or AMP in relation to any additional insurance cover I obtain through AMP superannuation product arising out of or in connection with my being under age 18.

12. Agreement and declaration (continued)

This agreement and declaration must be signed after you have read your duty of disclosure and completed your personal statement. Only sign this agreement and declaration if you agree to make the declaration.

Signature of applicant

✗

Date D D M M Y Y Y Y

Parent or legal guardian's declaration (for an applicant under age 18)

I agree and declare that:

- I am the parent or legal guardian of the applicant for additional insurance
- the applicant has the capacity to understand the consequences of applying to change the insurance cover in their AMP superannuation product
- I understand and the applicant understands the consequences of applying to change the insurance cover in their AMP superannuation product, including through reading all parts of the applicable product disclosure statement and by obtaining professional advice
- to the best of my knowledge, information and belief (after undertaking all reasonable enquiries), the information provided in this application is true and correct
- I take joint and several responsibility for the consequences of this application, and will reimburse and make the trustee and AMP whole in respect of any successful claims against the trustee or AMP made by, or in respect of, the applicant in relation to this application.

Parent or legal guardian's signature (for a family member applicant under age 18)

✗

Date D D M M Y Y Y Y

12a. Authority for medical report (To be completed and signed by the insured person)

I _____ (full name of insured person) hereby authorise you to release at any time, details of my personal and family medical history, including referrals to or treatment by other Practitioners, to AMP Life Limited ABN 84 079 300 379 and to any other person or entity acting on AMP Life's behalf. The purpose is to allow AMP to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. A photocopy of this authorisation shall be as valid as the original. Under Government Privacy legislation, I may access a copy of your report from AMP. Furthermore, I have been advised by AMP of the ways this information may be used and to whom it may be disclosed, and approve those purposes.

Insured person

✗

Date D D M M Y Y Y Y

13. Health questionnaires

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

1. High blood pressure (hypertension)

a. When was high blood pressure first diagnosed? D D M M Y Y Y Y

b. What was your blood pressure reading at that time?

c. What was your blood pressure when last tested?

Date	Blood pressure reading	Have treatments changed since this result?
/ /		

d. Have you taken medication to control your blood pressure? ☐ No ☐ Yes

If **'yes'**, please provide details of medication, ie type, dose and when taken:

e. Are you currently on the same medication as detailed above? ☐ No ☐ Yes

If **'no'**, please provide details of current treatment:

13. Health questionnaires (continued)

1. High blood pressure (hypertension) (continued)

f. Have you had any medical investigations relating to your high blood pressure? ☐ No ☐ Yes

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

g. Do you have any complications as a result of your blood pressure? ☐ No ☐ Yes

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

h. Does your usual doctor have details of your blood pressure and treatment? ☐ No ☐ Yes

If **'no'**, please provide the name and address of the doctor who has records of your investigations and treatment.

Date last consulted	Medical provider	Address
/ /		
/ /		

2. High cholesterol

a. When were you first diagnosed with high cholesterol? D D M M Y Y Y Y

b. What was your cholesterol level at this time?

c. What was your cholesterol level when last tested?

Date	Cholesterol reading	Have treatments changed since this result?
/ /		
/ /		

d. Have you ever taken medication to reduce your cholesterol? ☐ No ☐ Yes

If **'yes'**, please provide details of medication, ie type, dose and when taken:

e. Are you currently on the same medication as detailed above? ☐ No ☐ Yes

If **'no'**, please provide details of current treatment:

f. Does your usual doctor have details of your cholesterol results and treatment? ☐ No ☐ Yes

If **'no'**, please provide the name and address of the doctor who has records of your investigations and treatment:

Date last consulted	Medical provider	Address
/ /		
/ /		

3. Mental health disorders

a. Which of the following mental health disorder(s) do you have or have you had or received treatment or advice for? (please select all that apply)

- ☐ Anxiety, generalised anxiety or panic disorder
- ☐ Adjustment disorder or post traumatic stress disorder
- ☐ Obsessive compulsive disorder or attention deficit disorder
- ☐ Anorexia, bulimia or any other eating disorder
- ☐ Post natal depression
- ☐ Depression, including major depression, mood or any other depressive disorder
- ☐ Manic depression or bipolar disorder
- ☐ Schizophrenia or any other psychotic or personality disorder
- ☐ Alcohol or substance abuse disorder
- ☐ Other, please provide details:

13. Health questionnaires (continued)

3. Mental health disorders (continued)

b. Please describe your symptoms:

c. What do you think caused your symptoms?

d. When did you first experience symptoms and how long did they last?

e. Has this condition(s) ever required you to take time off work or does/did it impact your ability to perform your normal duties at work? For example, did you need to reduce the number of hours you worked or were your responsibilities or duties changed in any way? ☐ No ☐ Yes

If **'yes'**, please provide details including time away from work and if there were any changes to your duties:

f. Has this condition(s) ever affected your relationships, your ability to socialise with friends or family, your ability to sleep, eat, exercise or play sport? ☐ No ☐ Yes

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

g. How many episodes of this condition have you experienced? For example, if you were depressed and recovered twice in three years we would say you had two episodes of depression.

h. When was the last time you experienced symptoms?

Have you ever received any treatment for this condition? ☐ No ☐ Yes

If **'yes'**, please provide the details in the table below:

Type of treatment, eg counselling or medication etc	Name of medication (if applicable)	Dosage/ frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

i. Have you or are you being treated for this condition by a general practitioner, psychologist, psychiatrist, counsellor or any other therapist? ☐ No ☐ Yes

If **'yes'**, please provide details in the table below:

Field of practice, eg Psychologist or therapist etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /
			/ /
			/ /

13. Health questionnaires (continued)

3. Mental health disorders (continued)

j. Are you still receiving treatment for this condition(s)? ☐ No ☐ Yes

If **'no'**, please advise when you stopped treatment and was it at the direction of your treating health professional?

k. Have you ever not followed the advice of your treating health professional in relation to prescribed medication or other recommended treatment for this condition(s)? ☐ No ☐ Yes

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

l. Have you ever been hospitalised or admitted as an in-patient at a hospital or clinic for this condition(s)? ☐ No ☐ Yes

If **'yes'**, please provide details in the table below:

Name of hospital/clinic	Dates of hospitalisation	Treatment received
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

m. Have you ever thought about or tried to harm yourself or take your own life? ☐ No ☐ Yes

If **'yes'**, please provide the name and address of your doctor that would have the details:

n. Has any first degree blood related family member (father, mother, brother, sister) had a mental health disorder? ☐ No ☐ Yes

Note: You are only required to disclose family information relating to first degree blood related family members—living or deceased (father, mother, brother, sister).

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

4. Stress, fatigue, insomnia and/or sleeplessness questionnaire

a. Which of the following do you have or have you had or received treatment or advice for? (select all that apply):

i. ☐ Stress
ii. ☐ Fatigue
iii. ☐ Insomnia and/or sleeplessness

b. Did you see a doctor or other health professional for this condition(s)? ☐ No ☐ Yes

c. Were you diagnosed with anxiety, depression or any other mental health disorder? ☐ No ☐ Yes

If **'yes'**, please go to the **mental health disorders** questionnaire in section **13**.

If **'no'**, please continue to complete this questionnaire.

d. Did this condition(s) affect you to the point where you experienced any of the following? (select all that apply):

i. ☐ Physical symptoms such as headache, dizziness, soreness or irritability
ii. ☐ You found it difficult to go to work or were unable to go to work
iii. ☐ It had an impact on your relationships
iv. ☐ Your ability to sleep, eat, or think clearly
v. ☐ Problems with concentration, memory or tiredness during the day
vi. ☐ It caused you to use alcohol or drugs that were not prescribed for you by a doctor

If you have answered **'yes'** to any of the above, please provide full details including how much time you had away from work:

13. Health questionnaires (continued)

4. Stress, fatigue, insomnia and/or sleeplessness questionnaire (continued)

e. What do you think caused your symptoms?

f. When did you first experience symptoms and how long did they last?

g. When was the last time you experienced symptoms?

h. How many episodes of this condition have you experienced? For example, if you were stressed and recovered twice in three years we would say you had two episodes of stress.

i. Have you ever been treated for this condition(s)? ☐ No ☐ Yes

If **'yes'**, please provide full details including type of treatment, name of medication (if applicable) and dates the treatment started and ceased:

j. Please advise how often you see or saw your treating health professional for this condition and provide their name(s) and address(es):

5. General medical condition

a. Name of condition

Cause if known

b. Date your condition first began D D M M Y Y Y Y

Date of last symptoms D D M M Y Y Y Y

c. How often do you have symptoms?

Describe your symptoms

d. Have you ever taken medication for this condition? ☐ No ☐ Yes

If **'yes'**, please provide details (including name, dose and frequency):

e. Are you still taking this medication? ☐ No ☐ Yes

f. Have you ever had any other treatment (eg physiotherapy, surgery, etc) or been in hospital or received emergency treatment for this condition? ☐ No ☐ Yes

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

g. Are any tests, surgery or treatment planned or scheduled in relation to this condition? ☐ No ☐ Yes

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

h. Are there any residual complications or disabilities resulting from this condition? ☐ No ☐ Yes

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

13. Health questionnaires (continued)

5. General medical condition (continued)

i. Have you ever been absent from work or incapacitated as a result of this condition? ☐ No ☐ Yes

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

j. Does your usual doctor have details of this condition? ☐ No ☐ Yes

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

k. Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to this condition:

Date last consulted	Medical provider	Address
/ /		
/ /		

6. Abnormal pap smear

a. Please indicate ☒ the appropriate box(es)—the condition(s) you have had, or received treatment for:

- ☐ Carcinoma
- ☐ CIN3
- ☐ CIN2
- ☐ CIN1
- ☐ Human Papilloma Virus
- ☐ Atypia or change (caused by infection or irritation)
- ☐ Other abnormality

b. When was the condition diagnosed? Date D D M M Y Y Y Y

c. Has the abnormality been surgically removed? ☐ No ☐ Yes

If **'yes'**, please provide details for each abnormality you have selected, including dates:

d. Have you had a follow up pap smear? ☐ No ☐ Yes

If **'yes'**, please provide date and result:

e. Give details of your most recent visit to a doctor or hospital relating to this condition:

Date last consulted	Medical provider	Address
/ /		
/ /		

7. Breast investigation or symptoms

a. Test performed

- ☐ Mammogram
- ☐ Breast ultrasound
- ☐ Other – name of test

b. When was this test performed?

D D M M Y Y Y Y

c. What was the reason for the test?

d. What were the results of test?

e. Were any follow ups required (including other tests or consultations with specialists)?

13. Health questionnaires (continued)

7. Breast investigation or symptoms (continued)

f. Have you had the required follow ups? ☐ No ☐ Yes

If **'yes'**, what were the results?

If **'no'**, when will you have this follow up?

D D M M Y Y Y Y

8. Respiratory disorders (eg asthma, bronchitis etc)

a. Name of condition

b. How long has it been since you last experienced symptoms (including but not limited to, shortness of breath, coughing, chest tightness or wheezing)?

c. Do you use any inhalers? ☐ No ☐ Yes

If **'yes'** how often do you take your medication?

Medicine (eg Ventolin)	Dose	Frequency

d. Have you ever required treatment with oral steroids, or been admitted to hospital in the past 12 months as a result of this condition? ☐ No ☐ Yes

If **'yes'**, how many times have you used oral steroids or been hospitalised for this condition in the past 12 months?

e. Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to your condition:

Date last consulted	Medical provider	Address
/ /		
/ /		

9. Cyst/mole/skin lesion

a. Please indicate the condition(s) you have had, or received treatment for (select all that apply):

- ☐ Mole or naevi
- ☐ Hyperkeratosis or solar keratosis
- ☐ Sebaceous (fatty) cyst
- ☐ Basal Cell Carcinoma (BCC)
- ☐ Squamous Cell Carcinoma (SCC)
- ☐ Melanoma
- ☐ Other lesions (please describe below)

b. Please advise the location(s) of the skin lesion(s):

c. Has the lesion been fully removed? ☐ No ☐ Yes

i. If **'yes'**, please advise the method and date(s) of removal (eg frozen 'burnt', lasered off or surgically removed):

ii. If surgically removed, please also advise the pathology results?

iii. If **'no'** please advise the reason why it has not been removed?

13. Health questionnaires (continued)

9. Cyst/mole/skin lesion (continued)

d. Are any follow ups required? ☐ No ☐ Yes

If **'yes'**, please advise details including frequency

e. Give details of your most recent visit to a doctor or hospital relating to this condition:

Date last consulted	Medical provider	Address
/ /		
/ /		

10. Back or neck

a. What was the diagnosis given for your pain/disorder?

If no diagnosis, proceed to question **b**.

b. What part(s) of the back were or are affected? (select all that apply):

- ☐ Neck
- ☐ Middle
- ☐ Lower

c. Have you experienced any of the following? (select all that apply): ☐ No ☐ Yes

- ☐ Radiation or spread of pain down either the leg or arm (including shooting, stabbing or burning pain)
- ☐ Loss of feeling
- ☐ Loss of strength
- ☐ Pins and needles

If **'yes'**, give details:

d. i. When did you first have symptoms?

Date D D M M Y Y Y Y

ii. When was the last time you had symptoms?

Date D D M M Y Y Y Y

iii. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?

iv. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?

e. When you have pain, how would you rate your pain?

Scale 0–5 with 0 being no pain and 5 being the worst pain you ever felt?

10. Back or neck (continued)

f. i. Do you know the cause of your pain? ☐ No ☐ Yes

If **'yes'** > proceed to question ii

If **'no'** > proceed to question **g**.

ii. What do you think was the cause of your pain (select all that apply)?

a. ☐ Work

b. ☐ Sport

c. ☐ Other

d. ☐ Unknown

If you selected any of the above, provide details

g. i. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes

If **'yes'**, please provide the details of the total number of days or weeks you had off work

ii. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation to as a result of your pain/disorder? ☐ No ☐ Yes

If **'yes'**, please provide the details

If you have answered **'yes'** to i. or ii. please complete iii.

iii. Please advise which statements apply to you: (select all that apply)

I had time off work or restricted hours or duties because:

a. ☐ My work aggravated my pain

b. ☐ My work is too heavy for me

c. ☐ I think my work may cause further injury or pain

d. ☐ Other

If you selected any of the above – please provide details

h. i. Were you able to carry out daily activities such as, washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes

If **'no'**, please provide the details

ii. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes

If **'yes'**, please provide the details

13. Health questionnaires (continued)

10. Back or neck (continued)

i. Have you ever had investigations such as an x-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes

If **'yes'** please provide details in the table below:

Date	Investigation	Results(i)	Part of body (eg lower back)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession.

j. i. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes

If **'yes'**, please provide details in the table below

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

ii. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes

If **'yes'**, please provide the details in the table below

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

k. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes

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

11. Disorder or injury of the joints

a. What was the diagnosis given for your pain/disorder?

If no diagnosis, proceed to question **b**.

b. Please complete one questionnaire for each joint affected

Note: If both left and right joint is affected please complete one questionnaire for each joint

In which joint did you or do you have the pain, injury or disorder? (select all that apply):

☐ Shoulder ☐ right ☐ left ☐ Elbow ☐ right ☐ left

☐ Wrist ☐ right ☐ left ☐ Hip ☐ right ☐ left

☐ Knee ☐ right ☐ left ☐ Ankle ☐ right ☐ left

☐ Other – please advise which joint right/left:

13. Health questionnaires (continued)

11. Disorder or injury of the joints (continued)

c. Have you experienced any of the following? (select all that apply): ☐ No ☐ Yes

i. ☐ Radiation or Spread of the pain

ii. ☐ Loss of feeling or strength

ii. ☐ Loss of range of movement

iv. ☐ Pins and needles

v. ☐ weakness or instability

vi. ☐ Swelling or

vii. ☐ Other – please advise:

If you selected any of the above, please provide details:

d. i. When did you first have symptoms?

Date D D M M Y Y Y Y

ii. When was the last time you had symptoms?

Date D D M M Y Y Y Y

iii. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?

iv. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?

e. When you have pain, how would you rate your pain?

Scale 0–5 with 0 being no pain and 5 being the worst pain you ever felt?

f. i. Do you know the cause of your pain? ☐ No ☐ Yes

If **'yes'** > proceed to ii.

If **'no'** > proceed to question **g**.

ii. What do you think was the cause of your pain (select all that apply)?

a. ☐ Work

b. ☐ Sport

c. ☐ Other

d. ☐ Unknown

If you selected any of the above, provide details:

g. i. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes

If **'yes'**, please provide the details of the total number of days or weeks you had off work

ii. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation to as a result of your pain/disorder? ☐ No ☐ Yes

If **'yes'**, please provide the details

If you have answered yes to i. or ii. please complete iii.

13. Health questionnaires (continued)

11. Disorder or injury of the joints (continued)

iii. Please advise which statements apply to you: (select all that apply)

I had time off work or restricted hours or duties because:

a. ☐ My work aggravated my pain

b. ☐ My work is too heavy for me

c. ☐ I think my work may cause further injury or pain

d. ☐ Other

If you selected any of the above – please provide details

h. i. Were you able to carry out daily activities such as, washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes

If **'no'**, please provide the details

ii. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes

If **'yes'**, please provide the details

i. Have you ever had investigations such as an x-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes

If **'yes'**, please provide details in the table below:

Date	Investigation	Results(i)	Part of body (eg lower back)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession

j. i. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes

If **'yes'**, please provide details in the table below

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

ii. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes

If **'yes'**, please provide the details in the table below

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

k. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes

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

13. Health questionnaires (continued)

12. Diabetes

a. Which of the following best describes your condition:

- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Gestational Diabetes
- ☐ Not sure
- ☐ Glucose Intolerance
- ☐ Diabetes Insipidus
- ☐ Insulin Resistant

b. How long ago were you diagnosed with this condition?

c. How is this condition treated?

- ☐ Diet
- ☐ Oral medication
- ☐ Insulin
- ☐ Other

Please advise details including name of medication, dosage used per day:

d. Do you have any complications as a result of your diabetes (eg eye, kidney or nerve problems, high blood pressure or vascular disease etc)? ☐ No ☐ Yes

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

e. Have you ever suffered from a diabetic or insulin coma, or required hospitalisation due to your diabetes or any related condition? ☐ No ☐ Yes

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

f. When did you last have this condition checked by a medical practitioner?

g. What was the date and the result of your last Glycosylated Haemoglobin test?

h. For gestational diabetes – what was the date and result of your last Glucose Tolerance test?

i. Please provide your doctor's details, including name and address:

Date last consulted	Medical provider	Address
/ /		
/ /		

13. Occupational needle stick injury

a. Have you had any tests performed due to this needle stick injury? ☐ No ☐ Yes

If **'yes'**, please advise details of test(s) performed and the results if known:

b. Are any tests pending due to your needle stick injury? ☐ No ☐ Yes

If **'yes'**, please advise what test(s) are to be performed and when this is to occur:

14. Sporting activities questionnaires

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attached to your application.

1. Underwater Diving

a. Which of the following best describes your participation in this activity, please select all that apply:

☐ Scuba ☐ Enriched Air ☐ Mixed Gases
☐ Snorkel ☐ Other Diving Activity

b. Do you have recognised diving qualifications eg PADI, FAUI or NAUI and or relevant qualifications for mixed gases? ☐ No ☐ Yes

If **'yes'**, please provide details of all diving qualifications you have obtained:

c. How many dives do you perform per annum?

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

e. Do you dive:

In caves	☐ No	☐ Yes	At night	☐ No	☐ Yes
In dams or lakes	☐ No	☐ Yes	Potholing	☐ No	☐ Yes
In ice diving	☐ No	☐ Yes	Internal exploration of wrecks	☐ No	☐ Yes

If **'yes'**, please provide details including frequency:

f. Do you ever dive alone or participate in depth record attempts? ☐ No ☐ Yes

If **'yes'**, please provide details including number of dives and location of the dives:

2. Motor sport on land or on water

a. Are you a professional or sponsored driver (select all that you take part in)? ☐ No ☐ Yes

☐ Bicycles ☐ Jet ski racing ☐ Trucks
☐ Boats ☐ Karts/go karts ☐ Motorcycles
☐ Car ☐ Other (specify below):

b. Provide details of your involvement

Category	
Class	
Vehicle	
Fuel	
Engine capacity	
No. of events last 12 mths	
No. of events next 12 mths	
Maximum speed	
No. of vehicles per event	

c. Competition licence type Issuing body Years held

d. Do you have definite plans to compete overseas? ☐ No ☐ Yes

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

14. Sporting activities questionnaires (continued)

2. Motor sport on land or on water (continued)

e. Do you participate or intend to participate in record attempts, testing of prototypes or testing of vehicles? ☐ No ☐ Yes

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

f. Have you ever had a motor sport accident, or has your competition licence ever been suspended? ☐ No ☐ Yes

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

3. Aviation

a. Please indicate the activity(ies) you take part in:

Type of flying[1]	Fixed wing or helicopter	No. of hours – past 12 months	No. of hours – next 12 months

b. Type of aircraft that you usually fly?

c. Licence type _____ _____ Years held

d. Name of your pilot's club or association

e. Air navigation order under which your flying is controlled

f. Do you have any definite plans to upgrade or change your licence? ☐ No ☐ Yes

g. Do you have any definite plans to fly outside of Australia, or take off or land from anywhere that is not a registered airfield? ☐ No ☐ Yes

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

h. Have you ever been involved in flying accidents, been grounded or had your licence revoked? ☐ No ☐ Yes

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

4. Other activities

a. Please indicate the activity(ies) you take part in:

b. On what basis do you participate in this activity?

☐ Amateur ☐ Semi-professional ☐ Professional

c. Frequency of participation? _____ per annum Duration of participation? _____ years

d. Details of any licences or qualifications

e. Name of any club or organisation that you are a member of

1 Type of flying as defined by the aviation authorities: eg aerobatics; agricultural (including crop dusting and inspecting); airline operations; air racing; aircraft record attempts; ballooning; charter flying; commuter operations; competition flying; experimental flying; gliding; hang gliding; microlighting/powered hang gliders; paragliding and parascending; private flying or business commuting; record attempts; stunt flying; test flying; training/instructing; other (specify).

14. Sporting activities questionnaires (continued)

4. Other activities (continued)

f. Location(s) where you undertake or participate in this activity

g. Maximum altitude/depth or speed etc

h. Do you participate in competition? ☐ No ☐ Yes

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

i. Details of any injury(ies) as a result of participating in this activity

j. Details of any definite plans to change from what you stated above

k. Details of any other relevant features of your involvement in this activity

Where to send this form

Mail this completed form to:

AMP Corporate Superannuation
Locked Bag 5400
PARRAMATTA NSW 1741

Any questions?
1300 653 456

Office/Adviser use only

Plan number

Request ID

NS7580 01/17