



To be completed by the Life to be Insured

This form accompanies the Super Directions for Business PDS dated 31 August 2009 and is effective from 31 August 2009.

Please read the notices relating to 'Duty of Disclosure' and 'Privacy Use and Disclosure of Personal Information' within this form before completing the following questions.

Warning: You have a duty to disclose all information relevant to our decision to accept your Application. We rely on this information to assess your Application. Any incorrect information may affect your entitlement to benefits.

Your personal details

Form fields for Title, Surname (please print), Given name(s), and Maiden name, where applicable.

Form fields for Gender (Male/Female), Marital status, Date of birth, Age, and Place of birth.

Text input field for occupation title and industry.

Text input field for gross income less business expenses from personal exertion in the last 12 months.

Residential address

Form fields for Street number and name, Town/Suburb, State, Postcode, and Country.

Form fields for Home telephone, Business telephone, and Mobile.

Form fields for Employer, Plan reference, and Member reference.

Personal statement - to be completed if you do not qualify for automatic acceptance and:

- List of conditions for personal statement completion: 2.01 or more units of insurance, nominated benefit amount, multiple of salary, health questionnaire, or on request.

We may need to contact you regarding the details of your Application. Please provide contact number(s) and suitable contact times (8am to 8pm):

Contact phone numbers

Form fields for Daytime, Times, After hours, and Times.

DO NOT complete the Occupation and Income Details sections if you are only applying for life/death cover.

If you are applying for disablement cover, eg Total and Permanent Disablement (TPD) or Group Salary Continuance (GSC), please complete the Occupation and Income Details sections below.

Residence and travel details

Q1 Are you a permanent resident of Australia or New Zealand? [ ] No [ ] Yes

If no, please provide details including the type of visa you hold:

Text input field for visa details.

Q2 Including annual holidays, are you likely to live, travel or work overseas? [ ] No [ ] Yes

If yes, please provide details including where, when and for how long:

Text input field for overseas details.

### Insurance details

**Q3** Are you covered by, or are you applying for, life, disability, trauma, income protection or business expenses insurance with **any company**, including this one? Note: This includes benefits under superannuation, business or credit insurance or benefits provided by an employer.

No  Yes If yes, please provide details:

Name of company	Type of cover	Sum insured	Date commenced	To be replaced?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="   "/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="   "/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="   "/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="   "/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="   "/>	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Q4** Has **any company** refused or applied loadings, restrictions or exclusions to a proposal on your life, superannuation, sickness, accident, trauma, income protection, business expenses, lump sum disablement or disability insurance?  No  Yes

If yes, please provide details:

  


**Q5** For any type of trauma, lump sum disablement, disability/income protection, sickness, accident, unemployment, armed forces pension or allowance, workers' compensation, common law or third party benefit:

- (a) Have you ever made a claim?  No  Yes
- (b) Are you currently receiving benefits?  No  Yes
- (c) Are you entitled to receive benefits?  No  Yes

If yes, please provide details including dates, reasons and amounts and company claimed on:

  


### Your health details

'You' refers to the Person to be insured.

### Doctor details

**Q6** Provide below the details of your current General Practitioner (GP)/medical centre and the details of your last consultation.

Name of GP/medical centre

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Street number and name

Town/Suburb

State

Postcode



Phone number

Facsimile

How long have you been his/her patient?  years

Date of last consultation	Reason	Result
<input type="text" value="   "/>	<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"/>

## Personal habits

**Q7** Do you smoke or have you ever been a smoker?

No  ► Go to Q8

Yes  What do you or did you smoke?

Cigarettes  Pipes  Cigars  Other If other, please specify

If you have stopped, when?  month  year

On average, how many do you or did you smoke daily?

**Q8** How many standard drinks containing alcohol do you consume per week on average?  standard glasses per week

[standard drink = 1 nip spirits, 100ml wine, 10oz/285ml beer]

**Q9** Have you ever been advised to reduce your tobacco or alcohol consumption?  No  Yes

If yes, please advise previous amount, duration, reason for reduction or cessation:

**Q10** Do you or have you ever used recreational drugs or non-prescription drugs?  No  Yes

If yes, please give details:

**Q11** (a) What is your: Height  Weight

(b) Has your weight varied in the last 12 months?  No  Yes

If yes, please give details including amount of weight gain or loss and the reason:

**Q12** At any time in your life have you **ever** suffered from, received advice for, or experienced symptoms of the following (even if you have not seen a doctor):

- (a)  No  Yes Arthritis, bone fracture, joint injury, eg **hip, ankle, knee, elbow, wrist, shoulder**, or experienced symptoms of muscle or joint disorder, gout, tendinitis or tenosynovitis
- (b)  No  Yes Heart condition, rheumatic fever, chest pain, high blood pressure, raised cholesterol, vein or circulatory disorder
- (c)  No  Yes Cancer, tumour of any kind, cyst, growth or breast lump
- (d)  No  Yes Anaemia, leukaemia, haemophilia or any other blood disorder
- (e)  No  Yes **Asthma**, bronchitis, lung condition, breathing or respiratory disorder, sleep apnoea
- (f)  No  Yes Disorder of the kidney, bladder or prostate, urinary complaint or kidney stone
- (g)  No  Yes **Back or neck disorder, spinal condition, sciatica, whiplash**
- (h)  No  Yes **Mental illness, depression, anxiety, nervous condition, stress or post traumatic stress disorder**
- (i)  No  Yes **Chronic fatigue**, fibromyalgia, fibrositis, myalgia, **chronic pain syndrome**
- (j)  No  Yes Diabetes or thyroid disorder
- (k)  No  Yes Indigestion, gastric or duodenal ulcer, hernia
- (l)  No  Yes Bowel disorder, irritable bowel syndrome
- (m)  No  Yes Gall bladder or liver disorder, Hepatitis (please advise type, eg A, B, C or other)
- (n)  No  Yes **Epilepsy**, stroke, headaches, migraines, disorder of the brain or nervous system, dizziness, fainting
- (o)  No  Yes Disorder of the ears, eyes or speech
- (p)  No  Yes Psoriasis, eczema, dermatitis or other skin condition
- (q)  No  Yes Sexually transmitted disease
- (r)  No  Yes Any other illness, injury, operation or disability

**Females only**

- (s)  No  Yes Are you currently pregnant? If yes, please advise expected date of delivery
- (t)  No  Yes Have you ever had any complications with pregnancy or childbirth?
- (u)  No  Yes Have you ever had an abnormal pap smear, breast ultrasound or mammogram?

If you answered 'Yes' to any of the items in Q12, please provide details in the table below, EXCEPT for any condition in bold text above for which you should complete the relevant section of Q21 instead. If you answered 'No' to all items, go to Q13.

Item No.	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery %
	/ /				%
	/ /				%
	/ /				%
	/ /				%
	/ /				%

**Q13** In addition to the conditions you have already mentioned in this application. (There is no need to repeat information you have already told us.)

- (a)  No  Yes Have you ever been admitted to hospital?
- (b) **Have you in the last five years (not including colds or flu):**
- (i)  No  Yes Had any blood test, inherited disorder, counselling of any kind, review of a previously diagnosed condition or any diagnostic test of any nature eg genetic test, X-Ray, medical test?
  - (ii)  No  Yes Used or are you currently using any medication (taken by mouth, injections, inhaled spray, cream, ointment) for any symptoms, sickness, injury or medical condition?
  - (iii)  No  Yes Had any sickness, symptom or injury that prevented you from performing any of the duties of your usual occupation for more than three consecutive days?

If you answered 'Yes' to any of the items above, please provide details in the table below.

Item No.	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Date treatment or medication ceased (if applicable)	Time off work	Degree of recovery %
	/ /			/ /		%
	/ /			/ /		%
	/ /			/ /		%
	/ /			/ /		%
	/ /			/ /		%

**Q14** In addition to the conditions you have already mentioned in this application, have you consulted any other doctors, medical centres or health professionals (eg Chiropractors, Physiotherapists, Naturopaths, Osteopaths, Podiatrists, Herbalists etc) in the last two years?

No  Yes - please provide names, dates, addresses, reasons and results of any consultations:


**Q15** (a) Do you or any of your current or previous sexual partners have HIV/AIDS, or any sign of HIV infection?  No  Yes  
 For example, some signs are: unexplained weight loss, swollen glands or persistent diarrhoea.

(b) In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?  No  Yes

Note – HIV risk situations include but are not limited to:

- sex with or as a prostitute
- sex with an intravenous drug user
- contact with someone else’s blood (for example, through injection or scratch with a used needle)
- anal intercourse (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years).

**Q16** Do you contemplate seeking any medical advice, investigation or treatment including surgery in the near future?  No  Yes

If yes, please provide name of doctor, date of consultation if known and condition:


### Family history/sports and pastimes details

**Q17** Has either one of your parents, brothers or sisters suffered from heart disease, stroke, high blood pressure, diabetes, breast cancer, bowel cancer, other cancer, polycystic kidney disease, Huntington’s Chorea, inherited blood disease, inherited brain disease, kidney failure, muscular dystrophy, or any other inherited disease?  No  Yes

If yes, please provide details in the table 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)

**Q18** Have you in the last 12 months, do you currently or do you intend to take part in any of the following activities?

- (a)  No  Yes **Aviation (other than a fare paying passenger on a licensed public service)**
- (b)  No  Yes **Motor racing (including car, bike and boat)**
- (c)  No  Yes **Underwater diving**
- (d)  No  Yes Football
- (e)  No  Yes Motorbike riding, including trail bike riding
- (f)  No  Yes 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)

If you answered ‘Yes’ to items (d), (e) or (f), please provide details of each activity in the table below. For any activity in bold text above please complete the relevant section of Q19. If you answered ‘No’ to all items above, go to page 7.

Item No.	Activity or sport	Location	Other details (including remuneration received)	No. events/ hours per year	Amateur/ Professional?
					<input type="checkbox"/> Amateur <input type="checkbox"/> Professional
					<input type="checkbox"/> Amateur <input type="checkbox"/> Professional
					<input type="checkbox"/> Amateur <input type="checkbox"/> Professional
					<input type="checkbox"/> Amateur <input type="checkbox"/> Professional
					<input type="checkbox"/> Amateur <input type="checkbox"/> Professional

**Q19 Detailed sports and pastimes questionnaires**

► Only complete the relevant sections of this question if you answered 'Yes' to Question 18 (a), (b), or (c).

**(a) Aviation questionnaire**

- 1 Do you hold a Department of Transport licence to fly aircraft?  No  Yes – please state type and period held:
- 2 Do you intend to change the scope of your present licence?  No  Yes – please provide details:
- 3 Have you ever had an accident or been charged with violating civil aviation regulations?  No  Yes – please provide details:
- 4 Do you always use recognised Department of Transport airfields?  No  Yes – please provide details:
- 5 Please provide details of the type(s) of aviation you are involved in (eg commercial, private, agricultural, aero club, helicopter, ultralight aircraft):
- 6 Please provide details of the number of annual hours flown:  
(i) in total as a pilot   
(ii) in the last 12 months   
(iii) expected each year in the future
- 7 Do you intend to engage in any form of aviation other than the above categories? (eg ballooning, paragliding)  
 No  Yes If yes, please provide details:

**(b) Motor racing questionnaire**

- 1 Vehicle type  Engine size  Maximum speed
- 2 Number of times per annum
- 3  Professional  Amateur
- 4 Category of racing (eg touring cars)
- 5 Events (eg off-road or speedway)

**(c) Underwater diving questionnaire**

- 1 Type of diving
- 2 Average depth
- 3 Maximum depth
- 4 Number of times per annum
- 5  Professional  Amateur
- 6 What certification do you hold?
- 7 Do you participate in sink hole, wreck or other hazardous diving?  No  Yes – please provide details, including how often:
- 8 Do you dive at night?  No  Yes – please provide details:
- 9 Have you ever had a diving accident or sickness?  No  Yes – please provide details:

**Q20** Do you wish to be covered for the sports and pastime activities you have disclosed in this application?  No  Yes  
(Note: This is subject to approval by AXA underwriting.)

**Q21 Detailed health questionnaires**

► Only complete the relevant health questionnaires, if you answered 'Yes' to any items in bold text in Q12.

**(a) Joint disorders and pain questionnaire (eg knee, hip, elbow, wrist, shoulder, ankle)**

- 1 Please state specific condition/symptoms and diagnosis made
- 2 When did you **first** suffer from this disorder?
- 3 When did you **last** suffer from this disorder?
- 4 Please state which knee, ankle, elbow, wrist or shoulder was affected:
- 5 Please describe symptoms fully:
- 6 What was the cause or nature of the disorder?
- 7 What was the nature of the treatment? If surgery, please provide details, eg plates or screws inserted/removed, arthroscopy:
- 8 Have you had any recurrence of this disorder?  No  Yes - when and under what circumstances?
- 9 Please provide names and addresses of all doctors and health professionals consulted in relation to your joint disorder or pain and the approximate dates of consultations:
- 10 How long, if at all, have you been symptom free?
- 11 How much time have you lost from your employment due to this disorder?

**(b) Asthma questionnaire**

- 1 When was your asthma diagnosed?
- 2 When did you **first** have symptoms?
- 3 When did you **last** have symptoms?
- 4 Approximately how many times per year do you get symptoms?
- 5 Do the attacks occur in a particular season or during exercise?  No  Yes - please provide details:
- 6 How much time have you lost from work (or school) in the past due to asthma?
- 7 Please provide details of the treatment for your asthma, including dosage of drugs taken and frequency (detail aerosol spray, tablets or injections, amounts and number of times per day):

► Asthma questionnaire continued on next page

**Q21 Detailed health questionnaires (continued)**

**(b) Asthma questionnaire (continued)**

8 Please provide details of the doctor who you consult for your asthma:

  

9 When did you **last** consult this doctor for asthma?

10 Have you ever been treated for your asthma with steroids (eg Prednisone)?  No  Yes - please provide details, including dates:

  

11 Have you ever been hospitalised for asthma?  No  Yes - please provide details, including dates:

  

12 In the last three years, have you had a chest X-Ray or respiratory function test?  No  Yes - please provide dates and results:

**(c) Back/neck disorder questionnaire**

1  Neck disorder  Back disorder - please clarify which part of the back is/was painful (eg upper, lower, middle):

2 When did you **first** suffer from this disorder?

3 When did you **last** have any symptoms?

Please describe symptoms fully, including details of any radiation of pain down either the legs or arms:

  
  

4 What was the cause of the disorder (eg accident)?

5 Are you still receiving treatment?  No  Yes

6 What is or was the nature of the treatment? Please include details of any medication, physical therapy or surgery:

  

7 Have you had any investigations such as an X-Ray, CT Scan or MRI?  No  Yes - what were the results?

8 Have you had any recurrence of this disorder?  No  Yes - when and how often?  
(Include number of recurrences, the causes and how long they lasted)

9 Please provide names and addresses of all doctors and health professionals consulted in relation to your back or neck disorder and approximate dates of consultations:

  

10 How long, if at all, have you been symptom free?

11 How much time have you lost from your employment due to this disorder?

**Q21 Detailed health questionnaires (continued)**

**(d) Depression/anxiety/nervous condition questionnaire**

1 Have you ever suffered from, had treatment for or been diagnosed with any of the following? Please tick.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Stress             | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Chronic Fatigue         |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Fears or phobias    | <input type="checkbox"/> Chronic pain            |
| <input type="checkbox"/> Inability to sleep | <input type="checkbox"/> Compulsive Disorder | <input type="checkbox"/> Other – please specify: |

2 What was the date of the **first** symptom?

3 What was the date of the **last** symptom?

4 Please describe your symptoms fully:

5 Please advise of the cause of your disorder:

6 How long did you suffer from the disorder?

7 Have you had any recurrence?  No  Yes – please provide full details:

8 How long, if at all, have you been free of any signs or symptoms?

9 Please provide details and nature of treatment for this condition, eg were you treated with tranquillisers or other drugs, did you undergo counselling, therapy or surgery?

10 When did treatment cease?

If ongoing treatment – please provide details (eg dosage and type of medication, counselling):

11 Please provide names and addresses of all doctors and health professionals consulted for these disorders, including approximate dates of consultations:

12 Name of doctor or health professional last consulted for this disorder and the date of the **last** consultation:

13 How much time have you lost from your employment due to this disorder?

14 Are you currently fit and well and able to do your work without stress or discomfort?  No  Yes

If no, please provide details:

**Q21 Detailed health questionnaires (continued)**

**(e) Epilepsy questionnaire**

- 1 Please state type of epilepsy:
- 2 What was the date of onset?
- 3 Please detail the nature (including any loss of consciousness) and frequency of attacks:
- 4 Date of **last** attack?
- 5 Please provide details of any treatment you are currently taking (eg Dilantin, Epilim) and the daily dosage:
- 6 If not on treatment, please advise the date treatment ceased and the reason.
- 7 Have you ever been hospitalised due to epilepsy?  No  Yes - please provide details including dates and treatment:
- 8 Please provide names and addresses of all doctors and health professionals consulted for epilepsy including approximate dates:
- 9 How much time have you lost from your employment as a result of this disorder?

**Please ensure you have completed Q13 to Q20 on pages 4 to 6.**

## Occupation details

**To be completed by the person to be insured only if applying for Total and Permanent Disablement insurance or Salary Continuance.**

'You' refers to the Person to be insured (unless otherwise indicated).

**Q22** Please give details of your current and previous occupation or jobs over the last five years, including any period unemployed, travelling, studying, etc. If you have a second occupation please give details in Q30.

	From	To	Occupation	Employer	Tick which is applicable			
					Employed by own company	Self-employed	Partnership	Employee
Current principal occupation	<input type="text" value="/ /"/>	Present	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous occupation	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous occupation	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous occupation	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q23** How many hours per week do you spend at your principal occupation?  hours

**Q24** How many weeks per year do you spend at your principal occupation?  weeks per year

**Q25** In your principal occupation, what percentage of time do you spend performing the following types of duties:

	Describe details of specific duties performed	
Sedentary/Administrative	<input type="text" value=""/> %	<input type="text"/>
Supervising manual work	<input type="text" value=""/> %	<input type="text"/>
Light manual	<input type="text" value=""/> %	<input type="text"/>
Heavy manual	<input type="text" value=""/> %	<input type="text"/>
Other (including hazardous duties, eg handling dangerous substances, working at heights)	<input type="text" value=""/> %	<input type="text"/>
<b>Total duties</b>	<b>100%</b>	

**Q26** Please give details of your specific qualifications (eg degree, trade certificate):

**Q27** Do you work from home?  No  Yes

If yes, provide details of actual work you perform at home, your work set-up (eg separate office) and frequency and type of contact with clients:

  


**Q28** Have you or any business with which you have been associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration?  No  Yes

If yes, (a) when  (b) date of discharge

**Q29** Do you intend to change your occupation?  No  Yes If yes – please provide details below:

**Q30** Do you have a second occupation?  No  Yes If yes – please provide details below:

  


**Q31** Number of hours per week worked and annual income derived from second occupation:  hours

## Income details

### Q32 Insurable income

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, we may call for evidence of your income and business expenses.

► **If you are an employee, please complete Option 1.**

► **If you are self-employed, in a partnership or an employee of your own company, please complete Option 2.**

#### Option 1 – For employees

► **Only complete this section if you are an employee and do not have any ownership in your employer's business.**

(a) Please give details of your total remuneration package from all sources currently and for the last two financial years.

Please include any additional benefits (eg pre-tax superannuation contributions, regular bonuses and commissions, fringe benefits):

Current remuneration	Last financial year	Previous financial year
\$ <input type="text"/>	30 / 6 / <input type="text"/>	\$ <input type="text"/>
		30 / 6 / <input type="text"/>
		\$ <input type="text"/>

(b) If you become disabled, would all or part of your income (including investment income) continue?

No – go to (c) below  Yes – please answer (i) and (ii):

(i) What is the income amount that would continue, for how long, and the source (eg salary, sick pay, company profits, investments, rental)?

(ii) Is there an agreement in place (written or otherwise) that determines when this entitlement will cease?  No  Yes – details:

(c) Will you be providing supporting financial evidence with this application?  No  Yes

#### Option 2 – For self-employed

► **Only complete this section if you are self employed. This includes sole traders, partners, or if you are an employee in your own company.**

(a) How many people do you employ?

(b) What percentage of your work is on a contract basis?  %

Please provide contract details, including duration of contract and hourly rates of pay:

(c) What percentage of the business do you own?  %

(d) Please provide your company's business income details in the table below for the last two financial years for which tax returns, assessment notices and accounts are available.

Year ending	Gross income for entire business	Less all expenses incurred in earning that income	Equals net business income before tax	Your share of net business income	Wages/salary/super drawings/director's fees paid to you*	Your total income
30 / 6 / <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
30 / 6 / <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>

\* Do not include any amounts paid to you as wages/salary/super/drawings/director's fees which are paid from past profits, capital or loans.

(e) Has your business had a net operating loss over either of the last two financial years?  No  Yes

If yes, please provide copies of your full company accounts for the last two financial years, including any associated entities.

(f) So far this financial year, is your business trading profitably?  No – please provide details in the space below  Yes

(g) If you become disabled, would all or part of your income (including investment income) continue?

No  Yes – please provide the following details:

(i) What is the income amount that would continue, for how long, and the source (eg salary, sick pay, company profits, investments, rental)?

(ii) Is there an agreement in place (written or otherwise) that determines when this entitlement will cease?  No  Yes – details:

(h) Will you be providing supporting financial evidence with this application?  No  Yes

## Duty of Disclosure

### Insurance Contracts Act 1984

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know which is relevant to the insurer's decision whether to accept the risk of insurance and if so, on what terms.

You have the same duty to disclose those matters to the insurer before you renew or extend, vary or reinstate a contract of life insurance.

Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer;
- that is of common knowledge;
- that your insurer knows or, in the ordinary course of its business, ought to know,
- as to which compliance with your duty is waived by the insurer.

### Non-disclosure

If you fail to comply with your duty of disclosure (or make a misrepresentation to us) and the insurer would not have entered into the contract on any terms if the failure (or misrepresentation) had not occurred, the insurer may avoid the contract within three years of entering into it. If your non disclosure (or misrepresentation) is fraudulent, the insurer may avoid the liability for a particular member or avoid the contract, depending on the source of the non disclosure, at any time.

**An insurer who is entitled to avoid a contract of life insurance may, by notice given in writing to you, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.**

## Privacy – Use and disclosure of personal information

The privacy of your personal information is important to you and also to AXA. The purpose of collecting your information is to assess your application for, and manage your membership of, the Fund.

If you are also applying for insurance cover, we will collect additional information about you and your immediate family background, that is necessary for the purpose of assessing your application for insurance, or any claim you may make, and managing your Plan. This includes information about health, financial situation, occupation and lifestyle. If the information you give us is not complete or accurate, we may not be able to provide you with the products and services you have applied for.

In assessing your application for, and managing your membership of, the Fund, we may need to disclose your personal information to other parties, such as other providers of retirement and savings products, a financial adviser, your employer, re-insurers, medical and financial professionals, judicial or dispute resolution bodies and AXA Australia Group companies.

We will only use information about your nominated preferred dependant(s) or legal personal representative in the event of your death.

In the future, we may contact you about new products or special offers. If, at any time, you do not want to receive this information you can opt out by telephoning 133 056 and quoting your plan number.

You are entitled to request reasonable access to information we have about you. We reserve the right to charge an administration fee for collating the information you request.

For our policy on Privacy refer to [www.axa.com.au](http://www.axa.com.au) or contact our Customer Service Centre on 133 056.

## Declaration and consent

- I understand that my employer or I have applied to the Trustee for the provision of insurance cover in respect of me through the Fund.
- I have read the 'Your Duty of Disclosure' above and acknowledge that I have an obligation to reveal every matter that is relevant to AXA's decision whether to accept the risk and if so on what terms.
- I have checked the truth, accuracy and completeness of the answers in this form, and all statements in writing given in support of this application which shall, subject to the law, form the basis of the contract of insurance.
- I understand that if any of my answers in this form are untrue, incomplete or inaccurate, the insurer may be entitled to avoid its liability under the insurance contract and this may result in a reduction in the benefits payable to me or my beneficiaries under the Fund.
- I acknowledge that any change of material circumstances between the time the Trustee provides this statement to the insurer (AXA) and acceptance of the application for insurance by the insurer may entitle the insurer to cancel the arrangement under which insurance was to be provided.
- I give AXA permission to seek any medical information needed in connection with this application or any policy issued as a result.
- I have read and understood the Privacy Disclosure Statement contained above. I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement. I acknowledge that I can opt out from the use of that information for the purpose of direct marketing by telephoning 133 056.

X	/ /
Signature of member and life insured	Date

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### Authorities – medical and financial

#### Medical authorities

► Please complete ALL medical authorities below because many health professionals prefer an original signature.

##### Authority to release medical information to AXA

Person to be insured name

I,  authorise any medical practitioner, doctor, health professional, hospital or clinic to disclose to the insurer (NMLA trading as AXA Australia and its group of companies), or representatives appointed to collect, the full details of my health and medical history. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

Signature of person to be insured  /  /  Dated

##### Authority to release medical information to AXA

Person to be insured name

I,  authorise any medical practitioner, doctor, health professional, hospital or clinic to disclose to the insurer (NMLA trading as AXA Australia and its group of companies), or representatives appointed to collect, the full details of my health and medical history. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

Signature of person to be insured  /  /  Dated

##### Authority for AXA to release medical information to usual doctor

► Only complete this section if you authorise AXA to release medical information to your doctor upon an adverse assessment of your application.

I,  authorise NMLA trading as AXA Australia to advise Doctor  of the reason(s) behind any adverse assessment of my application if it was based on health evidence obtained during the assessment of this application. I also authorise AXA to provide copies of the relevant health evidence to the doctor noted above.

Signature of person to be insured  /  /  Dated

#### Financial authority

► Only complete this section if you want your accountant or financial adviser to release information to AXA.

##### Authority to release financial information to AXA

Person to be insured name

I,  authorise my accountant/financial adviser to release to the insurer (NMLA trading as AXA Australia and its group of companies), all information which the insurer requests for the purpose of assessing my application for insurance. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

Signature of person to be insured  /  /  Dated

Accountant/financial adviser name

Accountant/financial adviser address

( ) Accountant/financial adviser contact number(s)

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