PLEASE DO NOT STAPLE

B7BPHH

FirstChoice Employer Super Insurance Application Form

18 September 2017

Please complete this application form if you are applying for insurance. Please ensure that all relevant sections of the form are completed.

Please complete this form using BLACK INK and print well within the boxes in CAPITAL LETTERS. Start at the left of each answer space and leave a gap between words.

SECTION A – YOUR DETAILS

INSURED DETAILS

Existing account number (if known) 0 6 5

Date of birth (dd/mm/yyyy)

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Gender

Male ☐ Female ☐

Given name(s)

Surname

Postal address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode

Country

Residential address (if different from above)

Unit number | Street number | Street name

Suburb | State | Postcode

Country

Please provide the following details:

Height cm OR feet/inches

Weight kg OR stone/pounds

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

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

Please include, on average, how much you smoke per week

2 Do you drink alcohol?

No ☐ Yes ☐ If **'Yes'**, please provide the average number of units consumed per week

3 Are you a permanent resident of Australia or New Zealand?

No ☐ Yes ☐ If **'No'**, please provide details below, including visa type and length of time you have lived in Australia

4 Do you plan to travel, live or work in another country within the next two years?

No ☐ Yes ☐ If **'Yes'**, please answer below

a Please provide the date(s) and countries/cities you intend to travel to:

b Duration of your trip(s)?

c Reasons for travel? (Please tick appropriate box.)

Holidays ☐ Business ☐ Residing/Migrating ☐

OCCUPATION AND INCOME DETAILS

1 What is the main occupation you are currently working in?

Main occupation	Industry	Self-employed?	Hours per week?
		No ☐ Yes ☐	
		No ☐ Yes ☐	

2 Do you have any recognised trade, professional or tertiary qualifications relevant to your current occupation?

No ☐ Yes ☐ Please provide details below

3 Please select the income producing duties of your main occupation and the approximate percentage of time spent on each duty per week. Note: The list below represents the physical nature of duties only. Do not write or add to these descriptions.

Nature of duty	**% time**
Administrative/Clerical (eg filing, computer work, office duties, etc)	%
Light manual work only (eg driving with deliveries, lifting under 5kg, etc)	%
Supervisor of manual work (not actual performance)	%
Caring for dependants (only for TPD and if occupation is 'home duties')	%
Manual work (eg cleaning, lifting over 5kg, carpentry, plumbing, etc)	%
Flying (other than as a fare-paying passenger) or fly-in fly-out rotation on a job site	%
Truck driving greater than a distance of 800km from base; working above 15 metres; working underground; working at sea or handling explosives	%
Total	**100%**

4 What is your current annual income from your main occupation only (less all business expenses and superannuation, but before tax)?

Base annual salary (inclusive of any salary sacrifice arrangements) $

Commissions/Bonus (average of last three years) $

Total income $

5 Do you work from home?

No ☐ Yes ☐ If '**Yes**', what percentage of time is spent working from home? ☐☐☐%

6 Have you ever lost your licence to practise in your profession, had your employment terminated, been placed on performance management, disbarred or deregistered for professional misconduct or fraud?

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

PROPOSED INSURANCE COVER

Please read the 'Duty of Disclosure' in Section E before completing this form. Please refer to pages 9 and 12 for limits/maximums.

Type of insurance cover being applied for (in **addition** to any existing cover):

Death and Total and Permanent Disablement (TPD) ☐ Amount of death cover $ Amount of TPD cover $
(amount nominated will be **added** to any existing cover)

Note: When applying for death and TPD, the investor selected TPD cover amount cannot exceed the investor selected death cover amount.

OR ☐ **Full employer selected death and TPD cover** (where your current employer selected cover is restricted to the AAL)

Salary Continuance ☐ Percentage of your total income ☐☐% per month Super contribution component ☐☐% (max 10%)
(amount nominated will be **added** to any existing cover)
(The total of these two figures cannot be greater than 85% of your total income.)

Waiting period		Benefit period	
30 days	☐	2 years	☐
60 days	☐	5 years	☐
90 days	☐	to age 65	☐

OR ☐ **Full employer selected salary continuance cover (where your current employer selected cover is restricted to the AAL)**

SECTION B – PERSONAL STATEMENT

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

Have you answered 'Yes' to any Questions (1 to 5) or (7 to 8) in Section B?

No ☐ Go straight to Section E on page 50. Do not complete Sections C or D.

Yes ☐ For each '**Yes**' answer (except Question 6) you must complete a corresponding questionnaire, as noted in the column beside your '**Yes**' answer above. Proceed to the relevant questionnaire in Section C.

If you have answered 'Yes' to Question 6, a confidential questionnaire will be sent to you.

SECTION C – QUESTIONNAIRES

QUESTIONNAIRE A – PASTIME QUESTIONNAIRE

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

1 Do you currently engage in any of the following hazardous pastimes or pursuits?

a Flying (other than as a fare-paying passenger on a commercial airline) No ☐ Yes ☐

b Underwater diving No ☐ Yes ☐

If '**Yes**', **i** do you dive more than 40 metres in depth or in caves, wrecks or potholes? No ☐ Yes ☐

ii do you dive alone? No ☐ Yes ☐

c Football of any code (other than Touch or Oztag) No ☐ Yes ☐

d Motorised sports of any kind, eg motor cross, rally driving, ocean racing, car or bike racing No ☐ Yes ☐

e Trail bike or quad bike riding (including off road and dirt bike) No ☐ Yes ☐

f Any other sport or hazardous activities, eg parachuting, hang gliding, body contact sports, paragliding, competitive water sports, horse riding or recreations involving heights No ☐ Yes ☐

If you answered '**Yes**' to any of the above, please provide further details below.

What is/are the activity(ies) you engage in?

At what level do you participate?

Recreational only (non-competition) ☐ Recreational with competition ☐ Semi-professional/Professional ☐

Number of times you participate in this/these activity(ies) per annum (eg hours flown, number of dives, events, etc)

Do you receive any income from participating in this/these activity(ies)? No ☐ Yes ☐

QUESTIONNAIRE B – INSURANCE HISTORY QUESTIONNAIRE

Only complete if you answered '**Yes**' to **Question 2** of **Section B – Personal Statement.**

1 Other than this application, do you have or have you recently applied for life, total and permanent disability, trauma, or salary continuance insurance on your life with Colonial First State, CommInsure or any other insurance company?

No ☐ Yes ☐ Please provide details below

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

2 Has an application for life, total and permanent disability, trauma, or salary continuance insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?

No ☐ Yes ☐ Please provide details below

Insurance company name	Date	Terms offered and reason

3 Are you claiming or have you ever claimed a benefit from any source, eg TPD benefit from any superannuation fund, Workers' Compensation, disability pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits?

No ☐ Yes ☐ Please provide details below

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

QUESTIONNAIRE C – JOINT/MUSCULOSKELETAL QUESTIONNAIRE

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

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

2 Location of complaint, eg lower back, right knee, sciatic nerve

3 When did symptoms first begin?

4 Cause of condition, eg lifting, car accident, fall in workplace, unknown

5 Was an x-ray or scan taken?

No ☐ Yes ☐

If '**Yes**', please complete the details below

Date of most recent test

Details of results of tests taken

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

No ☐ Yes ☐

7 Are you still undergoing treatment or experiencing symptoms?

No ☐ Yes ☐

If '**No**', please complete the details below

Date symptoms ceased

Date treatment ceased

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

No ☐ Yes ☐

If '**Yes**', please indicate period(s) off work

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

No ☐ Yes ☐

If '**Yes**', please provide dates and details

10 Is your treating doctor different from your usual doctor?

No ☐ Yes ☐

If '**Yes**', please complete the details below

Name of doctor

Doctor's address

Phone number

Fax number

QUESTIONNAIRE D – MENTAL HEALTH QUESTIONNAIRE

Only complete if you answered '**Yes**' to **Question 4** of **Section B – Personal Statement.**

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

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

Bereavement/family illness ☐

Marital problems ☐

Post natal ☐

Work-related ☐

Other (please specify)

3 Date symptoms first commenced

4 Have the symptoms ceased?

No ☐ Yes ☐

If '**Yes**', please provide the date symptoms ceased

5 Have you taken or are you taking medication?

No ☐ Yes ☐

If '**Yes**', please provide details of the type of medication, including dosage

6 Are you currently taking medication?

No ☐ Yes ☐

7 Have you ever been hospitalised?

No ☐ Yes ☐

If '**Yes**', please indicate period(s) hospitalised

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

No ☐ Yes ☐

If '**Yes**', please indicate period(s) off work

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

No ☐ Yes ☐

If '**Yes**', please provide dates and details

10 Is your treating doctor different from your usual doctor?

No ☐ Yes ☐

If '**Yes**', please complete the details below

Name of doctor

Doctor's address

Phone number

Fax number

QUESTIONNAIRE E – HIGH BLOOD PRESSURE/RAISED CHOLESTEROL QUESTIONNAIRE

Only complete if you answered '**Yes**' to **Question 5a** of **Section B – Personal Statement.**

1 Name of condition

High blood pressure ☐ Raised cholesterol ☐

2 When were you first diagnosed with this condition?

3 Do you have any problems or complications resulting from this condition, eg heart disease, chest pain?

No ☐ Yes ☐

If '**Yes**', please provide details

4 Are you taking regular medication for this condition?

No ☐ Yes ☐

If '**Yes**', please provide details, including dosage

5 For blood pressure

When was your last blood pressure reading?

Was it considered to be well controlled, eg less than 140/90?

No ☐ Yes ☐

Don't know ☐

For raised cholesterol

When was your last cholesterol reading?

What was the result of your last cholesterol reading?

2.0 to 5.9 mmol ☐

6.0 to 6.9 mmol ☐

7.0 or above ☐

Don't know ☐

6 Is your treating doctor different from your usual doctor?

No ☐ Yes ☐

If '**Yes**', please complete the details below

Name of doctor

Doctor's address

Phone number

Fax number

QUESTIONNAIRE F – CYSTS, MOLES, SUNSPOTS OR SKIN LESIONS QUESTIONNAIRE

Only complete if you answered '**Yes**' to **Question 5b** of **Section B – Personal Statement.**

1 Please provide type:

Cyst ☐ Mole ☐ Sunspot ☐ Skin lesion ☐

Melanoma ☐ Basal cell carcinoma ☐

Other ☐ Please specify:

2 Location of growth(s)

Face/head ☐ Back/shoulder ☐ Chest/front ☐

Arm/leg ☐

3 When was this?

4 Was/were the growth(s) removed?

No ☐ Yes ☐ If '**Yes**', please complete below

When was it/were they removed?

Numbers of growths removed:

One ☐ Two ☐

Three ☐ More ☐

Method of removal:

Frozen/burnt off ☐

Surgical/cut out ☐

5 Was/were the growth(s) reported as cancerous (malignant)?

No ☐ Yes ☐

If '**Yes**', were any further tests, investigations, treatments, follow-up or re-excision required?

No ☐ Yes ☐

If '**Yes**', please provide dates and details of further tests, investigations, treatments, follow-up or re-excision

6 Is your treating doctor different from your usual doctor?

No ☐ Yes ☐

If '**Yes**', please complete the details below

Name of doctor

Doctor's address

Phone number

Fax number

QUESTIONNAIRE G – PERSONAL AND MEDICAL DETAILS QUESTIONNAIRE

Only complete if you answered '**Yes**' to **Question 5** (c to e) and/or **7** of **Section B – Personal Statement.**

1 When did you last consult a doctor?

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

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

a Reason for last consultation

b What was the result/outcome from your last consultation (please cross (X) the appropriate box)?

☐ Referral to specialist/health professional ☐ Tests conducted – results pending ☐ Not fully recovered yet

☐ Ongoing treatment (eg Ventolin inhaler) ☐ Routine tests conducted – results all clear/normal

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

c Is the doctor/medical centre mentioned above your usual doctor/medical centre? No ☐ Yes ☐

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

Name of doctor

Doctor's address State Postcode

Phone number Fax number

2 **This question is for females only**

a Are you currently pregnant?

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

Will you be returning to work in the same capacity as your current occupation, eg back to the same or greater hours within or at the end of your 12-month maternity leave? No ☐ Yes ☐

b Have you ever had any complications with pregnancy or childbirth (eg diabetes, ectopic pregnancy, pre-eclampsia and excluding elective caesarean or miscarriage in the first 15 weeks)?

No ☐ Yes ☐ If '**Yes**', please provide details including dates and results of treatment(s) and follow-up tests

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

i Pap smear No ☐ Yes ☐

ii Breast ultrasound No ☐ Yes ☐

iii Mammogram No ☐ Yes ☐

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

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

No ☐ Yes ☐ If '**Yes**', please provide details including dates and results of treatments and follow-up tests

e Have you ever sought treatment for any condition of the ovary, uterus, endometrium or perineum? No ☐ Yes ☐

If '**Yes**', please provide details including dates and results of treatments

QUESTIONNAIRE G – PERSONAL AND MEDICAL DETAILS QUESTIONNAIRE (CONTINUED)

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

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

If you have answered 'Yes' to any Question a to x above, please provide full details of each 'Yes' answer in Section D – General health questionnaire on page 49.

QUESTIONNAIRE H – FAMILY HISTORY QUESTIONNAIRE

Only complete if you answered '**Yes**' to **Question 8** of **Section B – Personal Statement.**

1 Please complete the table below

Family member	Condition – if cancer, please state type	Age diagnosed

2 Have you had or do you intend to have a genetic test? No ☐ Yes ☐

3 If '**Yes**', what was the result of the genetic test (cross (X) the appropriate box)?

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

☐ Positive (I have the gene) ☐ Unsure

SECTION D – GENERAL HEALTH QUESTIONNAIRE

If you have answered '**Yes**' to any part of **Question 3a** to **x** in **Questionnaire G**, please complete the table below.

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

SECTION E – DUTY OF DISCLOSURE

Duty of disclosure

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

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

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

The person entering into the contract does not need to tell the insurer anything that:

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

If the insurance is for the life of another person and that person does not tell the insurer something that they know, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms, this may be treated as a failure by the person entering into the contract to comply with their duty of disclosure.

If the person entering into the contract does not tell the insurer something

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

If the person entering into the contract does not tell the insurer anything they are required to, and the insurer would not have provided the insurance if they had been told, the insurer may avoid the contract within three years of entering into it.

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

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

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

These sections must be completed in all circumstances.

SECTION F – TELEPHONE UNDERWRITING

The telephone underwriting facility may reduce the need for follow-up information and medical reports, resulting in faster completion.

I permit the insurer (CommInsure) to call me (the life to be insured) to clarify or gain further information regarding any matter pertaining to the assessment and processing of this application. I understand that the call will form part of my Duty of Disclosure as described in Section E.

No ☐ Yes ☐ If '**Yes**', I am contactable on (phone) ______

between the hours of ☐☐☐☐☐ (note they must be usual business hours).

SECTION G – DOCTOR'S DETAILS

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

Name of doctor

Doctor's address

Phone number

Fax number

SECTION H – DECLARATION

This section must be completed in all circumstances.

I have read the Duty of Disclosure in Section E and I am aware of the consequences of non-disclosure.

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

I have read and understood the privacy section of the PDS. I acknowledge and consent to the use and disclosures of my personal information as detailed in that section.

I authorise:

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

I declare that:

- the answers to all the questions and the declarations on this Personal Statement are true and correct (including those not in my own handwriting)
- I have not withheld any information which may affect CommInsure's decision to provide insurance.

I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.

A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

Please be aware that CommInsure may request further medical evidence as a result of the answers given in this Personal Statement.

Original signature of the person to be insured

Print name

Date signed

(dd/mm/yyyy)

Please return the completed form, with attachments, to:
Colonial First State, Reply Paid 27, Sydney NSW 2001
If you have any questions or require assistance, please call 1300 654 666

ADVISER USE ONLY

Are you submitting any life insurance applications for this customer through CommInsure? No ☐ Yes ☐

Product name (eg Total Care Plan)

Proposal/Policy number

Should a blood test or a medical examination be required, please indicate whether you would like us to organise for a nurse to visit your client:

No ☐ Yes ☐

Adviser name

Contact number

Dealer ID

Adviser ID

Dealer/Adviser stamp (please use black ink only)

An address listed here may be used for adviser correspondence relating to the assessment of this application.

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