

When you join AustralianSuper you receive basic age-based cover for Death, Total & Permanent Disablement (TPD) and Income Protection (excluding Personal Plan and Super Only members). Age limits and conditions apply. Our insurance options allow you to apply for, adjust or switch your cover to suit your needs. You can choose from the following cover options:

| Cover options | | Cover available | |
|---------------------------------------|---|-----------------|-------------------|
| | | Death and TPD | Income Protection |
| Age-based cover | Both the amount of cover you get and the cost of it changes as you get older. | ☑ | ☑ |
| Age-based cover + extra (fixed) cover | You can add an extra amount of cover on top of your age-based cover. The extra amount is provided as fixed cover and will stay the same as you get older (unless you change it) but the cost will change. | ☑ | n/a |
| Fixed cover | You can apply for a total amount of fixed cover. This means your total amount of cover stays the same as you get older (unless you change it) but the cost will change. | ☑ | ☑ |

Use this form to apply for new cover or to increase, reduce, change or cancel your cover. AustralianSuper will only make changes to each type of cover you change on this form.

Before you change your cover, you should check your latest statement or log into your account to understand what type and how much cover you have. You should also read the *Insurance in your super* guide for your division. It contains all of the terms and conditions about insurance, including how much you can apply for, your eligibility for cover, cost of cover, when cover starts and stops, and any limitations or exclusions. Download a copy at australiansuper.com/InsuranceGuide

! Use our *Insurance calculator* at australiansuper.com/calculators to work out the right level of cover for you.

Duty of Disclosure

Your duty of disclosure to the insurer

Before you enter into a life insurance contract, you have a duty to tell the insurer anything that you know, or could reasonably be expected to know, may affect its decision to insure you and on what terms.

You have this duty until the insurer agrees to insure you.

You have the same duty before you extend, vary or reinstate your insurance cover.

You do not need to tell the insurer anything that:

- reduces the risk it insures you for, or
- is common knowledge, or
- the insurer knows or should know as an insurer, or
- the insurer waives your duty to tell it about.

If you do 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 they do, the insurer may apply the following rights separately to each type of cover.

If you do not tell the insurer anything you are required to, and the insurer would not have insured you if you had told the insurer, the insurer may avoid the contract to provide you with that insurance within three years of entering into it.

If the insurer chooses not to avoid the contract, the insurer may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told the insurer everything you should have. However, if the contract 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 you have been insured for, the insurer may, at any time vary the contract in a way that places the insurer in the same position it would have been in if you had told the insurer everything you should have. However, this right does not apply if the contract provides cover on death.

If your failure to tell the insurer is fraudulent, the insurer may have the right to refuse to pay a claim and treat the contract as if it never existed.

Our duty of disclosure

The Trustee has a similar duty to tell the insurer anything that it knows that may affect the insurer's decision to provide you with insurance, and if the Trustee fails to do so the consequences are comparable.

2. DEATH AND TPD COVER

Complete this section to:

- apply for age-based cover
- top up your age-based cover with extra (fixed) cover, or change your extra (fixed) cover amount
- apply for or change your fixed cover (includes switching your age-based cover to fixed cover), or
- remove multiples of cover (see the *Insurance in your super* guide for your division for details about multiples and how much cover you'll get).

You can apply for an unlimited amount of Death cover and up to \$3 million of TPD cover. Print (X) to confirm what you want to do. If you want to cancel any part of your cover (or all of it), go to Section 5.

| Cover options | Type of cover | Cover in \$1,000 amounts |
|---------------------|--|--|
| Age-based cover | <input type="checkbox"/> Age-based Death <input type="checkbox"/> Age-based TPD | Your cover amount will be based on your age. |
| Extra (fixed) cover | <input type="checkbox"/> Extra Death <input type="checkbox"/> Extra TPD* | \$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 0 \$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 0 The amount you write here will be added to your age-based cover, or replace your existing extra cover. |

| Cover options | Type of cover | Cover in \$1,000 amounts |
|--------------------|---|---|
| Fixed cover | <input type="checkbox"/> Fixed Death <input type="checkbox"/> Fixed TPD* | \$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 0 \$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> 0 <input type="text"/> 0 <input type="text"/> 0 The amount you write here will replace your existing cover (including age-based cover). |
| Remove my multiple | <input type="checkbox"/> Death <input type="checkbox"/> TPD | If your multiple is greater than 1.0 your age-based cover will reduce to the basic cover amount and any extra (fixed) cover you have will stay the same. If it is less than 1.0 your total cover amount (and any extra cover you have) will be fixed.* |

* Any amount of fixed TPD cover will reduce gradually from age 61 to zero at age 65, unless you're a Public Sector Division member.

If you're applying for or increasing your Death or TPD cover, complete the Health Questions in Section 6. You don't need to complete Section 6 if you're only switching your age-based cover to fixed cover.

3. INCOME PROTECTION COVER

Complete this section to apply for or change your Income Protection cover (includes switching your age-based cover to fixed cover).

The maximum amount of Income Protection you can apply for will be the lower of:

- 85% of your monthly salary* (up to 75% can be paid to you and up to 10% to your super), or
- \$30,000 a month.

* Salary is your annual (before-tax) salary, excluding employer super contributions.



Here's an example to help you work out the maximum amount of Income Protection cover you can apply for.

Ben earns \$78,000 a year (before-tax), excluding employer super contributions. The maximum cover amount he can apply for is:

$$\frac{\$78,000 \times 0.85}{12 \text{ (months)}} = \$5,525 \text{ a month} \rightarrow \text{Ben can apply for cover up to } \$5,600 \text{ a month.}$$

(rounded up to the nearest \$100)

Print (X) below to confirm what you want to do. If you want to cancel your cover, go to Section 5.

| Cover options | Type of cover | Cover in \$100 amounts |
|-----------------|--|---|
| Age-based cover | <input type="checkbox"/> Age-based Income Protection | Your cover amount will be based on your age. |
| Fixed cover | <input type="checkbox"/> Fixed Income Protection | \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> 0 0 a month The amount you write here will replace your existing cover (including age-based cover). |

If you're applying for or increasing your Income Protection cover, complete the Health Questions in Section 6. You don't need to complete Section 6 if you're only switching your age-based cover to fixed cover.

Complete this section to select or change your waiting period and/or benefit payment period (go to Section 4 if you don't want to make a change). Print (X) below to confirm what you want to do.

The cost of your cover will depend on the waiting period and benefit payment period you (as well as your work rating). For more information and the different costs download the *Insurance in your super* guide for your division at australiansuper.com/InsuranceGuide

| | | |
|------------------------|---|--|
| Waiting period | This is the minimum time you must wait before you'll start receiving an Income Protection benefit payment (as long as you're eligible). Payments are made one month in arrears. If you're applying for Income Protection cover your waiting period will be 60 days. You can change your waiting period to 30 days. A shorter waiting period will cost more. Your new waiting period is effective from the date we accept your application plus the number of days of your current waiting period. For example if you change your waiting period from 60 days to 30 days and then you claim within 30 days of making the change, you'll need to complete a 60 day waiting period. | <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days |
| Benefit payment period | If you're applying for Income Protection cover your benefit payment period is up to two years. This means benefits may be paid for a maximum of two years if you're temporarily unable to work due to illness or injury. You can apply for a benefit payment period of up to five years [†] or up to age 65 [†] . A longer benefit payment period will cost more. [†] There are some occupations where you can't have a benefit period of up to five years or up to age 65. These occupations are listed at australiansuper.com/occupations | <input type="checkbox"/> Up to two years <input type="checkbox"/> Up to five years [†] <input type="checkbox"/> Up to age 65 [†] |

Please complete the Health Questions in Section 6 if you're:

- applying for a benefit payment period of up to five years or up to age 65, or
- aged 63 or 64 and reducing your benefit payment period to two years (which means you're extending your cover to age 70).

You don't need to complete Section 6 if you're only changing your waiting period.

4. YOUR WORK RATING

You could pay less if your work is rated as Low Risk or Professional. Complete this section to apply to change your work rating*. For more information on work ratings download the *Insurance in your super* guide for your division at australiansuper.com/InsuranceGuide

1. Are the usual activities of your job 'white collar'? Yes No
 This means:
- you spend more than 80% of your job doing clerical or administrative activities in an office-based environment, or
 - you're a professional using your university qualification in a job that has no unusual work hazards (some examples of unusual work hazards include: working underground, working underwater, working at heights or working in the air).
2. Are you earning \$100,000 or more a year from your job? Yes No
3. Do you have a university qualification? Yes No
4. Do you have a management role in your company? Yes No

* If you're a Public Sector Division member, your work rating only applies to Income Protection.

5. CANCEL YOUR COVER

Complete this section to cancel all or part of your cover. Put an (X) next to each type of cover you wish to cancel.

When you cancel your cover you won't be insured for that cover from the date your cancellation is accepted. So, you (or your beneficiaries) won't be able to make an insurance claim for that type of cover, in the event of illness, injury or death. If you decide to apply for cover in the future, you'll need to supply detailed health information as part of your application.

I want to cancel ALL of my cover. Death TPD Income Protection

I only want to cancel my extra cover. Extra Death Extra TPD

Go to Section 9 if you're only completing Sections 1 and 5.

6. HEALTH QUESTIONS

1. Has an application for life, disability, trauma, accident or illness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? If Yes please provide details below. Yes No

| Insurance company name | Date | Terms offered and reason |
|------------------------|------|--------------------------|
| | | |
| | | |
| | | |

2. Are you claiming or have you ever claimed a benefit from any source (e.g. Total & Permanent Disablement benefit from any Superannuation Fund, Workers' Compensation, Disability pension, Veterans' Affairs or any other insurance policy providing accident or illness benefits)?

If Yes please provide details below. Yes No

Benefit type/source/reason for claim

| Claim date | Claim amount | Date claim finalised |
|------------|--------------|----------------------|
| | \$ | |

Benefit type/source/reason for claim

| Claim date | Claim amount | Date claim finalised |
|------------|--------------|----------------------|
| | \$ | |

3. What's your height and current weight? Height (cm) (ft/in) Weight (kg) (st/lb)

6. HEALTH QUESTIONS (CONTINUED)

4. Are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours a week), even if your actual employment is on a part-time or casual basis? Yes No
5. Have you in the last year had medication prescribed by a medical practitioner that is intended to be used for three months or longer (excluding contraceptives and treatment for hay fever, hair loss and acne)? Yes No
6. Have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last three years? Yes No
7. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions:
- a) Chest pain, high blood pressure, raised cholesterol or any heart/circulatory disorder? Yes No
 - b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition? Yes No
 - c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder? Yes No
 - d) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)? Yes No
 - e) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout? Yes No
 - f) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition? Yes No
 - g) Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind? Yes No
 - h) Drug dependence or abuse (either prescribed or non-prescribed), or alcohol dependence or abuse? Yes No
 - i) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhoea, or gastro where these were short, isolated episodes from which you have made a full recovery)? Yes No
 - j) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus? Yes No
8. Have you been infected with the Human Immunodeficiency Virus (HIV) or tested positive for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
9. **Apart from any condition already disclosed**, do you plan to seek or are you awaiting medical advice, investigation or treatment for any other current health condition or symptoms? Yes No

7. NEXT STEPS

If you answer **Yes** to any of the following questions, you'll also need to complete PART TWO of this form.

- Will your total Death or TPD cover exceed \$800,000 if this application is accepted? Yes No
- Will your total Income Protection cover exceed \$10,000 a month if this application is accepted? Yes No
- Are you applying for an Income Protection benefit payment period of up to five years or up to age 65? Yes No
- Have you answered **Yes** to any of the questions in Section 6 (Q1 to Q9)? Yes No

If you answer **No** to all of the above questions, please read, then sign and date the Declaration in Section 14.

* The Insurer may require medical evidence based on your age, amount of cover or health history. This may involve a medical exam or test which the Insurer will pay for.

PART TWO: DETAILED HEALTH STATEMENT

8. ACTIVITIES AND PASTIME DETAILS

Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger on a commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing?

Yes No

If Yes, provide further details below:

What are the activities you engage in?

At what level do you participate?

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

Number of times you participate on average in these activities a year (for example hours flown, number of drives, events)

Do you receive any income from participating in these activities?

Yes No

Maximum depth or speed reached (if applicable)

9. PERSONAL HEALTH DETAILS

1. Have you smoked in the last 12 months?

Yes No

If Yes, please indicate type (for example cigarettes or cigars) and average amount smoked in **one** of the following boxes.

| Substance smoked | A day | A week | A year |
|----------------------|---|--|---|
| <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

2. In the last five years have you smoked any substance other than tobacco?

Yes No

If Yes, please indicate substances smoked, frequency of use, date first smoked and when last smoked.

| Substance smoked | Frequency | Date first smoked | Date last smoked |
|----------------------|---|---|---|
| <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y |
| <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y |
| <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y |
| <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y | <input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y |

3. Do you drink alcohol?

Yes No

If Yes, please provide the average number of standard drinks you consume (one standard drink is: a nip of spirits, a glass (150ml) of wine, a pot (285ml) of beer).

| A day | A week | A year |
|---|---|---|
| <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

4. In the last five years have you engaged in any activity reasonably expected to having an increased risk of exposure to the HIV/AIDS virus (this includes unprotected anal sex, sex with a sex worker or sex with someone you know, or suspect to be HIV positive)?

Yes No

If Yes, we will contact you to complete a confidential questionnaire.

10. FAMILY HISTORY

Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 60: Heart disease (e.g. angina or heart attack), stroke, cardiomyopathy, cancer, diabetes, mental illness, Alzheimer's disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, polycystic kidney disease, Huntington's disease or any other inherited blood or neurological disorder?

Unknown No – go to Section 11 Yes – complete the following table

| Relationship to member | Condition (e.g. Type 2 diabetes, breast cancer) | Approximate age of onset | Age at death (if applicable) |
|------------------------|---|--------------------------|------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

11. DOCTOR DETAILS

1. What's the name and address of the last doctor or medical centre you visited?

Full name of doctor or medical centre

Street address and suburb

State

Postcode

Telephone

Facsimile

2. a) What was the date of your last consultation?

Within the last month

7-12 months ago

1-3 months ago

12 months to 2 years ago

4-6 months ago

Over 2 years ago

b) What was the reason for your consultation? (Please specify a reason for the consultation)

c) What was the result/outcome from your last consultation?

Referral to specialist/health professional

Ongoing treatment (for example ventolin inhaler)

Tests conducted – results pending

Routine tests conducted – results all clear/normal

Not fully recovered yet

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

3. Is the doctor/medical centre mentioned above your usual doctor/medical centre?

Yes

No

12. GENERAL HEALTH QUESTIONNAIRE

If you have answered **Yes** to questions 4 to 9 in Section 6, please complete the table below.
Please ensure you write the question number in the box above each column.

| | Question number <input type="text"/> | Question number <input type="text"/> | Question number <input type="text"/> |
|--|---|---|---|
| 1. Name of condition | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2. Date symptoms first started | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |
| 3. Date symptoms ceased | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |
| (if ongoing please state) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. How often do/did you have symptoms? Please choose one of the following daily, weekly, monthly, quarterly, half-yearly, yearly, one-off, other. | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 5. Severity of condition Please choose from one of the following mild, moderate, severe, never had symptoms, symptoms ceased. | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 6. Did you take medication or have you had any other treatment (ie physiotherapy or an operation) for this condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If Yes , name the treatment/condition: | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 7. Are you still on treatment, including medication? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Have you ever been off work due to this condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Details (if there is insufficient space please attach an additional sheet) | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| If Yes , please state the total time off work? | | | |
| Date from: | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |
| Date to: | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |
| 9. Have you had any residual, ongoing effects or restrictions as a result of this condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If Yes , please provide details and dates: | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date from: | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |
| Date to: | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |
| 10. Is your treating doctor different from your usual doctor? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If Yes , please provide doctor's details: | | | |
| Full name of doctor | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Address (street/state/postcode) | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Phone and fax number | <input type="text"/> | <input type="text"/> | <input type="text"/> |

13. SPECIFIC HEALTH QUESTIONNAIRE

Please complete relevant questionnaire below if you have answered **Yes** to either Question 7d) or 7e) in Section 6.

A. Asthma and bronchitis or any other lung complaint questionnaire

a) Name of condition

b) Have you been diagnosed within the last 12 months? Yes No

c) Frequency of symptoms in the last five years

Daily

Weekly

Occasionally

One-off episode

None – childhood only

d) Severity of symptoms in the last five years:

Nil symptoms – childhood only

Mild (ie exercise-induced only, seasonal (related to hay fever allergy, colds or flu)

Moderate (ie all year round, specific triggers)

Severe (ie constant, reduced lung capacity, restriction of lifestyle or work duties)

e) Have you required over the last five years:

Daily preventative inhalers, such as ventolin Yes No

Occasional use of a nebuliser or oral steroid medication eg prednisolone Yes No

Hospitalisation/emergency treatment Yes No

f) Maximum number of consecutive days off work/school you have had over the last two years due to this condition?

Number of days

g) Is your treating doctor different from your usual doctor? Yes No

If **Yes**, please complete details below:

Full name of doctor

Street address

Suburb State Postcode

Phone number

Fax number

B. Joint/musculoskeletal questionnaire

If applying for Death only cover complete Questions a) and b) only.
 If applying for TPD or Income Protection cover, complete all questions.

a) Nature of complaint (doctor's diagnosis), ie sciatica, back pain, broken bone

b) Location of complaint, eg lower back, right knee, sciatic nerve

c) When did symptoms first begin?

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

e) Was an x-ray or scan taken?
 No Go to Question f
 Yes Complete below
 Date of tests taken
 Details of results of tests taken

f) Is the nature of the condition degenerative or a disc problem? Yes No

g) Are you still undergoing treatment or experiencing symptoms? Yes No

If **No**, complete below:
 Date symptoms ceased
 Date treatment ceased

h) Have you ever been off work as a result of this complaint or been unable to perform your normal day-to-day activities? Yes No

If **Yes**, please indicate period/s off work:
 Date from Date to

i) Do you have any residual, ongoing effects or restrictions as a result of this condition? Yes No

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

j) Is your treating doctor different from your usual doctor? Yes No

If **Yes**, complete below:

Full name of doctor

Street address

Suburb State Postcode

Phone number

Fax number

14. DECLARATION

This section must be completed in all circumstances.

I have read the Duty of Disclosure at the start of this form 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 in writing by AustralianSuper and the Insurer.

I authorise:

- The Insurer to provide any information included in my insurance application (and any medical reports and statements made in connection with my application) 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 the Insurer any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.

A photocopy of this authorisation is as valid as the original.

I declare that:

- The answers to all the questions and the declarations on this form are true and correct (including those not in my own handwriting).
- I have not withheld any information which may affect any decision to provide insurance.
- I understand that I may need to provide further medical authorities if requested.
- I have read and understood the Product Disclosure Statement for my division.
- I have read and understood the *Insurance in your super* guide for my division at australiansuper.com/InsuranceGuide

- If I'm a Public Sector Division member I understand that the work rating will only apply to my Income Protection cover.
- I have read the Privacy Collection Statement and I agree with how AustralianSuper will use my personal information.

A summary of AustralianSuper's Privacy Collection Statement is at the end of this form. Our Privacy Collection Statement and Privacy Policy may change from time to time. The latest versions will be available online at australiansuper.com/CollectionStatement and australiansuper.com/privacy

For information on the Insurer's privacy and information-handling practices, read their Privacy Policy Statement at tal.com.au or call 1300 209 088 for a copy.

I acknowledge that:

- The answers I have provided, together with any special conditions, will form the basis of the contract of insurance, and that cover will only be provided on the terms and conditions set out in the contract of insurance with the Insurer and as agreed between AustralianSuper and the Insurer from time to time.
- If I fix any of my cover, I understand that my cover amount won't change (TPD cover reduces gradually from age 61 to zero at age 65, unless you're a Public Sector Division member) but the cost will increase with age.
- If I have chosen to cancel any of my cover, I'll no longer be insured for that cover, and if I decide to apply for cover in the future I'll need to supply detailed health information as part of my application.
- Any change in cover will start from the later of the date it is accepted by the Insurer (as long as my employer is paying contributions) or, I have received confirmation that my cover has started or restarted, and hasn't stopped (depending on the plan I belong to). Please refer to the *Insurance in your super* guide for my division at australiansuper.com/InsuranceGuide for details.

Sign here:



Date

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | 2 | 0 | Y | Y |
|---|---|---|---|---|---|---|---|

Print full name

Privacy Collection Statement

Please read this Privacy Collection Statement to see how AustralianSuper uses your personal information.

AustralianSuper Pty Ltd (ABN 94 006 457 987) of 26/50 Lonsdale Street, Melbourne, Victoria, collects your personal information (PI) to run your super account (including insurance), improve our products and services and keep you informed. If we can't collect your PI we may not be able to do these tasks. PI is collected from you but sometimes from third parties like your employer. We will only share your PI where necessary to perform our activities with our administrator, service providers, as required by law or court/tribunal order, or with your permission. Your PI may be accessed overseas by some of our service providers. A list of countries can be found at the URLs below. Our Privacy Policy details how to access and change your PI, as well as the privacy complaints process. For complete details on the above go to australiansuper.com/CollectionStatement and australiansuper.com/privacy or call us on 1300 300 273.

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