BT Super for Life
Application Form

BT Customised Insurance:

Death and Total & Permanent Disability (TPD) cover
Salary Continuance Insurance cover

INSURER
AIA Australia Limited ABN 79 004 837 861 AFSL 230043
TRUSTEE
BT Funds Management Limited ABN 63 002 916 458
as trustee of Retirement Wrap ABN 39 827 542 991

USE THIS FORM IF:

- you are applying for Customised insurance cover within BT Super for Life; and you are
- applying for Death and Total Disablement cover; AND/OR
- you are applying for Salary Continuance Insurance cover.

You must be working over 20 hours per week to apply for Salary Continuance Insurance.

This attachment consists of two forms:

- Application Form
- Personal Statement

If you answer 'Yes' to the medical questions in Section D of the Personal Statement (page 3), please also complete the relevant medical questionnaires.

Please note: Any Standard cover you hold will be cancelled if you are accepted for Customised cover.

Please submit the forms to the following address:

BT Super for Life
GPO Box 3958
SYDNEY NSW 2001

Questions? Please call BT Customer Relations on 1300 653 553.

PLEASE READ BEFORE SIGNING THIS FORM

This Application Form, forms part of the BT Super for Life Product Disclosure Statement (PDS). The BT Super for Life Product Disclosure Statement is referred to as the PDS. Before you complete this Application Form please read:

- the section titled Privacy in the PDS
- the information about your Duty of Disclosure below.

DUTY OF DISCLOSURE

If you, as the person whose life is to be insured under the life insurance contract, do not tell us or the insurer something that you know, or could reasonably be expected to know, may affect the insurer's decision to provide insurance and on what terms, this may be treated as a failure by us to comply with our Duty of Disclosure.

This could affect the insurance cover provided to you as described below.

INSURED'S DUTY OF DISCLOSURE

A person who enters into a life insurance contract has a duty, before entering into the contract, to tell the insurer anything that he or she knows, or could reasonably be expected to know, that may affect the insurer's decision to provide the insurance and on what terms.

The person entering into the contract has this duty until the insurer agrees to provide the insurance.

The person entering into the contract has the same duty before he or she extends, varies or reinstates the contract.

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

- reduces the risk the insurer 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 them about.

If you do not tell the insurer something that you know, or could reasonably be expected to know, or that 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 tell the insurer something that he or she must tell them.

IF THE PERSON ENTERING THE CONTRACT DOES NOT TELL US 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 the person entering into the contract does not tell the insurer anything he or she is required to, and the insurer would not have provided the insurance if he or she had disclosed that information to them, the insurer may avoid the contract within 3 years of entering into it.

If the insurer chooses not to avoid the contract, the insurer 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 he or she had told the insurer everything he or she should have. However, if the contract has a surrender value, or provides cover on death, the insurer may only exercise this right within 3 years of entering into the contract.

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

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

PERSONAL INFORMATION

By completing this form, you consent to any personal information, including sensitive information, that AIA Australia may collect about you (including your responses in this Personal Statement) being handled, used and disclosed in accordance with the *Privacy Act 1988* (Cth) and the AIA Australia Privacy Policy at aia.com.au .

OTHER IMPORTANT INFORMATION

We are required or authorised to collect personal information from you by certain laws. Details of these laws are in the BT Privacy Policy. The BT Privacy Policy is available at bt.com.au or by calling 132 135. It covers:

- how you can access the personal information we hold about you and ask for it to be corrected;
- how you may make a complaint about a breach of the Australian Privacy Principles, or a registered privacy code, and how we will deal with your complaint; and
- how we collect, hold, use and disclose your personal information in more detail.

The BT Privacy Policy will be updated from time to time. Please read and understand the Privacy information contained in the PDS.

FOR OUR CUSTOMERS LOCATED IN THE EUROPEAN UNION

The General Data Protection Regulation (GDPR) regulates the collection, use, disclosure or other processing of personal data under European Union (EU) law. Personal data means any information relating to you from which you are either identified or may be identifiable. The GDPR aims to protect the personal data of individuals located in the EU and harmonise data protection laws across EU Member States.

Our collection, use, disclosure and other processing of your personal data is regulated by the GDPR if:

- you interact with our Westpac UK branch;
- we offer products or services to you whilst you are located in the EU; and/or
- we monitor your behaviour whilst you are located in the EU (such as through our use of cookies when you interact with us online or for our fraud detection and prevention purposes).

Please refer to our EU Data Protection Policy on our website at westpac.com.au/privacy/eu-data-protection-policy for information about how we manage your personal data under the GDPR.

ACCOUNT HOLDER DETAILS — SECTION A

Complete this section for all applications

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Surname

Maiden name (if you changed your name through marriage)

Given name(s)

Date of birth (dd/mm/yyyy) / /

Telephone number ( )

Gender

Male ☐ Female ☐

Occupation

BT Super for Life Account number

Please note the address for notices will be the same as the address on your superannuation account.

Are you a member of the Westpac Group Plan? Yes ☐ No ☐

Email address for contact

CUSTOMISED DEATH & TPD COVER — SECTION B

Complete this section for all Customised Death & TPD applications

Please note the occupation you state in the Personal Statement may result in an occupational loading to be applied.

Cover for the Account holder	
Death cover	$
TPD cover	$

Please note the amount of TPD cover applied for cannot exceed the amount of Death cover applied for and any Standard cover you have will be cancelled upon acceptance of your application for Customised cover.

CUSTOMISED SALARY CONTINUANCE INSURANCE — SECTION C

Complete this section for all customised Salary Continuance Insurance cover applications

BENEFIT DETAILS

Monthly benefit applied for

$

Benefit Period

2 years ☐ 5 years ☐ Age 65 ☐

Waiting Period (days)

30 days ☐ 90 days ☐ 180 days ☐ 720 days ☐

The following combinations are available:

Waiting Period	Benefit Period
30 day, 90 day	2 years, 5 years, to age 65
180 day, 720 day	to age 65

Please note:

- Maximum sum insured is 75% of your gross monthly earnings including superannuation
- You must be working over 20 hours per week to apply for Salary Continuance cover
- The minimum monthly benefit is $1,000 per month
- Minimum premium is $14.00 per month (plus Administration Fee and Stamp Duty, if required)

The insurer has restrictions depending on your occupation category. You will be notified if you are not eligible for your selected Waiting and Benefit Period.

PREMIUM PAYMENT DETAILS — SECTION D

Premiums will be deducted from your BT Super for Life account on a monthly basis.

DECLARATION AND AGREEMENT — SECTION E

Complete this section for all applications

I understand and acknowledge that:

- By signing this form I agree I want my insurance to start and continue, even if my account is, or becomes, inactive*; has not had a balance of at least $6,000 ever; or I am under age 25. This declaration includes any additional benefit that I may add to my account in the future, until I notify otherwise.

  ** inactive means no contributions or rollovers have been received for a continuous period of 16 months (or longer) in my superannuation account.*

- I have read the completed application form and confirm that the statements made and information contained therein are true and correct as at the date I signed this application
- I have read the Privacy Section of the PDS and I agree to the various uses and disclosures of my personal information set out in that section. I also agree to make any beneficiary nominated by me aware of the matters set out in that section
- I have received and read the BT Super for Life PDS
- this application form and the accompanying Personal Statement/s and any related documents (including the PDS) shall form the basis of cover issued
- I understand that any existing Standard Death and TPD cover will be cancelled, upon acceptance by the Insurer of my application for Customised Death and TPD cover
- I have read and understood the Duty of Disclosure contained in the PDS. I acknowledge that I have complied with the Duty of Disclosure
- I understand that failure to comply with the Duty of Disclosure could result in avoidance or cancellation of my Policy, or any claim not being paid in accordance with my expectations
- the insurance I have applied for will not become effective until this application form is accepted by the Insurer in writing and I have added money to my BT Super for Life account.

Account holder signature

Date (dd/mm/yy) / /

Please complete the Personal Statement form over the page.

BT Super for Life
Personal Statement

BT Customised Insurance:
Death and Total & Permanent Disability (TPD) cover
Salary Continuance Insurance cover

A. LIFE INSURED

Life insured to complete this section in full.

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Surname

Given name(s)

Gender

Male ☐ Female ☐

Date of birth (dd/mm/yyyy) / / Age next birthday

Residential address

State *Postcode*

Country, if not Australia

Postal address *(if different from above)*

State *Postcode*

Country, if not Australia

We may need to contact you to clarify information you have provided in the application. If so we will contact you during business hours. Please nominate a preferred local contact time:

8am – 11am ☐ 11am – 2pm ☐ 2pm – 6pm ☐

Home phone number ( )

Mobile phone number

Work phone number ( )

Email

Country of Birth

Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia (as approved by the Department of Immigration and Citizenship)? Yes ☐ No ☐

If 'No', are you applying for, or intending to apply for, Permanent Residency in Australia? Yes ☐ No ☐

Please advise what type of visa you hold

Date of visa expiry (dd/mm/yyyy) / /

B. TYPE OF INSURANCE

Please tick one

New ☐ Increase ☐

Please tick one	**Amount**
☐ Death Only	$
☐ Death and TPD	$
☐ Income Protection	$

Income Protection only:

Benefit Period

2 years ☐ 5 years ☐ Age 65 ☐

Other – Please specify

Waiting Period (days)

30 days ☐ 60 days ☐ 90 days ☐

Other – Please specify

days

Continued on page 2

C. PERSONAL HISTORY

Life insured to complete this section in full.

1 A Do you have, or are you applying for life, disability or trauma insurance on your life (including any pending applications held with any insurer)? Yes ☐ No ☐

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

Policy Number	Date Commenced	Policy Owner	Insurer	Type of Cover	Amount of Cover	Existing Income Protection: Waiting Period/Benefit Period	To be replaced Yes	To be replaced No
	/ /						☐	☐
	/ /						☐	☐
	/ /						☐	☐

	Yes	No
B Have you ever been declined, deferred or accepted on special terms for life, disability or trauma insurance?	☐	☐
C Have you ever claimed benefits from any source (excluding unemployment), e.g. Accident, Sickness, Workers Compensation, Social Security, Disability Income Insurance or Pension? If 'Yes', please give the name of the company, date, amount and reason for each claim below.	☐	☐

If you answered **'Yes'**, to 1(b) or 1(c) please provide details.

2 A Have you smoked tobacco or any other substance during the last twelve months? Yes ☐ No ☐

If **'Yes'**, please state substance and daily quantity below. (Please note 'packet' is not sufficient detail.)

State substance

Quantity

daily

B How many standard drinks do you consume per week on average? One standard drink = one nip (30 ml) spirits, 100 ml wine, 10 oz/285 ml beer

C Have you ever used illicit drugs or received advice, treatment or counselling for the use of alcohol or illicit drugs? Yes ☐ No ☐

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

3 What is your current height and weight?

Height

cm OR ft in

Weight

kg OR st lb

4 Do you intend to travel or reside overseas? Yes ☐ No ☐

If **'Yes',** provide details

Cities/Countries	
Duration of travel	
Frequency of travel	
Reason for travel	
Date of departure	/ /

Cities/Countries	
Duration of travel	
Frequency of travel	
Reason for travel	
Date of departure	/ /

5 Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes including touch football), long-distance sailing, hang gliding, scuba diving, motor racing, non-competitive off-road motorcycle sport (trail bike riding/dirt bike riding/motocross), parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? Yes ☐ No ☐

If **'Yes',** please fill in **Section G** (Aviation or Activities/Pursuits Questionnaire).

Continued on page 3

FAMILY HISTORY

6 Ⓐ Have any of your immediate family (father, mother, brother, sister), prior to the age of 60 (living or dead), ever suffered from:

	Yes	No
Heart disease or stroke?	☐	☐
Breast cancer, ovarian cancer, prostate cancer or colon (bowel) cancer?	☐	☐
Polycystic kidney disease or diabetes?	☐	☐
Mental disorder?	☐	☐
Huntington's chorea, Alzheimer's disease, dementia, motor neurone disease, multiple sclerosis, muscular dystrophy or Parkinson's disease?	☐	☐
Any other hereditary disease?	☐	☐

If **'Yes'** to question 6(a), please provide details in the table below.

	Condition/Illness (for heart disease or cancer please specify the type)	Age at onset (approx.)	Age at death (if applicable)
Father			
Mother			
Brothers			
Sisters			

Ⓑ Are you required to undergo any regular screening as a result of your family history? Yes ☐ No ☐

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

D. MEDICAL AND HEALTH HISTORY

Life insured to complete this section in full and complete relevant questionnaire.

1 Have you ever suffered symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?

	Yes	No
Ⓐ High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke. If 'Yes', please complete Section H – **High Blood Pressure/High Cholesterol Questionnaire.**	☐	☐
Ⓑ Asthma, chronic lung disease, sleep apnoea or other respiratory disorder. If 'Yes', please complete Section I – **Asthma Questionnaire**.	☐	☐
Ⓒ Indigestion, gastric or duodenal ulcer or any bowel disorder. If 'Yes', please complete Section J – **Multi-Purpose Questionnaire.**	☐	☐
Ⓓ Depression, anxiety/stress state, fatigue (including chronic fatigue syndrome), panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder. If 'Yes', please complete Section K – **Mental Health Questionnaire**.	☐	☐
Ⓔ Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness or recurrent headaches or any neurological disorder including multiple sclerosis. If 'Yes', please complete Section J – **Multi-Purpose Questionnaire.**	☐	☐
Ⓕ Arthritis, repetitive strain injury (RSI), chronic fatigue syndrome, fibromyalgia. If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.	☐	☐
Ⓖ Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles. If 'Yes', please complete Section L – **Spinal/Joints Disorder Questionnaire.**	☐	☐
Ⓗ Psoriasis or eczema, skin disorder or abnormality with hearing, eyesight or speech. If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.	☐	☐
Ⓘ Diabetes, abnormal blood sugar, gout or thyroid disorder. If 'Yes', please complete Section J – **Multi-Purpose Questionnaire.**	☐	☐

If you have answered 'Yes' to any of the above questions, please also complete a questionnaire for each condition (see Sections H to L).

	Yes	No
Ⓙ Cancer, cyst, lump, tumour or growth of any kind.	☐	☐
Ⓚ Liver disorder (including fatty liver), pancreas, prostate, kidney or bladder disorder, renal colic or stone.	☐	☐
Ⓛ Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia.	☐	☐
Ⓜ Hepatitis B or C or are a Hepatitis B or C carrier, Acquired Immune Deficiency Syndrome (AIDS) sufferer or infected with the HIV virus.	☐	☐

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Females Only

	Yes	No
Ⓝ Are you pregnant? If 'Yes', please provide estimated date child is due. ☐☐/☐☐/☐☐☐☐	☐	☐

Have you ever had or been advised to have treatment for:

	Yes	No
Ⓞ Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound?	☐	☐
Ⓟ An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries?	☐	☐
Ⓠ Abnormal vaginal bleeding within the last 12 months?	☐	☐

	Yes	No
Ⓡ Have you ever suffered symptoms of, or had any other illness, disease or disorder? **Do not include:** colds, flu, hayfever, dental related matters, uncomplicated pregnancies (including caesarean sections, miscarriage), abortions and menopause.	☐	☐

❷ In the last 5 years have you:

Ⓐ Had any medical examinations, consultations, x-rays, pathology tests or procedures? Yes ☐ No ☐

Ⓑ Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? Yes ☐ No ☐

❸ Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? Yes ☐ No ☐

❹ Are you currently under ongoing monitoring, consultation or review for any condition, complaint or finding? Yes ☐ No ☐

For each 'Yes' answer in questions 1J–1R, 2, 3 and 4 above, please provide full details in the table below.

Question Reference	Illness, Injury or Tests	Date of Illness/Injury	Time off Work	Degree of Recovery %*	Results of Tests	Reason and type of treatment including date of last symptoms	Full name and address of doctor or hospital (if any)
		/ /		%			
		/ /		%			
		/ /		%			
		/ /		%			
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		/ /		%			

❺ Lifestyle Statement

Ⓐ Have you ever injected yourself with any illicit drugs not prescribed by a medical practitioner? Yes ☐ No ☐

Ⓑ In the past 5 years have you: Yes ☐ No ☐

(i) engaged in unprotected anal sex (except in a relationship between you and only one other person where neither of you has had unprotected anal sex with anyone else in the past 5 years)?

(ii) had sex without a condom:
- – with someone you know or suspect to be HIV positive; or
- – with someone who injects non-prescribed drugs; or
- – with a sex worker or as a sex worker?

Continued on page 5

E. DOCTOR'S DETAILS

Life insured to complete this section in full.

1 Ⓐ Details of your personal doctor.

IF NO PERSONAL DOCTOR, PLEASE STATE NAME/ADDRESS OF LAST DOCTOR OR MEDICAL CENTRE YOU ATTENDED.

Doctor's name

Address

State *Postcode*

Telephone number ( )

Fax number ( )

Email

Ⓑ What was the date of your last consultation?
(Give approximate date if exact date unknown.)

/ /

Ⓒ How long have you been attending the surgery/ practice?

F. PRESENT OCCUPATION

Life insured to complete this section in full.

1 Ⓐ What is your usual occupation?

Ⓑ Employer name:

Ⓒ Type of industry:

Ⓓ Do you work from home more than 30% of your time? Yes ☐ No ☐

If '**Yes**', give details including:

(i) percentage of time working at home %

(ii) office arrangement (i.e separate entrance, separate office etc)

(iii) how often you are required to leave home as part of your duties %

(iv) where you work at these times

Ⓔ What trade, professional, business or tertiary qualifications do you have?

Ⓕ Do you perform any manual work? Yes ☐ No ☐

If '**Yes**', please describe duties and percentage of time spent in each

Type of work	**% of time**
Sedentary	
Please describe your specific duties and where they are performed	

Type of work	**% of time**
Light manual	
Please describe your specific duties and where they are performed	

Type of work	**% of time**
Heavy manual	
Please describe your specific duties and where they are performed	

How many hours per week do you work in your principal/main occupation?

Ⓖ Please state your employment structure:

Permanent Yes ☐ No ☐

Temporary (state date the position will cease/terminate)

/ /

Please advise if you work:

Full time ☐ Part time ☐

Do you work on a Casual basis (under a casual work agreement) Yes ☐ No ☐

If '**Yes**', how many years have you been working continuously for the same employer:

< 1 year ☐ ≥ 1 year to < 2 years ☐ ≥ 2 years ☐

as a contractor Yes ☐ No ☐

If '**Yes**', please state expiry date of your contract:

/ /

If your contract expires within 6 months, will it be renewed? Yes ☐ No ☐

If '**Yes**', please state for how long the contract will be renewed.

Ⓗ How much driving do you do as part of your occupation? (Commuting to your primary workplace should not be included.)

0–100 km per week ☐ 100–300 km per week ☐
300–500 km per week ☐ Over 500 km per week ☐

Ⓘ What percentage of your working hours is spent driving?

0% – 5% ☐ 5% – 10% ☐ 10% – 25% ☐ Over 25% ☐

Continued on page 6

2 What is your annual earned income?

(Do not include unearned income such as dividends, interest, rental income, proceeds from asset sales or royalties.)

$

3 A Do you have any other occupation? Yes ☐ No ☐

B Do you contemplate or expect any change in occupation (including retrenchments/redundancy or changes in your role or duties or working hours)? Yes ☐ No ☐

4 Does your occupation require you to work underground, at heights (above 10 metres), off-shore or near dangerous materials or substances? Yes ☐ No ☐

If '**Yes**', please give details below, eg. locations, depths, heights, frequency etc.

If you have answered '**Yes**' to Question 3 a, 3 b or 4, please provide full details below.

5 Are you or any business with which you are associated, contemplating voluntary administration, or ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? Yes ☐ No ☐

Date of discharge

☐☐/☐☐/☐☐☐☐

IF YOU ARE SELF-EMPLOYED, IN A BUSINESS PARTNERSHIP OR EMPLOYEE OF OWN COMPANY, PLEASE COMPLETE THE REMAINING QUESTIONS.

6 Do you operate as a

sole trader ☐ business partnership ☐
company ☐ trust ☐

7 What percentage of your work is:

Freelance? %

Contract? %

8 A When was the business purchased/started?

☐☐/☐☐/☐☐☐☐

B Please state what percentage of interest/shareholding you have in the business/practice? %

9 How many people do you employ?

QUESTIONNAIRES

Life insured to complete this section in full.

G. AVIATION QUESTIONAIRE

1 Please state the number of hours flown where applicable:

A Private flying

Type of Aircraft	Previous 12 months		Next 12 months	
	Pilot	Passenger	Pilot	Passenger
Fixed Wing				
Rotary				
Other *(e.g. Ultralight Microlight)*				

B Commercial flying

(excluding large mainstream carriers, e.g. Qantas)

Type of Aircraft	Previous 12 months		Next 12 months	
	Pilot	Passenger	Pilot	Passenger
Fixed Wing				
Rotary				
Other *(e.g. Ultralight, Microlight)*				

C Agricultural flying

Type of Aircraft	Previous 12 months		Next 12 months	
	Pilot	Passenger	Pilot	Passenger
Fixed Wing				
Rotary				
Other *(e.g. Ultralight, Microlight)*				

2 Are your flying activities:

Recreational ☐ OR Required for your occupation? ☐

Please provide details

3 A Name of aircrafts flown.

B Make and model of the aircrafts.

C If pilot only.

(i) Age of the aircrafts flown.

☐☐☐ years

(ii) Is the aircraft serviced and maintained in Australia? Yes ☐ No ☐

If **'No'**, where is the aircraft serviced?

Continued on page 7

4 Do you fly or intend to fly outside Australia? Yes ☐ No ☐

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

5 Do you participate in or intend to participate in any flying activities such as aerobatics, stunt flying or exhibitions? Yes ☐ No ☐

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

6 Have you ever been involved in any aviation accidents? Yes ☐ No ☐

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

G. ACTIVITIES/PURSUITS QUESTIONNAIRE

1 Please describe the activity or pursuit.

2 Please advise the number of times you engage in the activity per year.

3 How many actual events/hours/trips/flights/dives/climbs/jumps/others, did you participate in over the last twelve months approximately?

4 What qualifications, certificates, licences, associations and club memberships do you hold?

5 How long have you been involved in this activity?

6 Where do you engage in this activity and in what locations?

7 Do you ever engage in this activity alone, or are you always with a group?

8 Do you compete in this activity? Yes ☐ No ☐

If **'Yes'**, please advise the level of competition and names of events.

9 Do you receive any payments for your involvement in this activity? Yes ☐ No ☐

If **'Yes'**, please advise details.

10 Please advise the maximum heights, speeds, depths the activity includes

11 Are any of the above likely to change over the next 2 years? Yes ☐ No ☐

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

12 Are you involved in any record attempts? Yes ☐ No ☐

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

13 Are all recognised/standard safety measures and precautions followed?

Please provide any additional details.

14 Please provide details including engine size and model for any cars, boats, planes (state fixed wing or rotary) or other equipment used. For martial arts state whether contact or non-contact.

15 Have you ever been involved in any accident/mishap whilst participating in this activity? Yes ☐ No ☐

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

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H. HIGH BLOOD PRESSURE/HIGH CHOLESTEROL QUESTIONNAIRE

1 When was high blood pressure/ high cholesterol first diagnosed?

☐☐/☐☐/☐☐☐☐

2 What were the blood pressure/cholesterol readings (including total cholesterol, HDL, LDL and Triglyceride) at time of diagnosis?

Readings	Results	Date diagnosed
Blood Pressure		/ /
Total Cholesterol		/ /
HDL		/ /
LDL		/ /
Triglycerides		/ /

3 Please provide details of your past and current treatment. Include names of medication and dosage.

Date	Medication	Dosage
/ /		
/ /		
/ /		
/ /		
/ /		

4 Are you still on treatment? Yes ☐ No ☐

If **'No'**, when was treatment discontinued and why?

5 Please give date(s) and result(s) of any electrocardiography (ECG), echocardiogram, x-rays, urine tests or other investigations which may have been carried out.

Date	Procedure	Results
/ /		
/ /		
/ /		

6 Regarding the monitoring of your condition:

A Name of medical attendant:

B How often do you attend for follow-up?

C When was your last consultation? Please provide details of your blood pressure reading and/or cholesterol (including total cholesterol, HDL, LDL and Triglyceride) reading at that time.

D Have you suffered from any of the following conditions:

	Yes	No
(i) Eye disorder (other than short/long sightedness)	☐	☐
(ii) Symptoms or disorder relating to heart or circulatory system	☐	☐
(iii) Kidney disorder or protein in urine	☐	☐
(iv) Dizziness, fainting episodes or stroke	☐	☐

If you answered **'Yes'**, to any of the above, please provide details:

Date	Symptoms	Investigations	Results
/ /			
/ /			
/ /			
/ /			
/ /			

E How long has your blood pressure/cholesterol been well controlled?

< 6 months ☐ 6 months to 12 months ☐ > 12 months ☐

7 Please provide any additional information on your condition which you feel will be helpful in processing your application.

8 Please attach copies of any reports or results (e.g. x-rays, pathology, ultrasound, etc) you may have.

I. ASTHMA QUESTIONNAIRE

1 Date asthma first diagnosed.

☐☐/☐☐/☐☐☐☐

2 How often do you experience symptoms?

e.g. wheezing, breathlessness, chest tightness.

Daily ☐ Weekly ☐ Monthly ☐ Other ☐

3 When was your most recent episode of asthma?

☐☐/☐☐/☐☐☐☐

4 Are you aware of any causes that trigger your symptoms?

e.g. allergy, exercise.

5 Have you ever been off work due to asthma? Yes ☐ No ☐

If **'Yes'**, please advise when, and for how long.

6 Name of medications.

A Dosage

B Frequency

Continued on page 9

C When was the last time you received medication?

D What additional treatment do you use to control an attack?

7 Have you ever required steroid therapy (by tablet or syrup)? Yes ☐ No ☐

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

8 Have you ever been in hospital or received emergency treatment for asthma? Yes ☐ No ☐

If **'Yes'**, please state when, for how long and where?

9 Have you ever undergone a lung function test? Yes ☐ No ☐

If **'Yes'**, please advise dates and highest and lowest readings, if known.

10 Have you ever consulted a specialist for this condition? Yes ☐ No ☐

If **'Yes'**, please advise name and address of doctor of last consultation

11 Please provide details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

J. MULTI-PURPOSE QUESTIONNAIRE

1 Name of condition (exact diagnosis).

2 A What part of the body was affected?

B Please state which side.

Left ☐ Right ☐ Not applicable ☐

3 The cause.

4 A Date symptoms commenced.

☐☐/☐☐/☐☐☐☐

B How long have you been free of symptoms?

C How often do/did you have symptoms?

5 Have you ever been off work or your normal daily activities restricted in any way related to this condition? Yes ☐ No ☐

If **'Yes'**, please state when, duration and reason/restriction.

6 Have you any residual, on-going effects or restriction in your daily activities? Yes ☐ No ☐

If **'Yes'**, please give details

7 Have you taken regular or occasional medication for this condition? Yes ☐ No ☐

If **'Yes'**, advise names of medication(s), dosage(s) and frequency.

Are you still taking this medication? Yes ☐ No ☐

	Yes	No
8 Have you had any other treatment for this condition (e.g. physiotherapy, operation, alternative remedies)?	☐	☐
9 Have you had any diagnostic investigations (e.g. scope, scan, x-rays, EEG, ECG etc)?	☐	☐
10 Have you ever been in hospital or received emergency treatment for anything related to this condition?	☐	☐
11 Have you seen a doctor or other therapist for anything related to this condition? If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.	☐	☐

Continued on page 10

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

⓬ Has further treatment been recommended for this condition? Yes ☐ No ☐

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

⓭ Does your usual doctor have details of this condition? Yes ☐ No ☐

If **'No'**, provide name and address of doctor who has full details.

J. MULTI-PURPOSE QUESTIONNAIRE

❶ Name of condition (exact diagnosis).

❷ Ⓐ What part of the body was affected?

Ⓑ Please state which side.

Left ☐ Right ☐ Not applicable ☐

❸ The cause.

❹ Ⓐ Date symptoms commenced.

☐☐/☐☐/☐☐☐☐

Ⓑ How long have you been free of symptoms?

Ⓒ How often do/did you have symptoms?

❺ Have you ever been off work or your normal daily activities restricted in any way related to this condition? Yes ☐ No ☐

If **'Yes'**, please state when, duration and reason/restriction.

❻ Have you any residual, on-going effects or restriction in your daily activities? Yes ☐ No ☐

If **'Yes'**, please give details

❼ Have you taken regular or occasional medication for this condition? Yes ☐ No ☐

If **'Yes'**, advise names of medication(s), dosage(s) and frequency.

Are you still taking this medication? Yes ☐ No ☐

	Yes	No
❽ Have you had any other treatment for this condition (e.g. physiotherapy, operation, alternative remedies)?	☐	☐
❾ Have you had any diagnostic investigations (e.g. scope, scan, x-rays, EEG, ECG etc)?	☐	☐
❿ Have you ever been in hospital or received emergency treatment for anything related to this condition?	☐	☐
⓫ Have you seen a doctor or other therapist for anything related to this condition? If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.	☐	☐

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

⓬ Has further treatment been recommended for this condition? Yes ☐ No ☐

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

⓭ Does your usual doctor have details of this condition? Yes ☐ No ☐

If **'No'**, provide name and address of doctor who has full details.

Continued on page 11

K. MENTAL HEALTH QUESTIONNAIRE

1 Please indicate the condition(s) you have had or received treatment for.

- ☐ Anxiety including generalised anxiety, panic or phobic disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression or mild depression
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenic or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic fatigue
- ☐ Other (Please specify)

2 Describe your symptoms including the date started and how long they lasted.

Symptoms	Date from	Date to
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

3 A Has any reason for your condition been identified or are there any factors which trigger your condition?

B Have you ever had suicidal thoughts or attempted suicide? Yes ☐ No ☐

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

4 A Date symptoms commenced.

☐☐/☐☐/☐☐☐☐

B Date of last symptoms.

☐☐/☐☐/☐☐☐☐

C Have you had any recurrences of this condition? Yes ☐ No ☐

If **'Yes'**, how many times?

when

☐☐/☐☐/☐☐☐☐

5 A Please advise all treatments you have received and/or are receiving, including counselling, name(s) of medications, hospitalisation etc.

Type of treatment	Date commenced	Date ceased
	/ /	/ /
	/ /	/ /
	/ /	/ /

B Are you currently receiving treatment? Yes ☐ No ☐

C If 'Yes', please provide details.

6 Please provide details of doctors or health professionals, including psychiatrists and psychologists, consulted for your condition.

Name and address	Date first consulted	Date last consulted
	/ /	/ /
	/ /	/ /
	/ /	/ /

7 Have you ever been off work or your normal daily activities restricted in any way due to your condition? Yes ☐ No ☐

If **'Yes'**, when and how long?

8 Have you any ongoing effects or restriction to your activities of any kind due to your condition? Yes ☐ No ☐

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

L. SPINAL/JOINTS DISORDER QUESTIONNAIRE

1 Area of spine (e.g. neck, upper or lower back) and/or joints affected (e.g. left knee, right hip, shoulders, elbows etc).

2 Please state the precise diagnosis.

3 When did symptoms first occur?

☐☐/☐☐/☐☐☐☐

4 A What was the cause?

Continued on page 12

Ⓑ Please describe your symptoms.

Ⓒ Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? Yes ☐ No ☐

Ⓓ State frequency and severity of attacks/symptoms prior to treatment.

5 Ⓐ Are you still experiencing symptoms? Yes ☐ No ☐

If 'No', date of last experienced symptoms.

☐☐/☐☐/☐☐☐☐

Ⓑ If 'Yes', how frequently have symptoms occurred since commencing treatment?

Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

6 Ⓐ What is the nature of the treatment (e.g. medication, physiotherapy, exercise, etc)?

Ⓑ Are you still receiving treatment? Yes ☐ No ☐

(i) If **'No'**, when did you cease treatment?

☐☐/☐☐/☐☐☐☐

(ii) If **'Yes'**, how often do you attend for follow-up

and date of last consultation?

☐☐/☐☐/☐☐☐☐

Ⓒ Name and address of doctor or therapist consulted.

7 Have you had any x-rays or other investigations or have you ever consulted a specialist for this condition? Yes ☐ No ☐

If **'Yes'**, please provide date(s) and full details including names of hospital and consultant/surgeon.

8 Have you had an operation for this condition or is an operation being considered? Yes ☐ No ☐

If **'Yes'**, please provide date(s) and full details including names of hospital and consultant/surgeon.

9 Ⓐ Have you ever been off work due to your symptoms? Yes ☐ No ☐

If **'Yes'**, when and for how long?

Ⓑ Are your occupation duties restricted in any way? Yes ☐ No ☐

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

Ⓒ Is it necessary to avoid lifting or to restrict your daily activities in any way? Yes ☐ No ☐

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

M. DECLARATION

- I declare that the information I provided in this Personal Statement (whether written in my hand or not) is true and correct and that no information material to the insurance has been withheld.
- I agree that any personal statements made (including this one) together with any relevant supporting documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.
- I also understand that my duty to disclose continues after I have completed the insurance application until AIA Australia has accepted the risk. I understand AIA Australia may cancel the cover from inception or provide cover on amended terms if I do not comply with my duty of disclosure.
- I consent to AIA Australia collecting sensitive information, i.e. health information about me, for the purpose of the performance of this contract.
- I agree that cover will not commence until the premium is paid and AIA Australia has accepted the risk.
- I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy section of this form and the AIA Australia Privacy Policy available at aia.com.au as updated from time to time, including the exchange with third parties located in Australia and overseas. I agree that any personal and sensitive information AIA Australia holds will be governed by the most current Privacy Policy on AIA Australia's website.

I confirm the Declarations are true and accurate.

Signature

Date (dd/mm/yy) / /

N. AUTHORITY TO RELEASE MEDICAL INFORMATION

I, (Name of Life Insured)

authorise any medical practitioner, hospital, clinic or other person (including any life insurance company or underwriter), to disclose to AIA Australia Limited, full details of my health and medical history. I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Signature of Life Insured

Date (dd/mm/yy) / /

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O. PRIVACY

Your privacy is important to us. The AIA Australia Privacy Policy sets out how your personal information (including sensitive information) is collected, used, handled and disclosed by us, and other important information. AIA Australia's current Privacy Policy is available at aia.com.au or by calling 1800 333 613. In summary, for the purposes set out in AIA Australia's Privacy Policy (including for the purposes of administering, assessing or processing your insurance or any claim) AIA Australia may:

- collect personal and sensitive information from you, including from application forms or other information submitted in respect of your insurance, or when interacting with you (including online);
- collect your personal and sensitive information from, and provide to, third parties in Australia and overseas, such as your financial adviser, employers, health professionals, reinsurers, government agencies, service providers and affiliates;
- be required or authorised to collect your personal and sensitive information under various laws including insurance, taxation, financial services and other laws set out in the AIA Australia Privacy Policy; and
- disclose personal and sensitive information to third parties which may be located in Australia, South Africa, the US, Europe, Asia and other countries including those set out in our Privacy Policy.

If you do not provide the required personal and sensitive information, AIA Australia may not be able to provide insurance or other services to you. Information about how to access or correct your personal information held by AIA Australia or lodge a privacy-related complaint is set out in AIA Australia's privacy policy.