



AustSafe Super

INDUSTRY

Personal Statement

IMPORTANT: Please carefully read the information in the Industry Member Guide (Product Disclosure Statement (PDS)) before completing this form.

A – Your details

Membership number	Surname	Given name/s	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name of Superannuation fund		Employer	
<input type="text" value="AustSafe Super"/>		<input type="text"/>	
Salary or yearly remuneration		Occupation	
<input type="text"/>		<input type="text"/>	

B – Short Personal Statement

	Tick (✓) no or yes
1 Will your total Death only or Death and Total and Permanent Disablement (TPD) (automatic cover plus any additional units) exceed \$800,000 if this application is accepted?	No <input type="checkbox"/> Yes <input type="checkbox"/>
2 Will your total cover for income protection under this scheme exceed \$6,000 per month if this application is accepted?	No <input type="checkbox"/> Yes <input type="checkbox"/>
If you answer 'Yes' to any or both of the two questions above or any of the Questions 3 to 12 below, please do not continue completing this section. Instead, proceed to Sections C – J (Full Personal Statement)	
3 Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?	No <input type="checkbox"/> Yes <input type="checkbox"/>
4 Are you claiming or have you ever claimed a benefit from any source, eg. TPD benefit from any superannuation fund, worker's compensation, disability pension, Veterans' Affairs pension or any other insurance policy providing accident or sickness benefits?	No <input type="checkbox"/> Yes <input type="checkbox"/>
5 Are you at the date of this application, due to injury, accident or illness:	
• off work?	No <input type="checkbox"/> Yes <input type="checkbox"/>
• restricted from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours per week), even though your actual employment can be on a full-time, part-time or casual basis?	No <input type="checkbox"/> Yes <input type="checkbox"/>
6 Have you lost the sight of an eye or the total and permanent loss of the use of a limb ('limb' includes whole hand or whole foot)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
7 Please provide the following details: Height <input type="text"/> cm and Weight <input type="text"/> kg	
8 Excluding the contraceptive pill and inhaled asthma medication, have you been advised to take, or been given prescribed medication by a medical practitioner that has intended to be used for three months or longer within the last year (including but not limited to blood pressure, diabetes, oral steroids for asthma or depression medication)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
9 Have you been unable to work because of sickness or injury for more than two consecutive weeks in the last three years?	No <input type="checkbox"/> Yes <input type="checkbox"/>
10 Have you undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any illness or injury that would affect your long-term health and require ongoing medical supervision. This includes, but is not limited to:	
• cancer or diabetes	
• high blood pressure, cholesterol or any heart complaint	
• alcohol or drug abuse	
• stroke, paralysis, neurological disorder or multiple sclerosis	No <input type="checkbox"/> Yes <input type="checkbox"/>
11 Have you been infected with, or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or hepatitis B and C?	No <input type="checkbox"/> Yes <input type="checkbox"/>
12 Have you received any medical advice, or undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery, for any of the following:	
• Any injury or complaint of the back, neck, knee or shoulder requiring time off work in the last twelve months and/or any disease, disorder or degeneration to the muscles, tendons, bones, discs or joints?	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post traumatic stress, behavioural or nervous disorder)?	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Chest pain, asthma, bronchitis or any other lung complaint requiring hospitalisation within the last five years?	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Disorders of the kidney, bladder, prostate, ovaries, gall bladder, bowel, or liver?	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Epilepsy?	No <input type="checkbox"/> Yes <input type="checkbox"/>

IMPORTANT

Have you answered 'Yes' to any of the questions in Section B (1–12)?

No **Go straight to Section K. Do not complete Sections C – J**Yes **Continue to Section C. Complete all Sections C – J****Please note:** Section L needs to be completed in all circumstances.**C – Insurance history details (Full Personal Statement)****1** Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?No Yes **Please provide details below**

Fund or insurance company name	Date commenced	Terms offered and reason
	/ /	
	/ /	

2 Are you claiming or have you ever claimed a benefit from any source, eg. TPD benefit from any superannuation fund, workers compensation, disability pension, Veterans' Affairs pension or any other insurance policy providing accident or sickness benefits?No Yes **Please provide details below**

Benefit type/source/reason for claim	Claim date	Claim amount	Date claim finalised
	/ /	\$	/ /
	/ /	\$	/ /

D – Activities and pastimes (Full Personal Statement)**1** Do you currently engage in, or intend to engage in, any of the following sports or hazardous activities:

Tick (✓) no or yes

• Flying (other than as a fare paying passenger on a commercial airline)?

No Yes

• Underwater diving?

No Yes

• Motor sports of any kind, eg. rally driving, trail bike riding, ocean racing?

No Yes

• Football of any code (including touch football or tag)?

No Yes

• Any other sport or hazardous activities, eg. parachuting, hang-gliding, body contact sports, paragliding, competitive water sports or recreations involving heights?

No Yes **If you have answered 'Yes' to any of the above questions, please answer the question below**

What are the activity/ies you engage in?

Tick (✓) the appropriate box

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

At what level do you participate?

Number of times you participate on average in this activity/ies per annum (eg. hours flown, number of drives, events etc.)

Tick (✓) no or yes

Do you receive income from participating in this activity/ies?

No Yes **E – Personal health details (Full Personal Statement)****1** What is your height and current weight?**Height** cm**Weight** kg

E – Personal health details (Full Personal Statement) continued

2 Have you smoked tobacco, or any other substance, at any time during the last twelve months?

No

Yes Please indicate type (eg. cigarettes, cigars, etc.) and average amount smoked below

Substance smoked	Per day	Per week	Per year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3 Do you drink alcohol?

No

Yes Please provide the average number of drinks consumed

If 'Yes', please provide the average number of drinks consumed in one of the following boxes

Per day	Per week	Per year
<input type="text"/>	<input type="text"/>	<input type="text"/>

F – Family history (Full Personal Statement)

Have any of your immediate family (i.e. parents, brothers, sisters) suffered from or been diagnosed with any of the following?

- Heart problems, stroke, high blood pressure, diabetes;
- cancer (breast, ovarian, cervical, bowel or other)
- depression or any mental illness

hereditary disorders such as

- Huntington's disease, muscular dystrophy, polycystic kidney, familial polyposis;
- any other inherited or hereditary disease.

Unknown

No Go to Section G

Yes Complete the following table

Family member	Condition	Approximate age at onset	Age at death (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

G - Doctor details (Full Personal Statement)

1 What is the name and address of the last doctor or medical centre you visited?

Full name of doctor

Phone number

()

Facsimile number

()

Address

State Postcode

2 a What was the date of your last consultation? (please tick (✓) the appropriate box)

Within the last month

1 – 3 months ago

4 – 6 months ago

7 – 12 months ago

13 months to 2 years ago

Over 2 years ago

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

c What was the result/outcome from your last consultation? (please tick (✓) the appropriate box)

Referral to specialist/health professional

Tests conducted – results pending

Not fully recovered yet

Ongoing treatment (eg. ventolin inhaler)

Routine tests conducted – results all clear/normal

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?

No Yes

H – Lifestyle declaration (Full Personal Statement)

To the best of your knowledge, is there any possibility that you have ever been infected with, or have you ever tested positive for, AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or hepatitis, or are you in a high-risk category (eg. injected drugs other than as prescribed by a medical practitioner, shared needles, engaged in unprotected male to male sexual intercourse, worked as or, engaged the services of a prostitute)?

No

Yes **Please provide details below**

Please note: If you answered 'Yes' to the declaration above, you will be asked to complete a **Specific lifestyle questionnaire**.

I – Medical history (Full Personal Statement)

Have you ever had, or sought advice or treatment, experienced symptoms, or suffered from any of the following:

- | | | | |
|---|--|----------------------------------|------------------------------|
| 1 | Asthma, bronchitis or any other lung complaint? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 2 | Cysts, moles, sunspots or skin lesions? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 3 | Diabetes or abnormal blood sugar? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 4 | Back, neck, shoulder, knee, elbow complaints , sciatica, disc or spine complaints, or injury of the joints, bones or muscles? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 5 | Depression or mental disorder (including but not limited to stress, anxiety, panic attacks, behavioural or nervous disorder)? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 6 | Chest pains, heart complaint, heart murmur, high blood pressure, raised cholesterol, palpitations or rheumatic fever? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 7 | Stroke, paralysis, neurological disorder, multiple sclerosis or blood vessel disorder? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 8 | Cancer, tumour or melanoma? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 9 | Thyroid, glandular or pancreatic disorder? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 10 | Gastric or duodenal ulcer, persistent indigestion, irritable bowel or other bowel disorder? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 11 | Any disorder of the gall bladder or liver (including hepatitis B, C or raised liver function)? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 12 | Varicose veins, haemorrhoids or hernia? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 13 | Disorder of the kidney, bladder or prostate, blood in urine or kidney stones? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 14 | Epilepsy, fits of any kind, fainting episodes, or recurring headaches or migraines? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 15 | Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 16 | Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 17 | Eczema, dermatitis, psoriasis, or any other skin disorder? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 18 | Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 19 | Any impairment of sight (other than corrected by glasses or lenses) or blurred vision? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 20 | Any impairment of hearing, including tinnitus, or speech? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 21 | Any sexually transmitted diseases? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 22 | Any other illness, injury, disease or disorder not mentioned above? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 23 | Other than those conditions mentioned above, are you taking any regular prescribed medication (excluding contraceptives)? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 24 | Within the last three years, have you had: <ul style="list-style-type: none">Any blood tests which revealed an abnormality?Any tests such as ECG, X-ray (excluding broken bones or joint strains), genetic test or ultrasound (other than for pregnancy)? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 25 | Are you considering seeking medical advice, treatment, tests or surgery in the future? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Questions 26 and 27 are for females only | | | |
| 26 | Are you currently pregnant? <ul style="list-style-type: none">If yes: due date for birth of baby? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| | | <input type="text" value="/ /"/> | |
| 27 | Have you ever had any complications with pregnancy or childbirth (eg. diabetes, ectopic pregnancy)? <ul style="list-style-type: none">If yes: please provide details below | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <input type="text"/> | | | |

Please note:

- If you have answered 'Yes' to Question 1 to 5 above, we will ask you to complete a **Specific questionnaire** on the related condition.
- If you answered 'Yes' to question 6 to 25 above, please provide full details in **Section J – General health questionnaire on page 5**.

J - General health questionnaire (Full Personal Statement)

If you have answered 'Yes' to any part of questions 6 to 25 in **Section I**, please complete the table below.
Please ensure you write the question number in the brackets above each column.

	Question ()	Question ()	Question ()	
1	Name of condition	1.	2.	3.
2	Date symptoms first started	/ /	/ /	/ /
3	Date symptoms ceased (if applicable)	/ /	/ /	/ /
4	Are these symptoms ongoing	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
5	How often do/did you have symptoms? Please choose one of the following: daily, weekly, monthly, quarterly, half yearly, yearly, one off, other (please specify)			
6	Severity of condition Please choose from one of the following: mild, moderate, severe, never had symptoms, symptoms ceased			
7	Did you take medication or have you had any other treatment (eg. physiotherapy or an operation) for this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
	If 'Yes', name the treatment/condition			
8	Are you still on treatment, including medication?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
9	Have you ever been off work due to this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
	If 'Yes', provide details. If there is insufficient space please attach an additional sheet			
10	If 'Yes', also state the total time off work in days, months and years	days months years	days month years	days months years
11	Have you had any residual, ongoing effects or restrictions as a result of this condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
	If 'Yes', please provide details and dates			
		/ /	/ /	/ /

K – Duty of disclosure

Your Duty Of Disclosure

Before you enter into, or become insured, under 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, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate your 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 or
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your Duty of disclosure and the insurer would not have covered you on any terms if the failure had not occurred, the insurer may avoid the cover within three years of issuing it. If your non-disclosure is fraudulent, the insurer may avoid your cover at any time.

An insurer who is entitled to avoid your cover may, within three years of issuing it, may 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.

L – Declaration

This section must be completed in all circumstances.

I have read the Duty of disclosure in this Personal Statement 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 by The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 (CMLA) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports 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 CMLA any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.

I declare that:

- the answers to all the questions and the declarations on this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect CMLA's decision to provide insurance.

I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance.

I have read and understood the Privacy Section of the PDS. I acknowledge and consent to the use and disclosures of my personal information as detailed in that section.

A photocopy of this authorisation is as valid as the original. I agree to provide further medical authorities if requested.

I have read and understand the obligations outlined in the Duty of Disclosure in Section K above.

Full name

Signature of life to be insured

Date