Resolution Life

RLA Personal Super Plan

Insurance fact sheet

The information provided in this fact sheet is for customers applying for new insurance cover

RLA Personal Super Plan (the 'fund') offers the following types of insurance cover:

- Life insurance
- Total and Permanent Disablement (TPD) insurance
- Income Protection

Under the RLA Personal Super Plan, insurance is issued and underwritten by Resolution Life Australasia Limited (the insurer).

The following combinations of insurance cover are available under the RLA Personal Super Plan:

- Life insurance
- Life insurance and TPD insurance
- Life insurance and TPD insurance and Income Protection
- Life insurance and Income Protection

Who is the owner of the policy?

The policy is owned by the trustee of the National Mutual Retirement Fund, Equity Trustees Superannuation Limited (trustee). If a claim is admitted, the insurer will pay the insured amount to the trustee. Then, subject to legislative requirements having being met, the trustee will pay the benefits to:

Life insurance

- your dependants, your legal personal representative, or
- to you on terminal illness

TPD insurance and Income Protection

- you

Benefits

Life insurance

The insurer will pay a lump sum amount equal to the sum insured if you:

- die while this cover is in force, or
- are terminally ill with 12 months or less to live and request a payment.

The insurer pays any claims it admits under the policy to the trustee. On receipt of a death certificate, your investment will be transferred to the Cash investment portfolio. The amount payable is the sum insured, which is noted in your insurance schedule, plus investment held in the Cash investment portfolio.

The minimum sum insured is $50,000 and the minimum premium is $200 per annum. To add insurance to your plan, you require a minimum account balance of $2,000.

The maximum sum insured you can apply for is $5 million or $500,000 for an earning spouse. An earning spouse means a spouse who is in paid employment and works for a minimum average of 10 hours per week.

Under the Life Insurance policy the entry ages are 15 to 65 next birthday, with the cover renewable to age 70.

Terminal illness

If you are diagnosed with a terminal illness and given 12 months or less to live, the insurer will pay an advance payment of the sum insured, up to a maximum of $2 million (from all cover held with the insurer). Any remaining death benefit will be payable on death.

Terminal illness means any illness where:

a. in the insurer's opinion it will result in your death within 12 months, regardless of any treatment that might be undertaken. The insurer's decision will be based on medical evidence provided by your doctor, and any other evidence the insurer may require; and
b. two medical practitioners[1] (defined below) have certified, jointly or separately, that the illness has caused a reduction in life expectancy to 12 months or less; and
c. at least one of the medical practitioners is a specialist practising in an area related to the illness suffered by the person; and
d. for each of the certificates, 12 months has not elapsed from the date the certification was provided.

The sickness resulting in the terminal illness must occur, and the date any medical practitioner first certifies the person insured as being terminally ill must take place, while the person insured is covered under the policy.

1 Medical practitioner means a registered medical practitioner who is appropriately qualified to treat the person insured for their injury or sickness. The medical practitioner cannot be you or your family member, business partner, employee or employer. Nor can it be the person insured or their family member, business partner, employee or employer.

Where a terminal illness claim is admitted, the proceeds will be paid to the trustee. If the insurer pays the trustee a terminal Illness benefit the money will be retained in the fund on your behalf until it can be released, in accordance with superannuation legislation.

Indexation benefit

To protect your family against the effects of inflation, your cover is automatically increased each year up to age 64, taking into account the Consumer Price Index (CPI), using a minimum CPI figure of 5% per annum. Premiums increase accordingly. You may decline this increase in each or any year. Also, indexation will not be applied to your benefit once it reaches $1.5 million.

Conversion benefit

You may, subject to conditions specified in the policy document, convert this cover to another insurance policy held with the insurer, without the need for additional medical requirements.

Total and Permanent Disablement insurance

Total and Permanent Disablement (TPD) insurance cannot be taken without Life insurance. The amount of TPD insurance cannot exceed the amount of Life insurance. Where a TPD claim is admitted, the proceeds will be paid to the trustee. The trustee will need to be satisfied that you meet the permanent incapacity test as defined under superannuation legislation and the fund definition of Total and Permanent Disablement prior to making any payment from the fund.

The minimum sum insured for TPD Insurance is $100,000. The maximum sum insured is $2 million (or $300,000 under a spouse superannuation arrangement).

On payment of this benefit the sum insured of the Life insurance will be reduced by any amount we pay under TPD insurance.

Eligibility terms

For TPD cover, eligible persons must be:

- aged 15 years or more but less than the maximum entry age of 55 years old (cover renewable to age 65), and
- gainfully employed for at least 25 hours per week, or at least 10 hours per week for an earning spouse.

Total and permanent disablement means you must satisfy

- unlikely to work; and
- the permanent disability definition.

Unlikely to work

TPD occurs when all of the following apply to you:

- you suffer an injury or illness that wholly prevents you, continuously for six months, from following the most recent business, occupation or regular duties you were engaged in before the onset of the injury or illness, and
- since you became ill or injured, you have been receiving medical or other treatment or rehabilitation.

Permanent disability

Permanent disability means in the insurer's opinion you have become incapacitated by injury or illness (whether physical or mental) to such an extent that injury or illness wholly prevents you from ever engaging in any business, occupation or regular duties, whether paid or unpaid, which would be reasonable having regard to your education, training or experience.

For the purposes of 'unlikely to work', it is immaterial whether a business, occupation or regular duty is paid or unpaid.

Income Protection

This option can be added to your plan where you are gainfully employed and producing an income.

The minimum weekly benefit is $150 per week.

The maximum weekly benefit is the lesser of 75% of weekly income (before tax, less business expenses), or $4,620 per week ($20,000 per month) subject to underwriting approval.

Under the Income Protection insurance option the entry ages are 17 to 61 next birthday, renewable to age 65. The benefits available under the Income Protection policy and the exclusions which apply are listed below.

Benefits

The following summarises the benefits of the Income Protection policy:

- total disability benefit
- attempted return to work during the waiting period
- partial disability benefit
- recurrent disability
- worldwide cover
- waiver of premium, and
- leave without pay benefit.

The total disability benefit is the amount you are insured for. It is calculated weekly and payable monthly in arrears. If you make a claim for total disability the insurer will pay you the lesser of the total disability benefit and 75 per cent of your average weekly income over the most recent two years (excluding the waiting period) you have not been receiving a benefit.

The insurer may reduce your total disability or partial disability benefit if any amounts are received under legislation (other than social security), common law, paid sick leave from your employer or any other disability income, sickness or accident plan for the injury or sickness you are claiming for under the policy. The insurer will do this if the regular benefit received from the other sources and our policy total more than 75% of your pre-disability income.

If you receive an amount from any of the above sources or become entitled to receive an amount from any of the above sources, you must promptly inform the insurer in writing and provide full details of the amounts you have received or are entitled to receive. The insurer may then reduce your benefit or recover the amount of any benefits overpaid to you, which should have been reduced, by the amount from other sources.

No matter what your occupation, the insurer won't reduce your Total Disability Benefit if you receive lump sum total and permanent disablement benefits, superannuation benefits or any business overheads disability insurance indemnifying you against business expenses.

Amount of benefit insured

You may insure up to 75% of your income (as defined below). However, it is important to note that when making a claim, your benefit will be subject to the lesser of the sum insured or the average weekly income over the most recent two years (excluding the waiting period) the insurer has not been paying a benefit under the policy. Income means either:

- if you own part or all of a business or practice, income is money generated by the business due to your own activity, after all expenses in earning that income have been deducted
- if you are employed, your income is your total package, including commissions, regular bonuses, superannuation and fringe benefits.

Waiting period

The waiting period commences at the start of total disability, and must expire before you can begin receiving a benefit. You choose your waiting period, based on the premium you can afford (shorter waiting periods are generally more expensive) and how long you can maintain your lifestyle, without receiving a benefit from the policy.

You can choose a waiting period of 4, 8 or 13 weeks.

Benefit period

The benefit period is the maximum period for which benefits are payable for any one claim. The maximum benefit period under the policy is two years. However, for certain conditions the maximum benefit period is two years combined for
all claims.

Renewal of cover

Once your application for the Income Protection cover has been accepted (and provided premiums are paid and you comply with the policy terms), the insurer guarantees to renew your cover every year until the expiry date. No further conditions will be placed on your cover, regardless of claims history or changes in health, occupation or pastimes.

Total Disability benefit

If you become totally disabled the insurer will pay you the total disability benefit from the end of the waiting period. You are totally disabled if, because of injury or sickness, you are not capable of doing the important duties of your regular occupation, and you are not working in any occupation (whether paid or unpaid), and are under medical care.

Important duties mean one or more duties which involve 20% or more of a person insured's tasks and which are essential to producing the person insured's income.

Medical care means that you must be receiving and following treatment or advice recommended by a medical practitioner. The medical practitioner will have personally assessed you and been provided with full clinical details of your case. You will continue to be reviewed in these circumstances on at least a monthly basis unless the medical practitioner specifies otherwise.

Maximum benefit period for certain conditions

Subject to complying with the terms of this policy, you will be paid for a maximum total of two years' benefits for any and all claims arising from any of the following conditions:

- chronic fatigue syndrome
- regional pain conditions including fibromyalgia
- alcohol, drug or chemical abuse or dependency, and
- a recognised mental disorder.

For example, if you receive benefits for a recognised mental disorder for 18 months and at a later date suffer from chronic fatigue syndrome for 12 months, you will only be entitled to receive benefits for 6 months in respect of your claim for chronic fatigue syndrome.

A recognised mental disorder includes, but is not limited to, stress (including post-traumatic stress); physical symptoms of a psychiatric illness; mental disorders due to a general medical condition; anxiety; depression; psychoneurosis; psychosis; personality, emotional or behavioural disorders; or treatment and complications arising from a mental disorder.

Attempted return to work during the waiting period

The following applies if you have a four week waiting period. If, during the waiting period, you return to fulltime work for less than six days, then those days you worked will be added to the unexpired waiting period. However, if, during the waiting period, you return to work for six days or more, a new waiting period will commence from the date you are next totally disabled, before you are entitled to any benefit.

The following applies if your waiting period is eight weeks or more. If, during the waiting period, you return to full-time work for less than 10 days, then those days you worked will be added to the unexpired waiting period. However, if, during the waiting period, you return to work for 10 days or more, a new waiting period will commence from the date you are next totally disabled, before you are entitled to any benefit.

Partial disability benefit

If, immediately after a period of at least 14 days of total disability you can only return to work in a reduced capacity, earning less than 75% of your pre-disability income, we will pay a proportion of the total disability benefit. You will be entitled to be paid from the end of the waiting period. The amount we pay is the lesser of:

A − B or C − B where:

A is 75% of your pre-disability income

B is your income during the week in which you are partially disabled, and

C is your weekly benefit.

We will pay you for partial disability for a maximum of two years only.

Recurrent disability

If, following a disability claim for which the insurer was paying you, you return to full-time work and are disabled again within six months from the same or related cause (while cover is still current), the waiting period will not apply again. The claim will be treated as a continuation of the earlier claim and will be payable for up to the balance of the benefit period.

Worldwide cover

Worldwide cover means the Income Protection policy covers you anywhere in the world.

Waiver of premium

You don't have to pay the premium for your Income Protection cover while you are being paid a benefit under this policy.

Leave without pay benefit

If you take leave without pay the insurer will allow you to continue cover for up to 12 months. At the end of the 12-month period, you may continue your cover but you will not be entitled to receive a benefit if you are able to work in any occupation for which you are reasonably suited by education, training or experience. Additionally, you must continue paying the premiums while you are on leave.

When will your cover cease?

Your cover will cease as soon as one of the following happens:

- 30 days after the last premium is available
- you permanently retire from the workforce or cease to be employed (not applicable for Life Insurance). You must notify us if you are no longer employed
- on the expiry date of cover
- you request in writing to cancel the cover
- you make a fraudulent claim
- you die
- you cease to be a member of the National Mutual Retirement Fund
- you are paid a TPD claim from the National Mutual Retirement Fund, or
- your account balance has insufficient funds to maintain insurance premiums.

The insurer will retain all premiums already paid if the cover is cancelled.

Exclusions and limitations

Your cover may contain certain exclusions and limitations or unusual terms. When your cover is approved, you should carefully check your insurance schedule to see which, if any, exclusions or unusual terms apply to your cover.

Existing injuries or sickness

Please also note that the insurer won't pay for an injury or sickness that happened or began before the commencement date of your cover unless you told the insurer in writing about the injury or sickness when you applied for your insurance.

Life insurance

No amount of life cover is payable if you die as a result of suicide within 13 months of the commencement or reinstatement of cover.

This also applies for any increases to the sum insured (apart from CPI), within 13 months of that increase.

Total and Permanent Disablement insurance

The insurer will not pay you a benefit if your TPD is directly or indirectly attributable to or consequential upon:

- sickness or injury caused by you on purpose, or
- war (including war service), an act of a foreign enemy, hostilities or war-like operations (whether war is declared or not), civil commotion, civil war or rebellion.

Also, this cover will cease and the insurer will retain all monies paid for it if you cease employment or retire from your occupation for any reason other than TPD.

Income Protection

When your cover is approved, you should carefully check your insurance schedule to see which, if any, exclusions or unusual terms apply to your cover.

This policy does not cover you if your injury occurred or sickness commenced before the cover began, or was restored, unless you told the insurer about it in your application and the insurer agreed to cover it.

Also, the policy does not cover disability caused by:

- you on purpose, or
- uncomplicated pregnancy, miscarriage or childbirth, or
- war (including war service), an act of a foreign enemy, hostilities or war-like operations (whether war is declared or not), civil commotion, civil war or rebellion.

Premiums

Minimum premium

The minimum annual premium for life insurance (for all cover combined) and income protection is $200 ($16.67 per month if paying by direct debit).

Premium tables

Premium rate tables are available on request.

If you are over age 21, premiums will be calculated taking into account factors that include your smoker status. Whilst many of these factors are taken into account for members under age 21, we do not consider the smoker status. Once you turn 21, you should confirm your smoker status to ensure the appropriate premiums are applied.

Payment of premiums

Once your application has been accepted and provided all premiums are paid when due, the insurer guarantees to continue your cover until its expiry date.

For cover to remain current, funds must be available to pay premiums. If direct debit payments cease, an insurance transfer fee will apply if you selected the exit fee option. If your account balance falls below $1,000 your insurance cover will cease.

You don't have to pay the premium for your Income Protection cover while you are being paid a Total or Partial Disability Benefit under the Income Protection policy.

The premium is adjusted each year at the renewal date according to your age.

What are the charges?

All charges relating to Life, TPD insurance and Income Protection are fully described in this section. The insurer undertakes not to apply any new charges (other than government taxes and charges) without your specific consent.

Government stamp duty

A government stamp duty is imposed on your cover and this is in addition to the premium. The government may change the rate of stamp duty from time to time.

Variations

The insurer reserves the right to vary charges as described below:

- The insurer can revise the premium rate tables for insurance cover, however, any such changes to premium rate tables will be part of a general review that will apply to all plans of that type.
- The premium rates for insurance cover may increase with your age.
- In the event of a material change to fees and charges, you will be given at least three months' notice prior to the change occurring. All other changes, including those resulting from indexation or market variations will be advised in writing, following the change.

The insurer can change the standard premium rate tables, fees or charges at any time to take account of any change to taxation or revenue laws.

Information about your cover

Once the insurer has processed and accepted your application and first premium, you will be sent an insurance schedule. This will show full details of your cover, regular premiums and the insurance cover you have chosen. You should read this document carefully and contact your financial adviser or our Customer Service Centre on 133 731 if you have any concerns.

What you need to tell us

When you apply for insurance

When you apply for insurance, the insurer conducts 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.

The Duty to Take Reasonable Care Not to Make a Misrepresentation

! Read this if you are applying for insurance as the policy owner, if you will be an insured person under a policy owned by someone else, or if you will be an insured person under a superannuation plan.

Your legal duty

When you apply for insurance and up until your application is accepted by the insurer, there is a legal Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer.

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

You have the same duty if anything changes, or you remember more information, while we're processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer at that time.

You are responsible for all answers given, even if someone assists you with your application.

We may later investigate the answers given in your application, including at the time of a claim.

Where a **policy** owned by one person covers the life of another person, it's important that the other person does not make a misrepresentation when providing information to the insurer. If the other person does make a misrepresentation, then it may be treated as a failure by the owner of the **policy** in their Duty to Take Reasonable Care Not to Make a Misrepresentation. Therefore, you must take reasonable care not to make a misrepresentation when giving us information whether you're the owner of the **policy** or an **insured person** under it.

If you do not meet your legal duty

If you do not meet your Duty to Take Reasonable Care Not to Make a Misrepresentation, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. 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.

If there is a failure to comply with the Duty to Take Reasonable Care Not to Make a Misrepresentation, there are different remedies that may be available to the insurer. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put the insurer in the position it would have been in if the duty had been met. Therefore, if the person who answers our questions does not take reasonable care not to make a misrepresentation, it can have serious consequences for your insurance, such as those explained below:

- we may **treat the contract (or your cover) as if it never existed**.
- we may **reduce the amount you've been insured for** – to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would have had to pay if you'd told us everything you should have. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.
- we may **vary your cover** – to take into account the information you didn't tell us and put the insurer in the same position as it would've been if you'd told us. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.

Your total insurance cover forms one insurance contract. If you don't meet your legal duty, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

Whether the insurer can exercise one of these remedies depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances.This includes how clear and specific our questions were and how clear the information we provided on the duty was;
- what the insurer would have done if the duty had been met – for example, whether the insurer would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will let you know our reasons and the information we rely on and give you an opportunity to provide an explanation.

If we decide to exercise one of these remedies, we will advise you of our decision and the process to have this reviewed or make a complaint if you disagree with our decision.

Guidance for answering our questions

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 that we ask you.
- Do not assume that we will contact your doctor for any medical information.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it or check with us.
- Review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and make corrections if needed) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

After your cover starts

If, after the cover starts, you think you may not have met your duty, please contact us immediately.

Medical requirements

You will need to provide evidence so that your application can be assessed. In most cases, completion of the Personal statement is sufficient. For large sums insured, or where details of your medical history appear insufficient, further evidence may be required before your application is accepted.

For more information

If you have any questions or need help, please contact us on 133 731.

Resolution Life

Insurance Application
Information sheet

Important information for applicants

Please read these instructions carefully before starting this application.

Before you start

Before you complete this application form, you should be aware that your financial adviser is obliged to have provided you with the Insurance fact sheet (fact sheet). The fact sheet contains important information to help you understand the product and to decide whether it is appropriate to your needs.

We rely on what you tell us

Before we decide to issue a plan, we need to know exactly what the risk is that we are to insure and how likely you would be to make a claim.

What you need to tell us

When you apply for insurance

When you apply for insurance, the insurer conducts 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.

The Duty to Take Reasonable Care Not to Make a Misrepresentation

! Read this if you are applying for insurance as the policy owner, if you will be an insured person under a policy owned by someone else, or if you will be an insured person under a superannuation plan.

Your legal duty

When you apply for insurance and up until your application is accepted by the insurer, there is a legal Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer.

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

You have the same duty if anything changes, or you remember more information, while we're processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer at that time.

You are responsible for all answers given, even if someone assists you with your application.

We may later investigate the answers given in your application, including at the time of a claim.

Where a **policy** owned by one person covers the life of another person, it's important that the other person does not make a misrepresentation when providing information to the insurer. If the other person does make a misrepresentation, then it may be treated as a failure by the owner of the **policy** in their Duty to Take Reasonable Care Not to Make a Misrepresentation. Therefore, you must take reasonable care not to make a misrepresentation when giving us information whether you're the owner of the **policy** or an **insured person** under it.

If you do not meet your legal duty

If you do not meet your Duty to Take Reasonable Care Not to Make a Misrepresentation, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. 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.

If there is a failure to comply with the Duty to Take Reasonable Care Not to Make a Misrepresentation, there are different remedies that may be available to the insurer. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put the insurer in the position it would have been in if the duty had been met. Therefore, if the person who answers our questions does not take reasonable care not to make a misrepresentation, it can have serious consequences for your insurance, such as those explained below:

- we may **treat the contract (or your cover) as if it never existed**.
- we may **reduce the amount you've been insured for** – to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If

you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would have had to pay if you'd told us everything you should have. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.

– we may **vary your cover** – to take into account the information you didn't tell us and put the insurer in the same position as it would've been if you'd told us. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.

Your total insurance cover forms one insurance contract. If you don't meet your legal duty, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

Whether the insurer can exercise one of these remedies depends on a number of factors, including:

– whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was;
– what the insurer would have done if the duty had been met – for example, whether the insurer would have offered cover, and if so, on what terms;
– whether the misrepresentation was fraudulent; and
– in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will let you know our reasons and the information we rely on and give you an opportunity to provide an explanation.

If we decide to exercise one of these remedies, we will advise you of our decision and the process to have this reviewed or make a complaint if you disagree with our decision.

Guidance for answering our questions

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 that we ask you.
– Do not assume that we will contact your doctor for any medical information.
– Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it or check with us.
– Review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and make corrections if needed) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

After your cover starts

If, after the cover starts, you think you may not have met your duty, please contact us immediately.

Genetic test approach

You only need to tell us about any genetic testing you've had or intend having if the total combined sum insured with all life insurers for the benefit(s) being applied for is over the Genetic Test Standard financial limits. You can choose to tell us about a genetic test that you have had where the result was favourable. However, you must tell us if you're experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this form.

Note: Resolution Life complies with the Genetic Test Standard, a copy of the standard can be found at **fsc.org.au/resources/standards**.

Privacy - use and disclosure of personal information

The privacy of your personal information is important to you and also Resolution Life. We will only collect information about you and your immediate family background that is necessary for the purposes of assessing your Application for insurance or for the purposes of assessing any claim you may make under the plan. This includes information about health, financial situation, occupation and lifestyle.

If the information you give us is not complete or accurate we may not be able to provide you with the products and services you have applied for. In assessing your Application for insurance and any subsequent claim, Resolution Life may need to disclose your personal information to other parties, such as reinsurers, medical and financial professionals, judicial or dispute resolution bodies, and the companies in the Resolution Life group.

You are entitled to request reasonable access to information we have about you. Resolution Life reserves the right to charge an administration fee for collating the information you request.

Definitions in this application

'Person to be insured' is the person whose life, health or income is to be insured under this application.

'Adviser' refers to the financial adviser who is guiding you to complete this application.

'Plan owner' refers to the person who owns the plan. The Plan owner is Equity Trustees Superannuation Limited as trustee of the National Mutual Retirement Fund.

'You' refers to the Person to be insured.

'We/Us' refers to the underwriter, Resolution Life Australasia Limited (Resolution Life).

Contact us

phone 133 731

web resolutionlife.com.au

Please keep this information sheet for your records—don't return it with your completed form(s).

Resolution Life

To be completed by the Person to be insured.

Insurance application form

Please print in CAPITAL LETTERS and place a cross ☒ in any applicable boxes.

1. Insurance application details

Alteration summary

This application form is effective from 21 April 2022

☐ Decrease sum insured/premium ☐ Review loading/exclusion ☐ Alter waiting period
☐ Increase sum insured/premium ☐ Any other alteration to the plan ☐ New cover

Existing plan number/member number

! As this form can be used for an alteration to an existing plan or application of a new insurance cover benefit, the latest **product disclosure statement** may not be relevant. Please refer to your plan document and insurance **fact sheet** for the terms and conditions of your plan.

Person to be insured

Title | Surname | Given name(s) | Previous name (if applicable)

Gender* ☐ Male ☐ Female | Marital status | Date of birth D D M M Y Y Y Y | Current age | Country of birth

Occupation title and the industry that the Person to be insured works in?

Insurable income in last 12 months $ (Personal exertion income after expenses but before income tax)

Residential address of Person to be insured

Address

Suburb | State | Postcode | Country

Home phone ( ) | Business phone ( ) | Mobile phone

Email address

Address for correspondence

! Only complete this section if different to the residential address of Person to be insured.

Address

Town/Suburb | State | Postcode | Country

1. Insurance application details (continued)

Life/TPD

	Existing/New cover	Proposed cover (including alteration)
Life sum insured	$	$
TPD sum insured	$	$
Yearly premium	$	$
Smoker	☐ No ☐ Yes	☐ No ☐ Yes
Exclusions or loadings		
Total yearly premium (including plan fee)	$	$

Income Protection

	Existing/New cover	Proposed cover (including alteration)
Weekly benefit	$	$
Waiting period	☐ 4 weeks ☐ 8 weeks ☐ 13 weeks	☐ 4 weeks ☐ 8 weeks ☐ 13 weeks
Yearly premium	$	$
Smoker	☐ No ☐ Yes	☐ No ☐ Yes
Exclusions or loadings		
Total yearly premium (including plan fee)	$	$

Insurance in super election

To prevent your super balance from being reduced by the cost of insurance, under super laws, you now need to make an election to include additional insurance cover inside your super.

To apply for insurance cover, please read the **important details** at **resolutionlife.com.au /whyinsurance** and then complete the election below.

☐ I'd like the insurance cover (including any additional insurance) to be provided and kept within my super account, even if:

- I'm under 25,
- my balance is below $6,000, or
- my account doesn't receive a contribution or rollover for 16 months.

2. Personal details

Do not complete this section if you would like to decrease sum insured premium.

! Please refer to "The Duty to Take Reasonable Care Not to Make A Misrepresentation" section in the **Information sheet**. Resolution Life relies on the information you provide to assess your application.
If the questions are not answered truthfully, accurately and completely the insurance you have applied for may be avoided (treated as if it never existed) or altered and if you have made a claim under the insurance it may not be payable or be reduced.

2. Personal details (continued)

'You' refers to the Person to be insured (unless otherwise indicated).

Contact details for Person to be insured

We may need to contact you between 8.00am and 7.00pm regarding the details of your application.

Daytime phone number ( )

Hours you can be contacted

After hours phone number ( )

Hours you can be contacted

Mobile number

Hours you can be contacted

Email address

Residence and travel details

1. a. Are you an Australian citizen or a permanent resident of Australia?
- ☐ Yes › go to question **2**
- ☐ No › go to question **1b**

b. Are you a New Zealand citizen?
- ☐ Yes › go to question **2**
- ☐ No - please provide details:

i. Which country has issued your current passport?

ii. How long have you lived in Australia? years months

iii. What type of visa do you hold?

iv. Have you applied for an Australian permanent residency visa? ☐ No ☐ Yes

If 'No', do you intend applying for an Australian permanent residency? ☐ No ☐ Yes
If you do intend on applying for an Australian permanent residency, please advise the date you can make the application.

D D M M Y Y Y Y

v. If applicable, do you have your family residing with you in Australia? ☐ No ☐ Yes

2. In the next 12 months, do you intend to leave Australia and go live in another country? ☐ No ☐ Yes
If 'Yes', please provide details:**3**

Where	Duration

3. Do you intend to travel outside Australia or New Zealand for holiday or business purposes? ☐ No ☐ Yes

If yes, please provide details:

Where	When	Duration

2. Personal details (continued)

Insurance details

4. Other than this application, are you covered by, or are you applying for, life, disability, trauma, income insurance or business expenses insurance with **any company**? ☐ No ☐ Yes

Note: This includes benefits under superannuation, business or credit insurance or benefits provided by an employer.
If 'Yes' please provide details:

Name of company	Type of cover	Sum insured ($)	Date commenced	To be replaced?
			/ /	☐ No ☐ Yes
			/ /	☐ No ☐ Yes
			/ /	☐ No ☐ Yes

Important notes: if this application for insurance is intended to replace the existing plan(s) listed in the table above or insurance cover held within the Resolution Life group that is being converted/replaced:

1 When the insurer notifies you that it has accepted your application for insurance, you must cancel such plan(s). If you do not cancel the existing plan(s) listed in the table above, any claim you make to Resolution Life for the insurance applied for and accepted may not be considered.

2 Under takeover terms, the insurance cover to be replaced must have been fully underwritten and not have been accepted under modified or limited underwriting requirements or on takeover terms previously.

3 If the existing insurance is held with us or another company within the Resolution Life group of companies, you authorise:

- us to cancel, or to instruct the other insurer to cancel, that insurance effective the date that the new insurance commences, and
- the other insurer (if any) to cancel that insurance at our request on the basis of this authority.

5. Has **any company** ever indicated they would not issue you insurance, or would apply a loading, modify, restrict or exclude your insurance in any way? ☐ No ☐ Yes

If 'Yes', please provide full details including reason, date, company name and type of cover:

6. In the last five years have you, or do you intend in the next 12 months, to claim unemployment benefits? ☐ No ☐ Yes

If 'Yes', please provide details:

Benefit type

Date D D M M Y Y Y Y

7. Have you ever, or do you intend to claim benefits under any insurance plan, government scheme, armed forces, pension or allowance, or court proceedings? If 'Yes', please provide details: ☐ No ☐ Yes

Company/benefit type	Reason	Benefit amount ($)	Date
			/ /
			/ /
			/ /

Personal Habits

8. a. Have you ever been a smoker or used any sort of tobacco products (including e-cigarettes and/or nicotine replacement products)? ☐ No ☐ Yes
If 'No' ❯ go to question **9**
If 'Yes', please advise which of the following apply and quantity consumed.

☐ Cigarettes **Quantity per:** day week month

☐ Tobacco pipes **Quantity per:** day week month

☐ Cigars **Quantity per:** day week month

☐ Nicotine replacement products

☐ E-cigarettes ☐ Other Please specify substance smoked:

2. Personal details (continued)

Personal Habits (continued)

If you have indicated that you use nicotine replacement products, e-cigarettes or any other substance, please answer questions i. and ii.

i. How often are or were these nicotine patches, e-cigarettes or other nicotine products used, replaced or refilled?

ii. What strength are they? mgs

b. If you have stopped smoking, using tobacco, nicotine replacement products or other substances, please advise when:

month year

c. Have you ever been advised by a health care professional to reduce your smoking because of a medical condition? If 'Yes', please advise the name of the condition and any treatment received: ☐ No ☐ Yes

Condition

Treatment

9. How many standard drinks containing alcohol do you consume per week on average? [standard drink = 1 nip/30ml of spirits, 1 x 100ml glass of wine, 1 x 250 ml glass of beer] standard glasses per week

10. Have you ever been advised by a health care professional to reduce your alcohol intake or seek alcohol treatment? ☐ No ☐ Yes
If 'Yes', please advise your alcohol intake amount at that time, reason you were advised and details of any treatment:

11. Have you ever used cocaine, marijuana, ecstasy, heroin or any other recreational drugs, or drugs not prescribed by a doctor? (You do not need to tell us about any paracetamol, anti-histamines or any other over-the-counter medication.) If 'Yes', please give details, including the type of drug and the date(s) used: ☐ No ☐ Yes

3. Your health details

Doctor details

12. a. Name and address of your usual doctor (if you do not have a usual doctor, then the last doctor that you saw)

Name	Address	Phone number
		( )
		( )
		( )

If you have known your doctor for less than 2 years, please provide details of the previous doctor.

Name	Address	Phone number
		( )
		( )
		( )

b. Date of last consultation with any doctor

D D M M Y Y Y Y

c. Name of doctor that you saw (if same as above, write 'as above')

d. Please advise reason for your last consultation

e. Please advise results/outcome of your last consultation

f. Were you referred for further tests, investigations or referred to a specialist? ☐ No ☐ Yes
If 'Yes', please provide full details

3. Your health details (continued)

Personal health history

13. a. What is your: Height _____ Weight _____

b. Has your weight varied in the last 12 months? ☐ No ☐ Yes

if 'Yes', please cross one of the following and provide the amount and the reason: ☐ Gain ☐ Loss

Amount _____ kg Reason _____

14. At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor):

a. **Back or neck pain, injury or disorder including slipped disc, sciatica, whiplash or any other condition of the neck, middle or lower back** ☐ No ☐ Yes

b. **Disorder, pain or injury of the wrist, elbow, shoulder, hip, knee, ankle** or any other **joints, or arthritis or gout** ☐ No ☐ Yes

c. Disorder or injury of the muscles, bones or limbs (eg fracture, tendonitis or tenosynovitis) ☐ No ☐ Yes

d. **Depression, adjustment disorder, post-traumatic stress disorder, post natal depression, major depression** or any other **mood or depressive disorder** ☐ No ☐ Yes

e. **Panic attacks, anxiety, attention deficit disorder, eating disorder, obsessive compulsive disorder** or any other **anxiety disorder** ☐ No ☐ Yes

f. **Schizophrenia, psychotic or personality disorder, manic or bipolar disorder** or any other **mental health disorder** ☐ No ☐ Yes

g. **Stress, fatigue, insomnia** or **sleeplessness** ☐ No ☐ Yes

h. Chronic fatigue or chronic pain syndrome ☐ No ☐ Yes

i. Fibromyalgia, fibrositis or myalgia ☐ No ☐ Yes

j. Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury ☐ No ☐ Yes

k. Multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, paralysis or cerebral palsy ☐ No ☐ Yes

l. Epilepsy, fit or blackout, migraine or recurrent headaches ☐ No ☐ Yes

m. Any neurological complaint or disorder of the nervous system including dizziness, involuntary shaking, memory loss, weakness, loss of feeling, or tingling of limbs or face ☐ No ☐ Yes

n. **High blood pressure or raised cholesterol** (including being advised to take medication or have your levels monitored) ☐ No ☐ Yes

o. Heart condition including irregular heartbeat, heart murmur, heart disease or chest pain ☐ No ☐ Yes

p. Disorder of the blood including anaemia or haemophilia ☐ No ☐ Yes

q. **Asthma** ☐ No ☐ Yes

r. Bronchitis, sleep apnoea, pneumonia or any other lung, respiratory or breathing disorder ☐ No ☐ Yes

s. Disorder of the thyroid ☐ No ☐ Yes

t. **Diabetes**, sugar in the urine or raised blood sugar levels ☐ No ☐ Yes

u. Disorder of the kidney or bladder including blood or protein in the urine, urinary infections or kidney stones ☐ No ☐ Yes

v. Disorder of the digestive system, gall bladder, stomach, bowel or liver including any changes to your usual bowel habits, hepatitis, haemochromatosis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, irritable bowel syndrome or hernia ☐ No ☐ Yes

w. Disorder of the eyes not corrected by glasses or contact lenses (eg iritis, glaucoma, optic neuritis, blurred or double vision) ☐ No ☐ Yes

x. Disorder of the ears or speech including hearing loss or tinnitus ☐ No ☐ Yes

y. Disorder of the skin including psoriasis, eczema or dermatitis ☐ No ☐ Yes

z. Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, **melanoma** or **skin cancer** or any malignant condition ☐ No ☐ Yes

3. Your health details (continued)

Personal health history (continued)

aa. Cyst, skin lesion, growth, lump (including breast lump), **mole or freckle** that has bled, become painful, changed colour or increased in size ☐ No ☐ Yes

ab. Any sexually transmitted infection or disease ☐ No ☐ Yes

! If you answered '**Yes**' to any of the items in **14**, please provide details in the table below, **except** for any condition in bold text above, for which you should complete the relevant Health questionnaires at question **22** instead. If you answered '**No**' to all items, go to **15**.

Item no. eg 'f'	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery (%)
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

15. At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor):

Males only

a. Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine or increase in night urination? ☐ No ☐ Yes

Females only

b. Are you currently pregnant? If 'Yes', please advise expected delivery date: D D M M Y Y Y Y ☐ No ☐ Yes

c. Have you ever had any complications with pregnancy or childbirth? If 'Yes', please provide details below, including whether resolved after delivery. ☐ No ☐ Yes

d. Have you ever had an **abnormal cervical screening or pap smear test**, **positive HPV test** or biopsy of the cervix or uterus? ☐ No ☐ Yes

! If you answered '**Yes**' to any of the items in **15**, please provide details in the table below except for any condition in bold text above, for which you need to complete the relevant Health questionnaires in question **22** instead.

Item no. eg 'b'	Date	Details of condition, advice or symptom including nature of treatment and/or results of investigations	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery (%)
	/ /				
	/ /				
	/ /				

3. Your health details (continued)

Personal health history (continued)

Females only –continued

e. Have you ever had a breast ultrasound or mammogram? ☐ No ☐ Yes

f. Have you ever had a breast lump, thickening, unexplained pain or change in the breast or nipples (even if you have not seen a doctor about it)? ☐ No ☐ Yes

If '**Yes**' for '**e**' or '**f**' – please advise date, reason, results and if any follow up required (including other tests or consultations with specialists) and if follow up pending when will this be?

Item no.	Date	Reason	Results	Follow up required	Name of doctor	Pending follow up	When
	/ /			☐ No ☐ Yes			/ /
	/ /			☐ No ☐ Yes			/ /

16. Other than what you have already told us in this application, have you in the last **five years** (not including colds or flu):

a. Attended any other medical appointment (eg counselling), or had any other test (eg x-ray, blood), including surveillance tests (eg ultrasounds or colonoscopies), surgery either in Australia or overseas, any preventative or prophylactic treatment (eg mastectomy), with any other doctors, medical centres or health care professionals, including chiropractors, physiotherapists, naturopaths, osteopaths, podiatrists or herbalists? ☐ No ☐ Yes
Important: Please refer to the **genetic test approach** in the **information sheet** when answering this question.

b. Used or are you currently using any medication, prescribed or unprescribed (taken by mouth, injections, inhaled spray, cream, ointment) or had any treatment for any symptoms, sickness, injury or medical condition? ☐ No ☐ Yes

c. Had any sickness, symptom or injury that prevented you from performing any of the duties of your usual occupation for more than 3 consecutive days? ☐ No ☐ Yes

! If you answered '**Yes**' to any of the items in **16**, please provide details in the table below.

Item no. eg 'b'	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Date treatment or medication ceased (if applicable)	Time off work	Degree of recovery (%)
	/ /			/ /		
	/ /			/ /		
	/ /			/ /		

17. Other than what you have already told us in this application:

a. Have you ever been admitted to hospital for any reason? ☐ No ☐ Yes

b. Are you experiencing any symptoms or complaints for which you have not consulted a doctor? ☐ No ☐ Yes

c. Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery either in Australia or overseas? ☐ No ☐ Yes

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

3. Your health details (continued)

Personal health history (continued)

18. a. Have you or any of your current or previous sexual partners tested positive for HIV/AIDS, or have any sign of HIV infection (eg some signs of HIV/AIDS are: unexplained weight loss, swollen glands or persistent diarrhoea)? ☐ No ☐ Yes

b. In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? ☐ No ☐ Yes

Note: HIV risk situations include but are not limited to:
- sex with or as a sex worker
- sex with an intravenous drug user
- contact with someone else's blood (eg through injection or scratch with a used needle)
- anal intercourse (except in a relationship between you and one other person only and neither of you has had sex with anyone else for at least three years).

(If you answered '**Yes**' to any part of 18 we will send you a confidential questionnaire to complete.)

Family history

19. Have any first-degree blood related family members (father, mother, brother, sister or your children) been diagnosed or suffered from any of the following?

☐ No, unknown/adopted – go to next section.

☐ Yes – please cross all that apply and provide the details further below:

- ☐ Breast and/or ovarian cancer
- ☐ Lynch syndrome, familial polyposis or bowel/colon cancer
- ☐ Diabetes
- ☐ Heart attack
- ☐ Haemochromatosis
- ☐ Multiple sclerosis
- ☐ Motor neurone disease
- ☐ Alzheimer's disease or any other type of dementia
- ☐ Any hereditary disorder or condition that runs in families
- ☐ Prostate cancer
- ☐ Polycystic kidney disease, renal cell cancer or kidney cancer
- ☐ Stroke
- ☐ Cardiomyopathy
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Huntington's disease
- ☐ Any other cancer or any other heart condition

Provide details for each box you've crossed:

Family member (eg mother, brother)	Condition	If cancer, type/site	Age at diagnosis	Age at death (if applicable)

20. a. Are you required to have any regular screening due to your family history? ☐ No ☐ Yes

Note: You are only required to disclose family information relating to first degree blood related family members—living or deceased (mother, father, sisters and brothers).

If 'Yes', please complete the table below:

Type of regular screening eg mammogram, Prostate Specific Antigen, colonoscopy	How often is this screening performed?	Date of last test	Results including any abnormalities	Doctor consulted
		/ /		
		/ /		
		/ /		

b. Are any tests or investigations pending? ☐ No ☐ Yes

If 'Yes', please give details of which tests are pending and when these will be performed.

To be completed by the Person to be insured.

4. Sport and pastimes details

21. Have you in the last 12 months, do you currently, or do you intend to take part in **any** of the following activities:

a. Aviation (other than a fare paying passenger on a licensed public service)? ☐ No ☐ Yes

b. Motor racing (including car, bike and boat)? ☐ No ☐ Yes

c. Underwater diving? ☐ No ☐ Yes

d. Football? ☐ No ☐ Yes

e. Motor bike riding, including quad bike riding, trail bike riding and commuting (please specify below)? ☐ No ☐ Yes

f. Any other hazardous activity, pursuit or sport not previously disclosed (including, but not limited to: rock climbing, hang-gliding, ocean racing, martial arts, horse riding, or any other motor sports)? ☐ No ☐ Yes

! If you answered '**Yes**' to items d, e or f, please provide details of each activity in the table below. For any activity in bold text above please complete the detailed sports and pastimes questionnaire(s) section below. If you answered '**No**' to all items above go to the detailed Health questionnaires question **22**.

Item no. eg 'f'	Activity/sport and location	Other details (including remuneration received)	No. events/ hours per year	Amateur/Professional?	Competitive/ Non-competitive?
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive

5. Detailed sports and pastimes questionnaires

! Only complete the relevant sections of this question if you answered '**Yes**' to **21** a, b or c.

a. Aviation questionnaire

1. Do you hold a Department of Transport licence to fly aircraft? ☐ No ☐ Yes
   if 'Yes', please state type of licence and period held:

2. Do you intend to change the scope of your present licence? ☐ No ☐ Yes
   if 'Yes', please provide details:

3. Have you ever had an accident or been charged with violating civil aviation regulations? ☐ No ☐ Yes
   if 'Yes', please provide details:

4. Do you always use recognised Department of Transport airfields? ☐ No ☐ Yes
   if 'Yes', please provide details:

5. Please provide details of the type(s) of aviation you are involved in (eg commercial, private, agricultural, aero club, helicopter, ultralight aircraft, aerobatics):

6. Please provide details of the number of hours flown:
   i. in total as a pilot
   ii. in the last 12 months
   iii. expected each year in the future

7. Do you intend to engage in any form of aviation other than the above? (eg ballooning, paragliding) ☐ No ☐ Yes
   if 'Yes', please provide details:

5. Detailed sports and pastimes questionnaires (continued)

b. Motor racing questionnaire

1. What type(s) of motor sports activities do you participate in (eg circuit racing, drag racing, formula racing, karting, rallies, speedway, stock car racing, time trials)?

2. What type(s) of motor vehicles do you drive or crew? Please state the make, model, year of manufacture, engine size, category, group and class details:

3. Please state the nature of your participation:
   ☐ Recreational ☐ Competitive ☐ Sponsored ☐ Amateur ☐ Professional

4. Number of events you participate in: Last 12 months ____ Next 12 months (expected) ____

5. Where have you, or do you intend to compete or race? Please provide the name of all organised events:

6. What maximum speeds do you reach? ____

7. Please provide details of your licences/certifications and memberships attained:

Licence/certification or membership details	When attained/ joined
	/ /
	/ /

8. Have you ever had your licence restricted or suspended for any reason? ☐ No ☐ Yes
   if 'Yes', please provide details:

c. Underwater diving questionnaire

1. What type of diving activities do you participate in (eg snorkelling, scuba diving, free diving)?

2. What diving certification do you hold? ____

3. Average depth you dive to ____ metres

4. Maximum depth you dive to ____ metres

5. Number of times you dive per year ____

6. ☐ Professional ☐ Amateur

7. Do your diving activities include pothole, cave or sink hole diving, wreck exploration or any other hazardous diving? ☐ No ☐ Yes
   If 'Yes', please provide details, including how often:

8. Do you ever dive alone? ☐ No ☐ Yes
   If 'Yes', please provide details, including where and how often:

9. Have you ever had a diving accident or sickness? ☐ No ☐ Yes

To be completed by the Person to be insured.

6. Health questionnaires

22. Detailed health questionnaires

! Only complete the relevant health questionnaires if you answered '**Yes**' to any items in bold text in **14** and **15**.

Back or neck disorder questionnaire

1. What was the diagnosis given for your pain/disorder?

   If no diagnosis, proceed to question **2**

2. What part(s) of the back were or are affected? (select all that apply):
   a. ☐ Neck
   b. ☐ Middle
   c. ☐ Lower

3. Have you experienced any of the following? (select all that apply): ☐ No ☐ Yes
   a. ☐ Radiation or spread of pain down either the leg or arm (including shooting, stabbing or burning pain)
   b. ☐ Loss of feeling
   c. ☐ Loss of strength
   d. ☐ Pins and needles

   If 'Yes', please give details

4. a. When did you first have symptoms?

   Date D D M M Y Y Y Y

   b. When was the last time you had symptoms?

   Date D D M M Y Y Y Y

   c. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?

   d. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?

5. When you have pain, how would you rate your pain? Scale 0–5 with 0 being no pain and 5 being the worst pain you ever felt.

6. a. Do you know the cause of your pain? ☐ No ☐ Yes
   If 'Yes' please proceed to question **b**
   If 'No' proceed to question **7**

   b. What do you think was the cause of your pain? (select all that apply):
   i. ☐ Work
   ii. ☐ Sport
   iii. ☐ Other
   iv. ☐ Unknown

   If you selected i, ii, iii or iv – please provide details

7. a. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes
   If 'Yes', please provide the details of the total number of days or weeks you had off work

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Back or neck disorder questionnaire (continued)

b. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation as a result of your pain/disorder? ☐ No ☐ Yes
If 'Yes', please provide the details

If you have answered 'Yes' to 7a or 7b – please complete 7c

c. Please advise which statements apply to you: (select all that apply)
I had time off work or restricted hours or duties because:

i. ☐ My work aggravated my pain
ii. ☐ My work is too heavy for me
iii. ☐ I think my work may cause further injury or pain
iv. ☐ Other

If you selected i, ii, iii or iv – please provide details

8. a. Were you able to carry out daily activities such as, washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes
If 'No', please provide the details

b. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes
If 'Yes', please provide the details

9. Have you ever had investigations such as an x-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes
If 'Yes', please provide details in the table below:

Date	Investigation	Results[(i)]	Part of body (eg lower back)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession.

10. a. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes
If 'Yes', please provide details in the table below

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

b. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)?, ☐ No ☐ Yes
If 'Yes', please provide details in the table below

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Back or neck disorder questionnaire (continued)

11. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes
If 'Yes', please provide details

Disorder or injury of the joints questionnaire

1. What was the diagnosis given for your pain/disorder?

If no diagnosis, proceed to question **2**

2. Please complete one questionnaire for each joint affected
Note: If both left and right joint is affected please complete one questionnaire for each joint
In which joint did you or do you have the pain, injury or disorder?

☐ Shoulder	☐ right	☐ left	☐ Elbow	☐ right	☐ left
☐ Wrist	☐ right	☐ left	☐ Hip	☐ right	☐ left
☐ Knee	☐ right	☐ left	☐ Ankle	☐ right	☐ left

☐ Other – please advise which joint and if right/left

3. Have you experienced any of the following? (select all that apply): ☐ No ☐ Yes
   a. ☐ Radiation or spread of the pain
   b. ☐ Loss of feeling or strength
   c. ☐ Loss of range of movement
   d. ☐ Pins and needles
   e. ☐ Weakness or instability
   f. ☐ Swelling
   g. ☐ Other – please advise:

   If 'Yes', give details

4. a. When did you first have symptoms?
   Date D D M M Y Y Y Y
   b. When was the last time you had symptoms?
   Date D D M M Y Y Y Y
   c. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?
   d. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?

5. When you have pain, how would you rate your pain? Scale 0–5 with 0 being no pain and 5 being the worst pain you ever felt.

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Disorder or injury of the joints questionnaire (continued)

6. a. Do you know the cause of your pain? ☐ No ☐ Yes
   If 'Yes' please proceed to question **b**
   If 'No' proceed to question **7**

   b. What do you think was the cause of your pain? (select all that apply):
   - i. ☐ Work
   - ii. ☐ Sport
   - iii. ☐ Other
   - iv. ☐ Unknown

   Please provide details

7. a. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes
   If 'Yes', please provide the details of the total number of days or weeks you had off work

   b. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation as a result of your pain/disorder? ☐ No ☐ Yes
   If 'Yes', please provide the details

   If you have answered 'Yes' to 7a or 7b – please complete 7c

   c. Please advise which statements apply to you: (select all that apply)
   I had time off work or restricted hours or duties because:
   - i. ☐ My work aggravated my pain
   - ii. ☐ My work is too heavy for me
   - iii. ☐ I think my work may cause further injury or pain
   - iv. ☐ Other

   If you selected i, ii, iii or iv – please provide details

8. a. Were you able to carry out daily activities such as, washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes
   If 'No', please provide the details

   b. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes
   If 'Yes', please provide the details

9. Have you ever had investigations such as an x-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes
   If 'Yes', please provide details in the table below

Date	Investigation	Results[i]	Part of body (eg right shoulder)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession.

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Disorder or injury of the joints questionnaire (continued)

10. a. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes
If 'Yes', please provide details in the table below

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

b. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes
If 'Yes', please provide details in the table below

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

11. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes
If 'Yes', please provide details

Mental health disorders questionnaire

1. Which of the following mental health disorder(s) do you have or have you had or received treatment or advice for? (Please select all that apply):
   - ☐ Anxiety, generalised anxiety or panic disorder
   - ☐ Adjustment disorder or post traumatic stress disorder
   - ☐ Obsessive compulsive disorder or attention deficit disorder
   - ☐ Anorexia, bulimia or any other eating disorder
   - ☐ Post natal depression
   - ☐ Depression including major depression, mood or any other depressive disorder
   - ☐ Manic depression or bipolar disorder
   - ☐ Schizophrenia or any other psychotic or personality disorder
   - ☐ Alcohol or substance abuse disorder
   - ☐ Other, please provide details:

2. Please describe your symptoms:

3. What do you think caused your symptoms?

4. When did you first experience symptoms and how long did they last?

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Mental health disorders questionnaire (continued)

5. Has this condition(s) ever required you to take time off work or does/did it impact your ability to perform your normal duties at work? For example, did you need to reduce the number of hours you worked or were your responsibilities or duties changed in any way? ☐ No ☐ Yes
If 'Yes', please provide details including time away from work and if there were any changes to your duties:

6. Has this condition(s) ever affected your relationships, your ability to socialise with friends or family, your ability to sleep, eat, exercise or play sport? ☐ No ☐ Yes
If 'Yes', please provide details:

7. How many episodes of this condition have you experienced? For example, if you were depressed and recovered twice in three years we would say you had two episodes of depression.

8. When was the last time you experienced symptoms?

9. Have you ever received any treatment for this condition? ☐ No ☐ Yes
If 'Yes', please provide details in the table below

Type of treatment, eg counselling or medication etc	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

10. Have you or are you being treated for this condition by a general practitioner, psychologist, psychiatrist, counsellor or any other therapist? ☐ No ☐ Yes
If 'Yes', please provide details in the table below

Field of practice, eg Psychologist or therapist etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /
			/ /

11. Are you still receiving treatment for this condition(s)? ☐ No ☐ Yes
If 'No', please advise when you stopped treatment and was it at the direction of your treating health professional?

12. Have you ever not followed the advice of your treating health professional in relation to prescribed medication or other recommended treatment for this condition(s)? ☐ No ☐ Yes
If 'Yes', please provide details in the table below

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Mental health disorders questionnaire (continued)

13. Have you ever been hospitalised or an in-patient at a hospital or clinic for this condition(s)? ☐ No ☐ Yes
If 'Yes', please provide details in the table below

Name of hospital/clinic	Dates of hospitalisation	Treatment received
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

14. Have you ever thought about or tried to harm yourself or take your own life? ☐ No ☐ Yes
If 'Yes', please provide the name and address of your doctor that would have the details:

15. Has any first degree blood related family member (father, mother, brother, sister) had a mental health disorder? ☐ No ☐ Yes
Note: You are only required to disclose family information relating to first degree blood related family members—living or deceased (father, mother, brother, sister).

Stress, fatigue, insomnia and/or sleeplessness questionnaire

1. Which of the following do you have or have you had or received treatment or advice for? (Please select all that apply)
   - ☐ Stress
   - ☐ Fatigue
   - ☐ Insomnia and/or sleeplessness
2. Did you see a doctor or other health professional for this condition(s)? ☐ No ☐ Yes
3. Were you diagnosed with anxiety, depression or any other mental health disorder? ☐ No ☐ Yes
If 'Yes', please complete the **mental health questionnaire.**
If 'No', please continue to complete this questionnaire.
4. Did this condition(s) affect you to the point where you experienced any of the following (please select all that apply):
   - ☐ physical symptoms such as headache, dizziness, soreness or irritability
   - ☐ you found it difficult to go to work or were unable to go to work
   - ☐ it had an impact on your relationships
   - ☐ it impacted your ability to sleep, eat, or think clearly
   - ☐ problems with concentration, memory or tiredness during the day
   - ☐ it caused you to use alcohol or drugs that were not prescribed for you by a doctor

   If you have answered '**Yes**' to any of the above, please provide full details including how much time you had away from work:
5. What do you think caused your symptoms?
6. When did you first experience symptoms and how long did they last?

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Stress, fatigue, insomnia and/or sleeplessness questionnaire (continued)

7. When was the last time you experienced symptoms?

8. How many episodes of this condition have you experienced? For example, if you were stressed and recovered twice in three years we would say you had two episodes of stress.

9. Have you ever been treated for this condition(s)? ☐ No ☐ Yes
If 'Yes', please provide full details including type of treatment, name of medication (if applicable) and dates the treatment started and ceased:

10. Please advise how often you see or saw your treating health professional for this condition and provide their name(s) and address(es):

High blood pressure or raised cholesterol questionnaire

1. Please indicate which of the following have been raised/high: ☐ Blood pressure ☐ Cholesterol ☐ Both
2. a. When did you first find that your readings/levels were raised or were you advised to have your reading/levels monitored or noted?

   b. What was your reading/level at the time noted in 2a?

   Blood pressure / Cholesterol
3. a. What was the last blood pressure/cholesterol reading, and when was this taken?

   Blood pressure / Date D D M M Y Y Y Y

   Cholesterol reading Date D D M M Y Y Y Y

   b. Is the reading above consistent with others when checked? ☐ No ☐ Yes
   If 'No', what is a typical reading?
4. How often are you required to see your doctor for reviews/check-ups?
   ☐ Monthly ☐ Quarterly ☐ Twice-yearly ☐ Annually ☐ Other—details:
5. When is your next check-up due? D D M M Y Y Y Y
6. Are you currently taking any medication for your blood pressure/cholesterol levels?
   ☐ No, go to question **8** ☐ Yes, please provide the name of any medication you take and the daily dosage

Condition	Medication	Daily dosage
Blood pressure		
Cholesterol		

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

High blood pressure or raised cholesterol questionnaire (continued)

7. Has your treatment type or dosage changed within the last 12 months?
☐ No, go to question **9** ☐ Yes, please provide the details below and continue to question **9**

When was it changed?	What was changed?	Why was it changed?

8. Have you ever been prescribed medication for blood pressure/cholesterol? ☐ No ☐ Yes
If 'No', how has the condition been managed?

If 'Yes', when and why have you ceased taking this medication?

9. Have you undergone or been referred for any other investigations (eg resting or exercise ECG, 24hr holter monitor, urinalysis, echocardiogram)? ☐ No ☐ Yes
If 'Yes', please provide details:

10. Has any underlying cause been found for your raised blood pressure/cholesterol? ☐ No ☐ Yes
If 'Yes', please provide details:

Asthma questionnaire

1. When was your asthma diagnosed? D D M M Y Y Y Y
2. When did you **first** have symptoms? D D M M Y Y Y Y
3. When did you **last** have symptoms? D D M M Y Y Y Y
4. Approximately how many times per year do you or did you get symptoms?
5. Does the environment in which you work or perform your normal daily duties, exacerbate or cause your symptoms of asthma (eg dust, sawdust, pollen, grass)? ☐ No ☐ Yes
If 'Yes', please provide details:

6. In the last 12 months have you taken time off work or been unable to perform your normal daily activities because of your asthma? ☐ No ☐ Yes
If 'Yes', please provide details including the number of times and days:

7. Please provide details of the treatment for your asthma, including dosage of drugs taken and frequency (eg aerosol spray, tablets or injections, amounts and number of times per day):

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Asthma questionnaire (continued)

8. Have you ever been treated for your asthma with steroids (eg Prednisone)? ☐ No ☐ Yes
If 'Yes', please provide details, including dates:

9. Have you ever attended a hospital emergency room or been admitted to hospital because of your asthma? ☐ No ☐ Yes
If 'Yes', please provide details:

10. In the last 3 years, have you had or been advised to have a chest x-ray or respiratory function test? ☐ No ☐ Yes
If 'Yes', please provide dates and results:

11. Have you ever had any complications or other conditions related to your asthma (eg cardiac or respiratory arrest, heart disease, chest deformities)? ☐ No ☐ Yes
If 'Yes', please provide details:

12. a. Please provide details of the doctor who you consult for your asthma:

b. When did you last consult this doctor for asthma? D D M M Y Y Y Y

Cyst, mole, skin lesion questionnaire

1. Please indicate in the appropriate box(es) the condition(s) you have had, or received treatment for:
   - ☐ Mole or naevi
   - ☐ Basal Cell Carcinoma (BCC)
   - ☐ Hyperkeratosis or solar keratosis or Squamous Cell Carcinoma (SCC)
   - ☐ Sebaceous cyst/ lipoma/ fatty cyst just under the skin
   - ☐ Melanoma
   - ☐ Other lesions (please describe below):

2. Please advise the location(s) of the skin lesion(s):

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Cyst, mole, skin lesion questionnaire (continued)

3. Has the lesion been fully removed? ☐ No ☐ Yes

If 'Yes', please advise the method and date(s) of removal (eg frozen, 'burnt', lasered off or surgically removed):

If surgically removed please also advise the pathology results?

If 'No', please advise the reason why it has not been removed?

4. Are any follow ups required? ☐ No ☐ Yes

If 'Yes', please advise details including frequency

5. Give details of your most recent visit to a doctor or hospital relating to this condition:

Date	Medical provider	Address
/ /		
/ /		
/ /		

Abnormal cervical screening or pap smear test or positive HPV test questionnaire

1. Please indicate in box(es), the relevant condition(s) and or result(s) you've had or received treatment for:

- ☐ Intermediate risk result
- ☐ Higher risk result
- ☐ Unsatisfactory result
- ☐ Carcinoma
- ☐ Human Papilloma Virus (HPV)
- ☐ CIN 1
- ☐ CIN 2
- ☐ CIN 3
- ☐ Atypia or change (caused by infection or irritation)
- ☐ Other abnormality

2. What date was the condition(s) diagnosed?

Condition(s)	Date
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

3. Did you receive any treatment?

If 'Yes' please confirm dates, type of treatment (eg colposcopy, biopsy, laser, LLETZ/loop excision) and results:

4. Have you had a follow up cervical screeningr pap smear test? ☐ No ☐ Yes ☐ Awaiting follow up

If 'Yes' please provide all dates and results since the abnormal results:

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Abnormal cervical screening or pap smear test or positive HPV test questionnaire (continued)

5. Provide details of your most recent visit to a doctor or hospital relating to the condition/result:

Date D D M M Y Y Y Y

Medical Provider

Address

6. When is your next screening due?

Diabetes questionnaire

1. Which of the following best describes your condition:

- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Gestational Diabetes
- ☐ Not sure
- ☐ Glucose Intolerance
- ☐ Diabetes Insipidus
- ☐ Insulin Resistant

2. How long ago were you diagnosed with this condition?

3. How is this condition treated?

☐ Diet ☐ Oral medication ☐ Insulin
☐ Other

Please advise details including name of medication, dosage used per day:

4. Do you have any complications as a result of your diabetes (eg eye, kidney or nerve problems, high blood pressure or vascular disease etc)?

If 'Yes', please provide details:

5. Have you ever suffered from a diabetic or insulin coma, or required hospitalisation due to your diabetes or any related condition?

If 'Yes', please provide details:

6. When did you last have this condition checked by a medical practitioner?

D D M M Y Y Y Y

7. What was the date and the result of your last Glycosylated Haemoglobin test?

6. Health questionnaires (continued)

22. Detailed health questionnaires (continued)

Diabetes questionnaire (continued)

8. For gestational diabetes – What was the date and result of your last Glucose Tolerance test?

9. Please provide your doctor's details, including name and address:

Date	Doctor	Address
/ /		
/ /		
/ /		

To be completed by the Person to be insured only if applying for Total and Permanent Disablement or Income Protection insurance.

7. Occupation details

! If you have not applied for Total and Permanent Disablement or Income Protection Insurance, go to page **30**.

'You' refers to the Person to be insured (unless otherwise indicated).

23. Please give details of your current and previous occupation or jobs over the last five years. If you have a second occupation, please give details in **33**.?

	From	To	Occupation	Employer
Current principal occupation	/ /	Present		
		Cross which is applicable	☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	

! If you work in the mining or oil and gas industry, please ensure you complete **35**.

24. In the last five years have you ceased or do you intend to cease working for reasons other than holidays (eg unemployment or end of contract)? ☐ No ☐ Yes

If 'Yes', please provide details:

To be completed by the Person to be insured only if applying for Total and Permanent Disablement or Income Protection insurance.

7. Occupation details (continued)

25. How many hours per week do you spend working in your main occupation? hours

26. How many weeks per year do you spend working in your main occupation? weeks per year

27. In your **main** occupation, what percentage of time do you spend performing the following types of duties:

	Describe details of specific duties performed	(%)
Sedentary/Administrative		
Supervising manual work		
Light manual		
Heavy manual		
Home duties (include details of dependants including ages and any other relevant information)		
Other (including hazardous duties, eg handling dangerous substances, working at heights/underground/ offshore, refinery)		
	Total duties	**100%**

28. a. What qualifications do you hold in relation to your main occupation (eg trade certificate, degree)?

b. When did you qualify/graduate? D D M M Y Y Y Y

c. Please give details of any other qualifications you hold:

29. Do you ever work from home? ☐ No ☐ Yes
If 'Yes', provide details of actual work you perform at home, your work set-up (eg separate office) and frequency and type of contact with clients:

30. Do you intend to change your occupation or employment status? ☐ No ☐ Yes
If 'Yes', please provide details below:

31. Have you ever been bankrupt or entered into a personal insolvency arrangement? ☐ No ☐ Yes
If 'Yes', please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable.

32. Has any business that you have, or have had ownership of, ever been liquidated or been placed under administration? ☐ No ☐ Yes
If 'Yes', please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable.

33. Do you have any other occupations or jobs? ☐ No ☐ Yes
If 'Yes', please provide details below including specific duties:

34. Number of hours per week worked and annual income derived from your other occupations or jobs. hours $

To be completed by the Person to be insured only if applying for Total and Permanent Disablement or Income Protection insurance.

7. Occupation details (continued)

! Only complete **35** if you work in the mining or oil and gas industry.

35. Questions to be completed by individuals working in the mining, oil and gas industries:

a. Please advise the type of resource mined/extracted/refined at the mine/plant/platform:

Metal	Coal	Oil	Gas	Other

b. How do you travel to and from your work location?

☐ Commute to your work location daily from home ☐ Fly in fly out to your work location

☐ Other, please provide details:

c. Please complete the table below regarding your salary and any allowances paid for the last 2 financial years:

	Last financial year ($)	Year immediately prior to last ($)
Salary (including super)		
Bonus		
Allowances (eg site allowance, living away from home allowance, travel allowance)		
Other		

8. Income details

36. Insurable income

What is Insurable income? This is income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will stop if you are unable to work. It does not include investment or interest income.

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, we may call for evidence of your income and business expenses.

! If you are **self-employed, in a partnership or an employee of your own company (or contractor)**, please complete the 'For self-employed' section below. **OR** If you are **an employee**, please complete the 'For employees' section on page **27**.

For self-employed (sole trader, partnership, employee of own company or trust)

! Only complete this section if you are self-employed. This includes sole traders, partners, contractors or if you are an employee in your own company.

a. Please provide your company's business income details in the table below for the last two financial years for which tax returns, assessment notices and accounts are available. **Do not include any amounts paid to you that are paid from past profits, capital or loans.**

Tax year ending	Gross income for entire business ($)	Less all expenses incurred in earning that income ($)	Equals net business income before tax ($)	Wages/salary ($)	Drawings/ director's fees paid to you ($)	Your total income ($)
30 / 06 /						
30 / 06 /						

b. Did your business contribute to a complying superannuation fund on your behalf? ☐ No ☐ Yes

If 'Yes', how much or what percentage?

c. What percentage of the business do you own? % If not 100% owner, please provide percentage ownership and roles/duties of the other owners. Please include details of any income splitting arrangements:

To be completed by the Person to be insured only if applying for Total and Permanent Disablement or Income Protection insurance.

8. Income details (continued)

36. Insurable income (continued)

For self-employed (sole trader, partnership, employee of own company or trust) (continued)

d. How many people do you employ?

e. What proportion of total business income is from your personal exertion? %

f. Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)? ☐ No ☐ Yes
If 'Yes', please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax ($)

g. If you were to become disabled, would any of your income (eg investment income and trail/renewal commission) continue? If 'Yes', please provide the following details: ☐ No ☐ Yes

i. What type and amount of income would continue if you were not working and if this is for an investment property, please advise if the property is positively or negatively geared?

ii. Is there an agreement in place (written or otherwise) in relation to this entitlement and when it may cease? ☐ No ☐ Yes
If 'Yes', please provide further details:

h. Has your business had a net operating loss over either of the last two financial years? ☐ No ☐ Yes
If 'Yes', please provide copies of your full company accounts for the last two financial years, including any associated entities.

i. So far this financial year, is your business trading profitably? If 'No', please provide details in the space below: ☐ No ☐ Yes

What is Insurable income? This is income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will stop if you are unable to work. It does not include investment or interest income.

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, we may call for evidence of your income and business expenses.

! If you are **self-employed, in a partnership or an employee of your own company (or contractor)**, please complete the 'For self-employed' section on page 26. **OR** If you are **an employee**, please complete the 'For employees' section below.

For employees

! Only complete this section if you are an employee and do not have any ownership in your employer's business.

j. Please indicate your current employment status:
☐ Permanent full-time ☐ Permanent part-time ☐ Casual or non-permanent ☐ Not currently employed

☐ other, please specify:

To be completed by the Person to be insured only if applying for Total and Permanent Disablement or Income Protection insurance.

8. Income details (continued)

36. Insurable income (continued)

For employees (continued)

k. Please give details of your total remuneration package from all sources currently and for the last two financial years.

	Current ($)	Last financial year ($)	Year immediately prior to last ($)
Salary			
Bonuses			
Commissions			
Regular overtime			
Superannuation			
Total			

l. What rate of superannuation guarantee is your employer contributing on your behalf? ____ %

m. Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)? ☐ No ☐ Yes
If 'Yes', please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax ($)

n. If you were to become disabled, would any of your income (including investment income) continue? ☐ No ☐ Yes
If 'Yes', please answer i and ii:

i. What is the income amount that would continue, for how long, and the source (eg salary, sick pay in excess of 100 days, company profits, investments, rental) and if this is for an investment property, please advise if the property is positively or negatively geared?

ii. Is there an agreement in place (written or otherwise) that determines when this entitlement will cease? ☐ No ☐ Yes
If 'Yes', please provide details:

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To be completed by the Person to be insured for all applications.

9. Medical authority

Before you complete this page please read 'Privacy use and disclosure of personal information' in the **Information sheet**.

Authority for Resolution Life to release medical information to usual doctor

Only complete this section if you authorise Resolution Life to release medical information to your doctor upon an adverse assessment of your application.

Family name | Given name(s) | Date of birth

I, _____ _____ D D M M Y Y Y Y authorise Resolution Life to advise Doctor _____ of the reason(s) behind any adverse assessment of my application if it was based on health evidence obtained during the assessment of this application. I also authorise Resolution Life to provide copies of the relevant health evidence to the doctor noted above.

Signature of Person to be insured

✗ _____ D D M M Y Y Y Y

Financial authority

Only complete this section if you want your accountant or financial adviser to release information to Resolution Life.

Family name | Given name(s) | Date of birth

I, _____ _____ D D M M Y Y Y Y authorise my accountant/financial adviser to release to the insurer (Resolution Life), all information that the insurer requests for the purpose of assessing my application for insurance. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

Signature of Person to be insured

✗ _____ D D M M Y Y Y Y

Accountant/financial adviser name

Accountant/financial adviser contact number

Accountant/financial adviser address

This page has been left blank intentionally.

To be completed by the Person to be insured.

10. Declarations and consent

Duty to Take Reasonable Care Not to Make a Misrepresentation – I acknowledge that I have read and understood the section entitled 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the **Information sheet**, and understand that any cover issued by the insurer will be based on the answers I provide to questions in this form and any other questions that are asked before the insurer advises me in writing that it has issued a policy. I understand that if the questions are not answered truthfully, accurately and completely the insurance I have applied for may be avoided (treated as if it never existed) or altered and if I have made a claim under the insurance it may not be payable or be reduced. If someone has assisted me to complete this form (such as my financial adviser) I have checked every answer (and if necessary made corrections) before this form is submitted.

Truth and accuracy – I have checked the truth, accuracy and completeness of the information submitted with this application form, and all statements in writing given in support of this application which shall, subject to law, form the basis of the contract of insurance. I have not given any further information relevant to the risks to a financial adviser of the insurer or the insurer itself.

Application – I propose to the insurer to provide insurance on the usual conditions set out in the Plan Document, including any modifications to the plan or changes in premiums which the insurer considers appropriate given the information submitted in connection with this Application form.

Financial information – I give the insurer permission to seek any financial information needed in connection with this Application or any plan issued as a result, I understand that if I withhold consent, Resolution Life may not be able to provide the products and services requested.

Privacy – I have read and understood the Privacy – use and disclosure of personal information. I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement. I acknowledge that I can opt out from the use of that information for the purpose of direct marketing by phoning the Customer Service Centre.

Acceptance of this Application – is subject to the insurer searching its records for any other business with the Person to be insured and the insurer may vary the terms of the plan to be issued on the basis of any information contained in its records.

I have read and understood the important details provided at **resolutionlife.com.au/whyinsurance**

Person to be insured's name (please print)

Person to be insured's signature

✗

Date signed

D D M M Y Y Y Y

Please complete for Spouse Superannuation plans only

Contributor's name (please print)

Contributor's signature

✗

Date signed

D D M M Y Y Y Y

Signature of proposer (Equity Trustees Superannuation Limited) by its duty appointed Attorney under Power of Attorney

✗

Where to send this form

Mail or email this completed form to:

Resolution Life Customer Service
GPO Box 5441
Sydney NSW 2001

askus@resolutionlife.com.au

Any Question?
133 731

11. Financial adviser checklist

Type of insurance

Have you spoken to our Underwriting team for pre-application advice? ☐ No ☐ Yes

If 'Yes', who did you speak to?

If this proposal is for a new plan, what is the total cover across all plans? $

Is there any other proposal being submitted for the person insured? ☐ No ☐ Yes

If 'Yes', what type? ☐ Life ☐ Income Protection ☐ Trauma ☐ Business Expenses ☐ TPD

Is the first premium enclosed with the Application? ☐ No ☐ Yes

Type of insurance

Is this proposal replacing an existing plan? ☐ No ☐ Yes Existing Resolution Life or AC&L plan number

Existing plan number other insurer

Is this proposal for a continuation option? ☐ No ☐ Yes Existing plan number

Have all the requirements been submitted? ☐ No ☐ Yes

Underwriting and financial requirements

Has the person to be insured completed and signed all the relevant authorities, including medical and/or financial authorities? ☐ No ☐ Yes

Have you arranged for any mandatory medical examinations or pathology tests to be completed? ☐ No ☐ Yes

If you have advised the life insured to have these tests specify name of doctor, paramedical facility or pathology laboratory who will arrange for the test:

Additional information

If changes have been made to the application, has the person to be insured initialled all changes? ☐ No ☐ Yes ☐ Not applicable

Has supporting financial evidence been included with this application? ☐ No ☐ Yes

Has an illustration/quote been provided with this application? ☐ No ☐ Yes

Is there any other documentation attached to this proposal? ☐ No ☐ Yes

If 'Yes', please specify:

Duty to Take Reasonable Care Not to Make a Misrepresentation

Has the person to be insured read 'The Duty to Take Reasonable Care Not to Make a Misrepresentation'? ☐ No ☐ Yes

Have you explained to the client the possible implications on the contract of any misrepresentation to the insurer? ☐ No ☐ Yes

Are there any other circumstances or facts, such as the client's background, not fully covered by answers provided herein which you feel may assist our assessment of this application? ☐ No ☐ Yes

If 'Yes', please specify: