BT Financial Group

BT Lifetime – Personal Super
Personal Statement – Part 2
Form issued 1 July 2007

BT Customer Relations ✆ 132 135 (8.00am – 6.30pm Mon-Fri, Sydney time)

BT Funds Management Limited ABN 63 002 916 458, AFSL 233724, RSE L0001090 is the trustee of BT Lifetime – Personal Super RSE R1003864

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.

*Please complete the form using **black pen** and print in clear **CAPITAL LETTERS**. Use crosses (✘) in boxes where applicable.*

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

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 ☐	No ☐
2.	been in a hospital, clinic or nursing home?	Yes ☐	No ☐
3.	been advised to have an operation?	Yes ☐	No ☐
4.	had any tests, including blood tests, ECG, x-rays, genetic tests, etc? *If you answered yes to this question, please refer to **Check-up Questionnaire** and complete questions 1 – 5*	Yes ☐	No ☐
5.	occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquillisers?	Yes ☐	No ☐

C. PERSONAL HISTORY

1. Do you smoke? *If 'Yes', what do you smoke?* cigarettes ☐ cigars ☐ pipe ☐ other ________ Yes ☐ No ☐

How much (daily)? ________

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C. PERSONAL HISTORY – *continued*

2. Do you drink alcohol? *If '**Yes**', what type of alcohol?* ______ Yes ☐ No ☐

   How much (daily)? ______

3. Has any company ever refused, or applied special or modified conditions or cancelled any proposal to insure you for life or disablement policy? Yes ☐ No ☐

4. Have you ever engaged or are you ever likely to engage in aviation (other than as a fare paying passenger) or in any hazardous occupation, recreation, pastime, pursuit or sport (e.g. motor racing, football – all codes, martial arts, scuba diving)? Yes ☐ No ☐
   *If '**Yes**', please provide details*

   ______

5. Are you a permanent resident of Australia? Yes ☐ No ☐

6. Do you intend to work, live or travel overseas? *If '**Yes**', please state destination, duration, frequency and purpose of travel?* Yes ☐ No ☐

   ______

D. ANSWERS IN DETAIL

If you answered yes to any question in sections A, B or C above, please provide details in the table below. If there is insufficient space, please provide a signed and dated supplementary statement.

Ref. *Section / Question (e.g. A3)*	**Test, or Nature of Condition or Complaint**	**Date Commenced**	**Duration**	**Time Off Work**	**Degree Of Recovery** *(%)*	**Full Details of Treatment and Results** *(Include type of operations)*	**Full name and address of Doctor or Hospital** *(If any)*

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E. FAMILY HISTORY

1. 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 ☐

2. Please fill in the following schedule of family history

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

F. DOCTORS DETAILS

Name of current doctor

Doctor's address

State Postcode

Daytime phone number ( )

Fax number ( )

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 AIG Life (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**

D D / M M / Y Y Y Y

Signature of **person to be insured** Date / /