



BT Funds Management Limited ABN 63 002 916 458 AFSL 233724 RSE L0001090 is the Trustee of BT Lifetime Super – Employer Plan RSE R1001327 ABN 39 827 542 991

Note: This form should only be completed if you have answered all questions relating to insurance in the Application form and have been directed to do so to be considered for insurance cover.

Depending upon how you answer these questions, you may be required to complete additional questionnaires. The additional questionnaires are located online at www.bt.com.au.

Complete this form using **black pen** – print in clear **CAPITAL LETTERS**

A. FURTHER MEDICAL DETAILS

Have you ever suffered symptoms of, or been told you had, or received advice or treatment for:

1.	high blood pressure or blood disorder eg Leukemia or Anaemia or Haemophilia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	heart, vein or circulatory disorder, including chest pain, heart attack, stroke, heart murmur, raised cholesterol, Rheumatic Fever?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	mental or nervous disorder (eg stress, depression) fainting, Epilepsy, paralysis, brain disorder? <i>If you answered yes to this question, please complete the Mental Health Questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Gout, Arthritis, Rheumatism, RSI, chronic fatigue, myalgia, cartilage or ligament injury, bone fracture, Hernia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	back pain, sciatic or other disorder of the back or spine including the neck (whiplash injury)? <i>If you answered yes to this question, please complete the Spinal/Joints Questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Asthma, Bronchitis or other respiratory disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	stomach, intestinal or rectal disorder, ulcer, gall bladder or liver disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Hepatitis B or C or been told you are a Hepatitis B or C carrier?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Diabetes, thyroid or prostate disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	Cancer, cyst, breast lump (even if you have not seen a doctor) tumour of any kind or any form of growth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	loss or reduction of hearing or sight or loss of any limb?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12.	Dermatitis, Psoriasis, or other disorder of the skin?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13.	kidney or bladder disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14.	sexually transmitted diseases?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15.	drug or alcohol dependency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16.	any other medical condition not mentioned above? <i>If you answered yes to this question, please complete the Multipurpose Questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Females only	a) any female organ disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	b) are you currently pregnant? <i>If yes, date of expected delivery</i> <input type="text"/> / <input type="text"/> / <input type="text"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

B. MEDICAL HISTORY

During the last five (5) years have you:

1.	had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	been in a hospital, clinic or nursing home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	been advised to have an operation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	had any tests, including blood tests, ECG, x-rays, genetic tests, etc? <i>If you answered yes to this question, please complete the Check-up Questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquillisers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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03-15-009-03

E. FAMILY HISTORY

1. Please fill in the following schedule of family history:

Relative	Living		Deceased	
	Age	State of health <i>(if not stated as good, give reasons)</i>	Age at Death	Cause(s) of Death <i>(to be state fully and exactly)</i>
Father				
Mother				
Brothers	1			
	2			
	3			
	4			
Sisters	1			
	2			
	3			
	4			

2. Have any of your immediate family (living or dead), ever suffered from diabetes, heart disease, mental illness, cancer, haemophilia, Huntington chorea, kidney disease or any other hereditary disorder? *If 'Yes', please give details.* Yes No

F. DOCTORS DETAILS

Name of current doctor

Daytime phone number Fax number
 () ()

Doctors address

 State *Postcode*

G. NAME AND SIGNATURE

I hereby declare that:

- the answers to the above questions are true and I have not deliberately withheld any information material to the proposed insurance.
- I consent to AIA Australia Limited (the Insurer), third party providers and BT Funds Management Limited on behalf of the Insurer, seeking medical information from any doctor who at any time I have consulted prior to the date below. While I am insured, I authorise the provision of such information to the Insurer.
- I acknowledge that I have read and understood my duty of disclosure in accordance with the Insurance Contracts Act 1984 as detailed in the insurance section of the Application form.
- A photocopy of this declaration shall be as valid as an authority as the original.

Full name of **person to be insured** (please print)

Date of birth of **person to be insured** (dd/mm/yyyy)
 / /

Signature of **person to be insured**

Date (dd/mm/yy)
 / /