ESUPERFUND SMSF Master Insurance Plan

Full Personal Statement

Policy Ref No.
(Office use only)

Australian Group Insurances

SMSF Provider Code:

Member No:
(Office use only)

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty applies to a new contract of insurance and also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. There are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984 (Cth)*. These are intended to put us in the position we would have been in if the duty had been met. Your cover could be avoided (treated as if it never existed), or its terms may be varied. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made. Before we exercise any of these remedies, we will explain our reasons and what you can do if you disagree.

About this application

The life insurance policy being applied for with this application is a consumer insurance contract within the meaning of the *Insurance Contracts Act 1984 (Cth)*. When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so, on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

Guidance for answering our questions

You are responsible for the information provided to us. When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted.

If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

If you need help

It's important that you understand this information and the questions we ask. Ask us or a person you trust, such as your adviser for help if you have difficulty understanding the process of buying insurance or answering our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help. If you want, you can have a support person you trust with you.

Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please contact us immediately and we'll let you know whether it has any impact on the cover.

A. Life Insured (Life insured to complete this section in full.)

1. Name — Title | Surname | Given Name

2. Date of Birth (dd/mm/yy)

3. Gender at Birth ☐ Male ☐ Female

4. Residential Address — No. | Street

Suburb | State | Postcode

5. Mailing Address (if different to above)

Suburb | State | Postcode

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 – 5pm

6. Contact Details — Phone (home) | Phone (work) | Mobile

E-mail

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Send your completed form to AGI at smsf@agigroup.com.au

The ESUPERFUND SMSF Master Insurance Plan is distributed and administered by
Australian Group Insurances Pty Ltd (AGI) ABN 97 140 572 434 AFSL 379565
Product Issuer: AIA Australia Limited ABN 79 004 837 861 AFSL 230043

A. Life Insured (continued) (Life insured to complete this section in full.)

7. 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 Home Affairs)? ..... 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 and expiry date.

B. Self Managed Superannuation Fund Details

Name of your Self Managed Superannuation Fund

ABN

Trustee Type

Name of Corporate Trustee *(if applicable)*

Trustee's Postal Address

Suburb State Postcode

C. Type of Insurance

Is this a new application for insurance or an application to increase your existing insurance cover with the ESUPERFUND SMSF Master Insurance Plan? ☐ New ☐ Increase

Cover	**Sum Insured**
Death	$

Total & Permanent Disablement (TPD)

TPD Cover	$

Income Protection (IP)

Income Protection cover (per month) (minimum $1,000, maximum $30,000)	$	(limited to 75% of your monthly Income)
Superannuation contribution benefit	%	What % of your cover represents the super contribution component?

Benefit Period ☐ 2 years (to age 65 if earlier) ☐ 5 years (to age 65 if earlier) ☐ To Age 65

Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days

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D. 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)? If 'Yes', please complete policy details below..... Yes ☐ No ☐

Policy Number	Commencing Date	Policy Owner	Insurer	Type of Cover	Amount of Cover	Existing Income Protection: Waiting Period/ Benefit Period	To Be Replaced 'Y' or 'N'

If you are intending to replace any existing cover that you hold as part of making this application, you should not cancel your existing cover until we have confirmed that we have accepted your application. If we don't accept this application, it could mean you have no cover.

The general risks of replacing life insurance cover may include but are not limited to:
- implications of any errors or omissions in your new application
- your existing policy containing differing terms, conditions, features and/or benefits to a new policy (e.g. waiting periods and qualifying periods restarting).

This information is general only and you should seek financial advice about the risks of replacing your policy to receive information that is specific to your circumstances.

(b) Have you **ever** been declined, deferred or accepted on special terms for life, disability or trauma insurance? ..... Yes ☐ No ☐

(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. ..... Yes ☐ No ☐

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

2. (a) In the last 12 months, have you smoked tobacco or any other substance such as cigarettes, cigars, pipes or used e-cigarettes or other nicotine products?..... Yes ☐ No ☐
If 'Yes', please state substance and daily quantity below. (Please note 'packet' is not sufficient detail.)

(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. (a) What is your height? ____ cm (b) What is your weight? ____ kg

4. Do you have definite plans to travel or reside overseas? If 'Yes', please state:..... Yes ☐ No ☐

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 and oztag), 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 I** (Aviation or Activities/Pursuits Questionnaire).

D. Personal History (continued) (Life insured to complete this section in full.)

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 heart disease, breast cancer, ovarian cancer, colon (bowel) cancer, polycystic kidney disease, diabetes, stroke, Huntington's chorea or any hereditary disease? You are only required to disclose family history information pertaining to first degree blood related family members. If 'Yes', please provide details in the table below. ..... Yes ☐ No ☐

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

Sexual Health

7. (a) In the last 5 years, have you had sexual intercourse **without** a condom with the following persons?

(i) Someone who might have exposed you to the Human Immunodeficiency Virus (HIV) infection ..... Yes ☐ No ☐
(This may include unprotected sexual intercourse with someone other than your regular partner whose HIV status is unknown to you.)

(ii) Someone who injects non-prescribed drugs ..... Yes ☐ No ☐

(iii) Someone who is a sex worker ..... Yes ☐ No ☐

(iv) Someone who is infected with Human Immunodeficiency Virus (HIV) infection ..... Yes ☐ No ☐

(v) Someone who is infected with Hepatitis B ..... Yes ☐ No ☐
(You may answer 'No' if you are vaccinated and have immunity for Hepatitis B.)

(vi) Someone who is infected with Hepatitis C ..... Yes ☐ No ☐

(b) In the last 5 years, have you been diagnosed with or experienced symptoms of Sexually Transmitted Infection/s (STIs) (examples, chlamydia, gonorrhoea, syphilis)? ..... Yes ☐ No ☐

Remainder of this page has been left intentionally blank.

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E. 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?

(a) High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke. ☐ Yes ☐ No
If 'Yes', please complete Section J – **High Blood Pressure/High Cholesterol Questionnaire**.

(b) Asthma, chronic lung disease, sleep apnoea, COVID-19 or other respiratory disorder. ☐ Yes ☐ No
If 'Yes', please complete Section K – **Asthma Questionnaire**.

(c) Indigestion, gastric or duodenal ulcer or any bowel disorder. ☐ Yes ☐ No
If 'Yes', please complete Section L – **Multi-Purpose Questionnaire**.

(d) Depression, anxiety/stress state, fatigue (including chronic fatigue syndrome), panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder. ☐ Yes ☐ No
If 'Yes', please complete Section M – **Mental Health Questionnaire**.

(e) Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness or recurrent headaches or any neurological disorder including multiple sclerosis. ☐ Yes ☐ No
If 'Yes', please complete Section L – **Multi-Purpose Questionnaire**.

(f) Arthritis, repetitive strain injury (RSI), fibromyalgia. ☐ Yes ☐ No
If 'Yes', please complete Section L – **Multi-Purpose Questionnaire**.

(g) Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles. ☐ Yes ☐ No
If 'Yes', please complete Section N – **Spinal/Joints Disorder Questionnaire**.

(h) Psoriasis or eczema, skin disorder, defect in hearing or sight. ☐ Yes ☐ No
If 'Yes', please complete Section L – **Multi-Purpose Questionnaire**.

(i) Diabetes, abnormal blood sugar, gout or thyroid disorder. ☐ Yes ☐ No
If 'Yes', please complete Section L – **Multi-Purpose Questionnaire**.

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

(j) Cancer, cyst, lump, tumour or growth of any kind including skin cancer such as melanoma, BCC, SCC (basal cell or squamous cell carcinoma) or skin lesions/moles that have changed in shape, colour or size.. ☐ Yes ☐ No

(k) Liver disorder (including fatty liver), pancreas, prostate, kidney or bladder disorder, renal colic or stone. ☐ Yes ☐ No

(l) Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia. ☐ Yes ☐ No

(m) Hepatitis B or C or are a Hepatitis B or C carrier, Acquired Immune Deficiency Syndrome (AIDS) sufferer or infected with the HIV virus. ☐ Yes ☐ No

Females only

(n) Are you pregnant? If 'Yes', please provide estimated date child is due. ……/……/…… ☐ Yes ☐ No

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

(o) Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound? ☐ Yes ☐ No

(p) An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries? ☐ Yes ☐ No

(q) Abnormal vaginal bleeding within the last 12 months or endometriosis? ☐ Yes ☐ No

2. Have you ever suffered symptoms of or had any other illness, disease or disorder? ☐ Yes ☐ No

3. In the last 5 years have you:

(a) Had any medical examinations, consultations, X-rays, pathology tests or procedures? ☐ Yes ☐ No

(b) Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? ☐ Yes ☐ No

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

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

For each 'Yes' answer in questions 1j–1q, 2, 3, 4 and 5 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)

. . . *continued* ☞

F. Doctor's Details (Life insured to complete this section in full.)

1. (a) Details of your personal doctor.
IF NO PERSONAL DOCTOR, PLEASE STATE NAME/ADDRESS OF LAST DOCTOR OR MEDICAL CENTRE YOU ATTENDED.

Name:		
Address:		Postcode
Phone ( )	Fax ( )	Email (if known)

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

(c) How long have you been attending the surgery/practice?

G. Present Occupation (Life insured to complete this section in full)

1. (a) What is your usual occupation?

(b) Do you perform any manual work? If 'Yes', please describe duties and percentage of time spent in each..... Yes ☐ No ☐

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

2. What is your annual income? $

3. Employer:
Hours currently working per week
☐ Zero ☐ 1–14 hours ☐ 15–60 hours ☐ >60 hours

. . . *continued* ☞

H. Further Income Details (Complete only if Income Protection is required)

1. a) Please state your monthly Income from your current occupation (net of business expenses but before tax)?
DO NOT INCLUDE INVESTMENTS AND MANDATORY SUPERANNUATION.

- **SELF EMPLOYED**
  Means the Income generated from the business due to your personal exertion or activities for the last 12 months less your share of necessarily incurred business expenses for the last 12 months. Income does not include unearned income such as dividends, interest, rental income or proceeds from the sale of assets but does include ongoing regular bonuses, regular management fees and regular commissions. Bonuses and commissions will be calculated based on the average of the last three years bonuses and commissions.
- **EMPLOYED**
  Means your pre-tax Income paid to you by an employer including salary, fees, regular bonuses, regular commissions, regular overtime, fringe benefits and salary sacrificed superannuation contributions but excluding mandatory superannuation contributions and unearned income (e.g. investment or interest income). Bonuses, overtime earnings and commissions will be calculated based on the average of the last three years received by you from an employer.

Principal Occupation: Current Year $ _____ per month Previous Year $ _____ per month

b) How long have you been at your current occupation? _____ years _____ months

c) How much of the above Income will continue if you are disabled? $ _____

i) For how long? _____ years/months

ii) State source of Income (e.g. sick leave, director's fees, Income Protection insurance, profit share from the business)

_____

2. If you become disabled, would you receive Income from **other** sources? ☐ Yes ☐ No

If YES:

a) How much? $ _____ per month

b) For how long? _____ years/months

c) State source of Income _____

3. Do you also perform another occupation? ☐ Yes ☐ No If YES, describe the daily duties of this occupation (including manual work)

_____

4. Do you contemplate or expect any change in occupation (including retrenchments/ redundancy or changes in your role or duties or working hours)? ☐ Yes ☐ No
If YES, please provide details including when, reason(s) etc.

_____

5. Do you receive any unearned Income? ☐ Yes ☐ No If YES, how much? $ _____ per month
(e.g. from investments such as rental property or dividends)?

6. What was your previous occupation? _____

7. Are you self-employed or employed by your own company? ☐ Yes ☐ No

If YES:

a) Date your business started _____

b) How long have you been self-employed? _____ years/months

c) What percentage of your work is: i) Freelance? _____ % ii) Contract? _____ %

d) How many people do you employ? _____

8. Has your business or practice had a net operating loss in the last 2 years? ☐ Yes ☐ No
If YES, please provide copies of Profit & Loss Statements for the last 2 years.

9. Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? ☐ Yes ☐ No

If YES, when _____ Date of discharge _____

10. Do you earn commission or bonuses? ☐ Yes ☐ No If YES, state percentage of total Income _____ %

. . . continued ☞

If you have answered 'Yes' to Section E, question 1a–1i, please also complete a questionnaire for each condition (see Sections J to N).

Questionnaires (Life insured to complete – may be photocopied for additional activities/pursuits.)

I. Aviation Questionnaire

1. Please state the number of hours flown where applicable:

(a) **Private flying**

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

(b) **Commercial flying** (excluding large mainstream carriers, eg. Qantas)

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

(c) **Agricultural flying**

Type of Aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed Wing				
Rotary				
Other (eg. 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.
(ii) Is the aircraft serviced and maintained in Australia? If 'No', where is the aircraft serviced? ☐ Yes ☐ No

4. Do you fly or intend to fly outside Australia? If 'Yes', please provide details. ☐ Yes ☐ No

5. Do you participate in or intend to participate in any flying activities such as aerobatics, stunt flying or exhibitions? If 'Yes', please provide details. ☐ Yes ☐ No

6. Have you ever been involved in any aviation accidents? If 'Yes', please provide details. ☐ Yes ☐ No

I. 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 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 details.

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J. 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-ray, urine test 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:

(i) Eye disorder (other than short/long sightedness) ☐ Yes ☐ No

(ii) Symptoms or disorder relating to heart or circulatory system ☐ Yes ☐ No

(iii) Kidney disorder or protein in urine ☐ Yes ☐ No

(iv) Dizziness, fainting episodes or stroke ☐ Yes ☐ No

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 (eg. xray, pathology, ultrasound, etc) you may have.

K. Asthma Questionnaire

1. Date asthma first diagnosed. / /

2. How often do you experience symptoms?
eg. 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?
eg. 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

(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.

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Questionnaires (continued) (Life insured to complete – may be photocopied for additional conditions.)

L. 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

8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No

9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No

10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No

11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
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.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
If 'Yes', please provide details.

13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
If 'No', provide name and address of doctor who has full details.

L. 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

8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No

9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No

10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No

11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
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.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
If 'Yes', please provide details.

13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
If 'No', provide name and address of doctor who has full details.

. . . continued ☞

Questionnaires (continued) (Life insured to complete – may be photocopied for additional conditions.)

M. 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? If 'Yes', please provide details. ☐ Yes ☐ No

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.

N. Spinal/Joints Disorder Questionnaire

1. Area of spine (eg. neck, upper or lower back) and/or joints affected (eg. 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?

(b) Please describe your symptoms.

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

(d) State frequency and severity of attacks/symptoms prior to treatment.

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

(a) If 'No', date of last experienced symptoms. / /

(b) If 'Yes', how frequently have symptoms occurred since commencing treatment?
☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

6. (a) What is the nature of the treatment (eg. medication, physiotherapy, exercise, etc)?

(b) 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?

(c) 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 type of investigations, results and name of doctor.

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. (a) Have you ever been off work due to your symptoms? If 'Yes', when and for how long? ☐ Yes ☐ No

(b) Are your occupation duties restricted in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

(c) Is it necessary to avoid lifting or to restrict your daily activities in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

. . . *continued* ☞

O. Privacy

Personal and sensitive information provided will be handled in the manner described in the AIA Australia Group Privacy Policy and AGI Privacy Policies as updated from time to time, accessible by visiting www.aia.com.au and www.agigroup.com.au respectively.

AIA Australia and AGI handles and collects personal and sensitive information for purposes which include the administration of your policy or claim, the provision of products and services, our business operations and other purposes set out in the respective Privacy Policies.

By providing information to us or your adviser (and the licensed dealer or broker they represent), the trustee or administrator of a superannuation fund, or other representative or intermediary, or by continuing your relationship and otherwise interacting with us, you confirm that you have been notified of the matters and consent to the collection, use, disclosure and handling of personal and sensitive information as described in the Privacy Policies as updated from time to time on the websites listed above.

We rely on the accuracy of the personal information provided to us. If any of your personal information reflected in this form or any of the attachments are incorrect, out of date or incomplete, please call us on 1800 333 610 and we can take reasonable steps to correct the personal information. Where you provide personal and sensitive information about someone else, you must have their consent to provide their information to us in the manner described in both AIA Australia's and AGI Privacy Policies.

P. Declaration

I, the trustee or the corporate trustee of the above named superannuation fund, request AIA Australia to issue the insurance cover under the Policy described in this form.

I agree to be bound by the terms and conditions of the policy document and the trust deed governing the superannuation fund.

I confirm that I have the power under the trust deed and/or constitution of the company governing the superannuation fund to effect cover under the Policy described on this form.

I agree that no benefit will be paid under this Policy in any circumstances if I make the application on behalf of another person.

I am a Permanent Resident of Australia and want to be covered under this Policy of insurance.

I have read and understood the ESUPERFUND SMSF Master Insurance Plan Product Disclosure Statement (PDS) in conjunction with this application and agree to be bound by its terms.

I have read and understood my duty to take reasonable care and I declare that all the information provided is true and correct and complete and I have not withheld or omitted any information relevant to this application for insurance. I also understand that my duty to take reasonable care continues after I have completed this application until AIA Australia has accepted the risk.

I have read and understood the Privacy Policies of AIA Australia and AGI and consent to the collection, use and disclosure of personal and sensitive information in accordance with the Privacy Policies as updated from time to time, including exchange with third parties located in Australia and overseas.

I understand that after I receive the first Policy Insurance Certificate from AGI, I have a 28-day cooling off period in which I may cancel the insurance by notifying AGI in writing and returning the Policy Insurance Certificate and I will receive a full premium refund (unless a claim has been or could be made under the Policy).

I have read and considered the PDS in making my decision to apply for this insurance. I have not received any personal advice from AGI in relation to my application for insurance or whether the insurance is right for my personal objectives, financial situation or needs.

I understand that cover will not commence until my application is accepted by AIA Australia.

I consent to AIA Australia and AGI communicating electronically with me about my cover under the Policy as described in the current PDS. In providing this consent, I nominate and authorise AIA Australia and AGI to act on instructions it has received electronically. This consent and authority will apply to all communications permitted to take place electronically by law (including any applicable industry Code or Code of Conduct) including but not limited to (a) statements of my cover under the Policy; (b) notices and other documents received by me about my cover under the Policy; (c) variations to the contract relating to my cover under the Policy; and (d) notices from me to AIA Australia or AGI. Any such communication is to be made to the nominated address in my personal capacity, and with respect to any communication to the Trustee of the superannuation fund that are permitted to be communicated electronically.

Yes, I have read and agree to the above declaration: ☐

. . . continued ☞

Authority to Release Health Information

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, (**AIA Australia**), collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **AIA Australia**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **AIA Australia** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **AIA Australia** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **AIA Australia** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature:

✗

Date:

Authority 2

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **AIA Australia**, or to third parties they engage, only if **AIA Australia** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **AIA Australia** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **AIA Australia** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature:

✗

Date:

☐ I/We authorise and consent to any life insurance company disclosing to AIA Australia personal and sensitive information about me/us with regard to previous or current applications for insurance cover or claims made under other insurance cover which may include details of my/our health and medical history.