Resolution Life

Application to increase insurance cover for individual super

– C-LIFE & PRU PRODUCTS
– PERSONAL SUPERANNUATION UMBRELLA INVESTMENT PLANS

Important information

How to apply

1. Read the Duty to take reasonable care section carefully on page 2 of this application form.
2. Complete, sign and date all relevant sections of this Application Form.
3. Mail this Application Form to:

Resolution Life, Locked Bag 5075, Parramatta NSW 2124.

Please note: To enable your insurance premiums to continue to be paid from your account you must ensure at the time each insurance premium is to be deducted that there are sufficient funds in your account for this purpose.

Section 1 – Checklist for applicants

Personal Statement	**Death, Total and Permanent Disablement (TPD) and Income Protection cover**
Section A – Occupation and income details	☐
Section B – Habits	☐
Section C – Height and weight	☐
Section D – Doctor's details	☐
Section E – Insurance history details	☐
Section F – Family history details	☐
Section G – Medical history details	☐
Section H – Additional medical details	☐
Section I – Lifestyle	☐
Section J – Residence and travel details	☐
Section K – Pastimes and activities	☐
Section L – General health questionnaire	☐
Section M – Specific questionnaires	☐
Section N – Pastimes and activities questionnaires	☐
Section O – Active Account Election	☐

Declaration	**Death, Total and Permanent Disablement (TPD) and Income Protection cover**
Section P – General declaration	☐

Section 1 – Checklist for applicants (continued)

Other requirements

☐ Read the duty to take reasonable care (page 2)

☐ Read the privacy collection statement (page 2)

☐ Sign the consent for accessing health information (page 4)

☐ Sign the customer contact authority (page 25)

Section 2 – Your duty to take reasonable care

About this application

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

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

The duty to take reasonable care

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

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

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

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. There are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). These are intended to put us in the position we would have been in if the duty had been met.

Your cover could be avoided (treated as if it never existed), or its terms may be varied. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Before we exercise any of these remedies, we will explain our reasons and what you can do if you disagree.

Guidance for answering our questions

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

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

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.

If you need help

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

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

Notifying the insurer

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

Section 3 – Privacy Collection Statement

Our privacy policy contains information on how we collect, use and disclose your personal information (including disclosure to overseas recipients). Visit **resolutionlife.com.au/aia/privacy** for a copy.

Section 4 – Consent for Accessing Health Information

Notes on releasing information about your health

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

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

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

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

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

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

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

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

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

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

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

I agree to all the following:

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

Name

Signature

X

Date (dd/mm/yyyy)

/ /

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

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

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

I agree to all the following:

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

Name

Signature

X

Date (dd/mm/yyyy)

/ /

Section 5 – Personal details

Life Insured

Policy / Account number

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please specify)

Given name(s) Surname

Residential address (PO Box is not acceptable)

State Postcode Country

Postal address

State Postcode Country

Mobile number Alternate phone number Date of birth (dd/mm/yyyy)

/ /

Email address Gender

☐ Male ☐ Female

Section 6 – Increased insurance cover application details

Please complete sums insured for the appropriate cover desired.

Type of cover	**Sum insured**	
Death	$	Minimum amount – $50,000 Maximum amount – No maximum
Total and Permanent Disablement (TPD)	$	Minimum amount – $50,000 Maximum amount – $1,000,000
Income Protection	$	Maximum amount – $10,000 per month

Please note: TPD cover can only be taken with Death cover and the amount of TPD cover cannot exceed the level of Death cover. You can apply for an increase to Death cover up to age 64, TPD cover up to age 54 and Income Protection cover up to age 54.

Section 7 – Personal statement

You need to complete all sections of this Personal statement as indicated.

Customer contact

Our underwriters are committed to assessing insurance applications as quickly as possible.
To do this, our underwriters or representatives may need to contact you directly to speed up the process.

Are you happy if we call/email you to clarify or gain further information?

Yes ☐ ▶ **Please complete below**

No ☐

Most convenient day to contact you:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any

Section 7 – Personal statement (continued)

Preferred method of contact		Preferred contact time (Monday to Friday 9 am to 5 pm (AEDT))			
Home phone number	☐	from	am/pm	to	am/pm
Business phone number	☐	from	am/pm	to	am/pm
Mobile phone number	☐	from	am/pm	to	am/pm
Email address	☐				

Section A - Occupation and income details

1. What is the main occupation you are working in?

What industry do you work in?

2. What is your employer's name (or business name if self-employed)?

3. What is your actual business address (not a PO box)?

State Postcode Country

4. Does your main occupation involve performing in any of the following hazardous duties or environments?

Working at heights above 15 metres (for more than 10% of the time)	☐ Yes	☐ No
Working in armed forces or with fire arms	☐ Yes	☐ No
Working on oil or gas rigs/platforms	☐ Yes	☐ No
Working underground or handling explosives	☐ Yes	☐ No
Underwater diving	☐ Yes	☐ No

Please provide full details of the hazardous duty including but not limited to the percentage of time on the duty.

5. What is your employment status? (please tick (✔) the appropriate box)

☐ Self-employed (or employee of own company)*/Contractor ☐ Employed ☐ Unemployed

☐ Home duties ☐ Student ☐ Retired

***If 'Self-employed', please complete questions below, otherwise go to Q6.**

a. How long have you operated in this capacity?

☐ Years ☐ Months

b. What are the number of hours you consistently work per week?

Section A - Occupation and income details (continued)

6. What is the nature of the work in your main occupation?

Please note: the list below represents the physical nature of duties only.

Nature of duty	Percentage (%) time spent on each duty
Administration/clerical (e.g. filing, computer work, office duties)	%
Light manual work (e.g. deliveries, lifting under 5kg)	%
Supervision of manual work	%
Care of dependants/homemaker (only if TPD and occupation is home duties)	%
Manual work (e.g. cleaning, lifting over 5kg, carpentry, plumbing)	%
Total	**= 100%**

7. Do you work from home?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q8**

a. What percentage of your time is spent working from home?

%

b. What weekly percentage of time are you in face-to-face contact (i.e. other than by phone or email) with your clients/employer?

%

c. Do you have the following in your business set-up?

Separate office	☐ Yes	☐ No
Separate entrance to place of residence	☐ Yes	☐ No
Separate business phone	☐ Yes	☐ No

8. What is your current annual income* earned through personal exertion (excluding superannuation) from your main occupation (less all business expenses), but before tax?

$ p.a.

Current annual income excludes superannuation, but includes reportable fringe benefits you earned. If you are self-employed, current annual income also excludes all business expenses, but includes eligible payments to your spouse, share of depreciation, director's fees or share of profit from a trust or supporting service company.

Additional income details – Only complete if you are applying for an increase to your Income Protection insurance cover.

9. What is the percentage (%) of superannuation contribution (e.g. up to 15%)?

%

10. What was your annual income earned through personal exertion, from your main occupation, less all business expenses, but before tax, over the last two financial years?

	Period		Annual income earned
Last financial year	**01/07/**	**– 30/06/**	$
Previous financial year	**01/07/**	**– 30/06/**	$

Section A - Occupation and income details (continued)

11. Do you receive other income from investments (e.g. interest, dividends, net rental income), which **exceeds 25%** of your current annual income?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q12**

Please provide details of other income from investments	**Amount p.a.**
Dividends and interest	$
Net rental income	$
Other source of income (please specify):	$
Total	**$**

12. If you became disabled, would any part of your income continue beyond 30 days?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q13**

Source of income (e.g. sick pay, pension, company profit, salary continuance insurance)	**Amount of income per month**	**How long would this continue?**	
	$	Years	Months
	$	Years	Months

13. Do you intend to change your occupation or duties, employment situation or take extended leave (e.g. sabbatical, maternity leave, paternity leave) in the next 12 months?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q14**

Please provide details of change

14. In the last five years, have you been made bankrupt or placed in receivership or liquidation, or are you currently in the process of being assessed for bankruptcy or insolvency?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section B - Habits**

a. Have you been discharged?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section B - Habits**

b. How long ago were you discharged?

☐ Years ☐ Months

Section B – Habits

1. Have you smoked tobacco at any time during the last 12 months?

Yes ☐ ▶ **Please indicate type and amount smoked below**

No ☐ ▶ **Go to Q2**

Type smoked	**Per day**	**Per week**	**Per month**	**Per year**
Cigarettes ☐				
Cigars/Pipes ☐				

Section B – Habits (continued)

2. Do you drink alcohol?

Yes ☐ ▶ **Please indicate the average number of standard drinks* in only ONE of the below**

No ☐ ▶ **Go to Section C – Height and weight**

Per day	Per week	Per month	Per year

*A standard drink is equivalent to: one nip of spirits, one glass of wine, 250ml of beer.

Section C – Height and weight

What is your current height and weight?

Height	cm	**OR**	feet	inches
Weight	kg	**OR**	stone	lbs

Section D – Doctor's details

1. Please provide the name and address of the last doctor or medical centre that you consulted.

Doctor's name or medical centre

Doctor/medical centre/hospital address

State Postcode Country

Phone number

2. Have you been a patient of this doctor or medical centre for less than 12 months?

Yes ☐ ▶ **Please provide the name and address of your previous doctor or medical centre below**

No ☐ ▶ **Go to Section E – Insurance history details**

Doctor's name or medical centre

Doctor/medical centre/hospital address

State Postcode Country

Phone number

Section E – Insurance history details

1. Other than this application, have you ever applied for, or are you currently applying for, any life, disability, trauma, accident or sickness insurance cover with Resolution Life or any other insurance company or under any superannuation scheme.

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q2**

Insurer	Type of cover	Insured amount	Policy number (if known)	Date policy commenced (dd/mm/yyyy)	To be replaced by this cover*?
		$		/ /	☐ Yes ☐ No
		$		/ /	☐ Yes ☐ No
		$		/ /	☐ Yes ☐ No
		$		/ /	☐ Yes ☐ No

*** Please note Applicants/Policyowners:** If it has been indicated above (i.e. by ticking 'Yes') that certain cover is to be replaced by the increased cover now being applied for, any increased cover Resolution Life issues is conditional on the other cover being cancelled before an insured event occurs under that cover. This means any increased cover Resolution Life, issues does not apply until the other cover has been cancelled as required.

2. Other than this application, have you ever applied for, or are you currently applying for, any life, disability, trauma, accident or sickness insurance cover with Resolution Life or any other insurance company or under any superannuation scheme.

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q3**

Insurer	Type of cover	Terms offered	Reason for terms	Date policy commenced (dd/mm/yyyy)
				/ /
				/ /

3. Are you claiming or have you ever claimed under legislation (e.g. Worker's Compensation, Disability Pension, Veterans' Affairs) or any other insurance policy providing accident or sickness benefits (including but not limited to disability, trauma insurance, insurance provided by a superannuation scheme, credit card insurance or travel insurance)?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section F – Family history details**

Benefit type/ Source	Reason for claim (dd/mm/yyyy)	Date claim made	Total claim amount	Date claim finalised (dd/mm/yyyy)
		/ /	$	/ / **OR** ongoing ☐
		/ /	$	/ / **OR** ongoing ☐

Section F – Family history details

The next few questions are about your family's medical history. You should only answer about your mother, father, sisters or brothers. Have your natural parents, brothers or sisters ever had any of the following conditions?

• Heart problems, cardiomyopathy, stroke, or sudden death • Diabetes • Any dementia, alzheimer's or parkinson's disease • Cancer of any type (specify type of cancer in table below e.g. breast or colon cancer) • Motor neurone disease, huntington's disease, multiple sclerosis, muscular dystrophy or polycystic kidney disease • Any other condition which runs in your family	☐ Yes ☐ No

If you answered 'Yes' please complete table below, otherwise go to Section G – Medical history details.

Section F – Family history details (continued)

Family member	Condition	Approximate age diagnosed

Please note: If you have a favourable genetic test result, for example, to show that you are not carrying a gene pattern associated with developing an illness that runs in your family, you may choose to disclose the result.

Section G – Medical history details

1. Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following?

a. **Asthma (except childhood), chronic bronchitis, emphysema, recurrent pneumonia** or any **other lung complaint** ☐ Yes ☐ No

b. **Diabetes, gestational diabetes, insulin resistance** or **abnormal blood sugar** ☐ Yes ☐ No

c. **Cysts, moles, sunspots, skin lesion** or **skin cancer** ☐ Yes ☐ No

d. **Back, neck, shoulder, knee, elbow** complaints, sciatica, disc or spine complaints, injury or disorder of the joints, bones or muscles ☐ Yes ☐ No

e. **Depression** or **mental illness** (including but not limited to stress, anxiety, panic attacks, behavioural disorders [attention deficit disorder, asperger's syndrome], nervous disorders or schizophrenia/bipolar disorder] ☐ Yes ☐ No

f. High blood pressure, raised cholesterol ☐ Yes ☐ No

If you have answered 'Yes' **to any part of Q1 a to f above**, please complete the **Specific questionnaire** on the related condition in **Section M – Specific questionnaires on page 16-21**.

2. Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following?

a. Chest pains, heart complaint, cardiomyopathy, heart murmur, palpitations or rheumatic fever ☐ Yes ☐ No

b. Stroke, paralysis, neurological disorder, multiple sclerosis, muscular dystrophy or blood vessel disorder ☐ Yes ☐ No

c. Alzheimer's, parkinson's, dementia or any other disorder of the brain ☐ Yes ☐ No

d. Cancer, tumour or melanoma ☐ Yes ☐ No

e. Thyroid, glandular, pituitary or pancreatic disorder ☐ Yes ☐ No

f. Gastric or duodenal ulcer, persistent indigestion, gastro-oesophageal reflux disorder or barrett's oesophagus ☐ Yes ☐ No

g. Ulcerative colitis, crohn's disease, colonic polyps, irritable bowel or any other bowel disorder ☐ Yes ☐ No

h. Any disorder of the gall bladder or liver (including fatty liver/raised liver function tests) ☐ Yes ☐ No

i. Varicose veins, haemorrhoids or hernia ☐ Yes ☐ No

j. Disorder of the kidney, bladder, blood in urine, kidney stones or prostate (including raised prostate specific antigen (PSA) ☐ Yes ☐ No

k. Epilepsy, fits of any kind, fainting episodes, dizziness, vertigo, recurring headaches or migraines ☐ Yes ☐ No

l. Lethargy, sleep apnoea or any sleeping disorder including insomnia ☐ Yes ☐ No

m. Arthritis (including osteo, rheumatoid or psoriatic), gout or osteoporosis/osteopenia ☐ Yes ☐ No

n. Chronic fatigue syndrome, ongoing tiredness, fibromyalgia, repetitive strain injury or any other chronic pain syndrome ☐ Yes ☐ No

o. Psoriasis, eczema, dermatitis or any other skin disorder ☐ Yes ☐ No

Section G – Medical history details (continued)

p. Anaemia, leukaemia, haemophilia, deep vein thrombosis, pulmonary embolus, haemochromatosis or any other blood disorder (e.g. factor V leiden) ☐ Yes ☐ No

q. Any impairment of sight including blurred vision (other than short or long sightedness), hearing including tinnitus, deafness and high frequency hearing loss or speech ☐ Yes ☐ No

r. Any sexually transmitted diseases ☐ Yes ☐ No

If you have answered 'Yes**' to any part of Q2 a to r above**, please complete the **General health questionnaire(s)** in **Section L on page 14 for each of these conditions**.

Section H – Additional medical details

1. In the last two years have you consulted a doctor or health professional for any other reason not already mentioned in **Section G Q1 and 2** in this application (excluding minor ailments such as colds and flu and contraceptive medication)?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q2**

a. When was this consultation? (please tick (✔) the appropriate box)

☐ In the last 3 months ☐ 3-6 months ago ☐ 6-12 months ago ☐ 12-24 months ago

b. What was the condition/reason for the consultation?

c. When was this consultation? (please tick (✔) the appropriate box)

☐ All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication

☐ Tests conducted – results pending

☐ Routine tests conducted – results all clear and normal

☐ Not fully recovered yet

☐ Referred to specialist/health professional

☐ Ongoing treatment/surveillance/on-going monitoring

2. In the next two years are you considering or been advised to seek medical advice, treatment or tests (other than for routine general health check-ups) or surgery in the future?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q3**

What is the reason for seeking advice, treatment, tests or surgery in the future?

3. Are you currently being tested for or have any signs or symptoms of ill health or disability not already mentioned in this application?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q4**

Please provide details of tests being conducted or symptoms

4. In the last 5 years, due to injury or illness, have you been off work for more than 5 consecutive days for any condition not already mentioned in this application?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q5**

Please provide details of the condition and the total time off work

Section H – Additional medical details (continued)

5. Do you take or have you ever taken or been prescribed any medications on a regular or ongoing basis for any conditions not already mentioned in this application?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q6**

Please provide details of the treatment or medication and the condition

6. Have you ever undergone screening for diseases or conditions such as, but not limited to, bowel cancer?

Yes ☐ ▶ **Please complete 'a' below**

No ☐ ▶ **Go to Q7**

a. Were you advised to seek further medical follow-up or specific ongoing monitoring?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q7**

Please provide details of the condition and follow up investigations

7. Do you have total cover (applied for including any cover with another insurer or superannuation fund) of more than
- $500,000 of lump sum death cover or
- $500,000 of total and permanent disablement cover (TPD) or
- $200,000 of trauma and/or critical illness cover or
- $4,000 a month in total of any combination of income protection and salary continuance?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q8 – females only. Otherwise proceed to Section I – Lifestyle**

Please note: If you have a favourable genetic test result, for example, to show that you are not carrying a gene pattern associated with developing an illness that runs in your family, you may choose to disclose the result

a. Have you had or do you in the next 12 months intend to have a genetic test?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q8**

Please note: If you have had a genetic test as part of a medical research study conducted by an accredited university or medical research institution where your individual test result has not been and will not be provided to you, or you have specifically asked not to receive the test results, then you may answer 'No'.

b. What is/was the reason for your genetic test?

c. What was the result of your genetic test?

☐ or test has not been done yet

Additional questions (for female life to be insured only).

8. Have you had an abnormal pap smear?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q9**

a. What type of abnormal pap smear did you have? (e.g. HPV CIN 1, CIN 2, CIN 3) (please tick (✔) the appropriate box)

☐ Atypia cells ☐ CIN 1 (low grade abnormality) ☐ CIN 2 (high grade abnormality)

☐ CIN 3 (high grade abnormality) ☐ Human Papilloma Virus (HPV) ☐ Not known

b. How long ago was this? (please tick (✔) the appropriate box)

☐ In the last 6 months ☐ 6-12 months ago ☐ 12-36 months ago ☐ 3-5 years ago ☐ More than 5 years ago

Section H – Additional medical details (continued)

c. Have you successfully been treated for this condition? (e.g. colposcopy, cone biopsy, hysterectomy, laser or Lletz)

☐ Yes ☐ No

d. Were your last three pap smears normal and at least six months apart?

Yes ☐ ▶ **Go to Q9**

No ☐ ▶ **Please provide details below**

9. Have you ever had a breast lump, cyst or any other type of breast abnormality (even if you have not consulted a doctor) or an abnormal breast ultrasound or mammogram test result?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q10**

a. How long ago was this? (please tick (✔) the appropriate box)

☐ In the last 6 months ☐ 6-12 months ago ☐ 12-36 months ago ☐ 3-5 years ago ☐ More than 5 years ago

b. Was this fully investigated by the following? (please tick (✔) the appropriate box)

☐ Ultrasound ☐ Fine needle aspiration ☐ Mammogram ☐ Not investigated

☐ Other (please specify):

c. What was the result/outcome of your test? (please tick (✔) the appropriate box)

☐ Test conducted – results pending ☐ Test conducted – results all clear and normal

☐ Ongoing treatment/investigations ☐ Ongoing monitoring

d. Have you been advised by your doctor that this condition was due to cancer, tumour or abnormal cells?

☐ Yes ☐ No

10. Have you ever had or sought treatment for any condition of the ovaries, uterus, endometrium or perineum?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q11**

11. Are you currently pregnant?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section I – Lifestyle**

a. How many weeks pregnant are you?

b. Do you or have you ever had any complications with pregnancy or childbirth (e.g. diabetes, pre-eclampsia, post natal depression) excluding elective caesarean or miscarriage within the first 15 weeks of pregnancy?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to C**

Please tick (✔) the appropriate box

☐ Gestational diabetes ☐ Pre-eclampsia (high blood pressure) ☐ Post-natal depression

☐ Other (please specify):

c. Will you be returning to work in the same capacity as your current occupation (e.g. back to the same or greater hours) within or at the end of 12 months from the date you commence maternity leave?

Yes ☐ ▶ **Go to Section I – Lifestyle**

No ☐ ▶ **Please complete below**

Please provide details of any intended change in working status, occupation, hours, etc.

Section I – Lifestyle

1. In the last 10 years have you taken any illegal drugs?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q2**

a. What type of drugs were they? (e.g. marijuana, ecstasy, speed, MDMA, GBH)

b. When did you start taking drugs? (dd/mm/yyyy)

/ /

c. When did you last take drugs? (dd/mm/yyyy)

/ /

2. In the last 10 years have you been advised to cease drinking alcohol or received counselling or treatment for alcohol or substance abuse?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q3**

a. I received counselling and/or treatment for the use of alcohol ☐ Yes ☐ No

b. I received counselling and/or treatment for the use of drugs ☐ Yes ☐ No

c. When did you start receiving counselling/treatment for the use of drugs or alcohol? (dd/mm/yyyy) / /

d. When did you last use drugs or drink alcohol? (dd/mm/yyyy) / /

3. Have you ever been tested positive for HIV, Hepatitis B or Hepatitis C or are you awaiting the results of such a test?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q4**

Please specify which condition you were tested positive for

4. **In the last 5 years have you had:**

a. Anal intercourse without a condom (except in a relationship between you and one other person only where neither of you had sex with anyone else for at least 5 years)? ☐ Yes ☐ No

b. Sex without a condom with someone you know or suspect to be HIV positive? ☐ Yes ☐ No

c. Sex without a condom with anyone who injects non-prescribed drugs? ☐ Yes ☐ No

d. Sex without a condom with a sex worker or as a sex worker? ☐ Yes ☐ No

If you have answered Yes to questions 4 a to d please provide details below. If you answered No to questions 4 a to d go to Section J.

Please note: you may be asked to complete a confidential questionnaire.

Section J – Residence and travel details

1. Are you a permanent resident of Australia or New Zealand?

Yes ☐ ▶ **Go to Q2**

No ☐ ▶ **Please complete below**

a. What country did you migrate from?

Section J – Residence and travel details (continued)

b. What type of visa do you hold? (please tick (✔) the appropriate box)

☐ 457 (Temporary work (skilled) visa) ☐ Spouse's visa ☐ 418 (Education or Student visa)

☐ 419 (Visiting academic visa) ☐ Tourist visa ☐ 426 or 427 (Domestic staff visa)

☐ Other (please specify):

c. When will your visa expire? (please tick (✔) the appropriate box)

☐ Within 12 months ☐ 12-24 months ☐ More than 2 years

2. Have you lived in Australia for more than 2 years?

Yes ☐ ▶ **Go to Q3**

No ☐ ▶ **Please complete below**

Please provide details of the type of visa or status held previously (e.g. bridging visa, spouse visa, refugee status) and the country you migrated from

3. In the next 12 months, do you plan to travel, live or work in another country?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Section K – Pastimes and activities**

a. What country/ies do you plan to travel to?

b. What is the reason for travelling? (please tick (✔) the appropriate box)

☐ Holiday ☐ Business ☐ Residing

☐ Visiting family/relatives ☐ Studying ☐ Emigrating

c. How often do you intend to travel to this country/ies in the next 12 months? (Please enter the number of times below)

d. What is the total duration of your trip/s? (Please advise the number of weeks)

weeks

Section K – Pastimes and activities

1. Do you currently engage or intend to engage, through your occupation(s) or pastimes, in any of the following sports or hazardous activities?

a. Flying (other than as a fare-paying passenger on a commercial airline) e.g. fixed wing, helicopter or ballooning ☐ Yes ☐ No

b. Underwater diving ☐ Yes ☐ No

c. Football of any code (excluding touch football and Oztag) ☐ Yes ☐ No

d. Motorised sports of any kind e.g. motorcross, rally driving or motorbike racing, etc. ☐ Yes ☐ No

e. Ocean racing, yachting, powerboat racing etc. ☐ Yes ☐ No

f. Trail bike, quad bike or three-wheeler bike riding (including off road and dirt bike) ☐ Yes ☐ No

g. Any other sport or hazardous activities e.g. body contact sports, parachuting, hang-gliding, competitive horse riding or cycling, abseiling, mountaineering or caving etc. ☐ Yes ☐ No

h. Any sport played in a professional or semi-professional capacity ☐ Yes ☐ No

Please note: if you have answered 'Yes' to any part of Q1 a to h above, please complete the **Pastimes and activities Specific questionnaire(s)** on the related activity in **Section N on pages 22-24.**

Section L – General health questionnaires

General health questionnaire 1 (indicate the question you answered 'Yes' in **Section G, Q2 a to r**)

a. Illness/Injury/tests

b. Main symptoms or cause

c. Date commenced (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years

☐ 6-12 months ☐ 3-6 months ☐ 5-10 years

☐ 2-5 years

d. Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates (dd/mm/yyyy)

e. How long ago did the symptoms cease? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years

☐ 6-12 months ☐ 3-6 months ☐ 5-10 years

☐ 2-5 years

f. Did you require time off work for this condition?

☐ Yes ☐ No

g. If **'Yes'** how long have you had off work?

☐ Days ☐ Weeks ☐ Months

h. What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i. Have you made a full recovery?

Yes ☐

No ☐ ▶ **Please provide details below**

j. Do you have any residual ongoing limitations?

Yes ☐ ▶ **Please provide details below**

No ☐

k. Does your usual GP have details of this condition?

Yes ☐

No ☐ ▶ **Please complete below**

Doctor's name or medical centre

Doctor/medical centre/hospital address

State Postcode Country

Phone number

Section L – General health questionnaires (continued)

General health questionnaire 2 (indicate the question you answered 'Yes' in **Section G, Q2 a to r**)

a. Illness/Injury/tests

b. Main symptoms or cause

c. Date commenced (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years
☐ 6-12 months ☐ 3-6 months ☐ 5-10 years
☐ 2-5 years

d. Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates (dd/mm/yyyy)

e. How long ago did the symptoms cease? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years
☐ 6-12 months ☐ 3-6 months ☐ 5-10 years
☐ 2-5 years

f. Did you require time off work for this condition?

☐ Yes ☐ No

g. If **'Yes'** how long have you had off work?

☐ Days ☐ Weeks ☐ Months

h. What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i. Have you made a full recovery?

Yes ☐
No ☐ ▶ **Please provide details below**

j. Do you have any residual ongoing limitations?

Yes ☐ ▶ **Please provide details below**
No ☐

k. Does your usual GP have details of this condition?

Yes ☐
No ☐ ▶ **Please complete below**

Doctor's name or medical centre

Doctor/medical centre/hospital address

State Postcode Country

Phone number

Section M – Specific questionnaires

If you answered 'Yes' to:
Section G Q1a on page 9, then please complete **Asthma, bronchitis or any other lung complaint** questionnaire below
Section G Q1b on page 9, then please complete **Diabetes and abnormal blood sugar** questionnaire below
Section G Q1c on page 9, then please complete **Cysts/Moles/Sunspots/Skin lesions** questionnaire **on page 17**
Section G Q1d on page 9, then please complete **Joint/Musculoskeletal** questionnaire **on page 18**
Section G Q1e on page 9, then please complete **Mental health** questionnaire **on page 19**
Section G Q1f on page 9, then please complete **High blood pressure and raised cholesterol** questionnaire **on page 21**

1. Asthma, bronchitis or any other lung complaint questionnaire

a. Please tick (✔) the appropriate box

☐ Asthma ☐ Chronic bronchitis ☐ Recurrent pneumonia
☐ Emphysema ☐ Other (please specify)

b. Frequency of symptoms in the last 2 years? (please tick (✔) the appropriate box)

☐ Daily ☐ None – childhood only ☐ One-off episode
☐ Occasionally ☐ Weekly

c. Severity of symptoms? (please tick (✔) the appropriate box)

☐ Mild – Infrequent attacks, exercise induced or seasonal
☐ Moderate – Frequent symptoms, no specific triggers, occasional steroid therapy
☐ Severe – Very frequent attacks with almost constant wheezing, restriction of work duties and frequent use of oral steroids

d. In the last two years have you required hospitalisation or emergency treatment?

☐ Yes ☐ No

e. In the last two years have you required more than three prescriptions for oral steroids?

☐ Yes ☐ No

f. In the last 12 months has this caused you to have time off work?

Yes ☐ ▶ **Please complete below**
No ☐
Total number of days you had off work in the last 12 months?

g. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**
No ☐
Name of doctor

Doctor/medical centre/hospital address

State Postcode Country

Phone number

2. Diabetes and abnormal blood sugar questionnaire

a. Please tick (✔) the appropriate box

Gestational diabetes ☐ ▶ **Go to b**
Diabetes type 1 – insulin dependent ☐ ▶ **Go to c**
Diabetes type 2 – diet controlled, oral medication ☐ ▶ **Go to c**
Abnormal blood sugar ☐ ▶ **Go to c**
Insulin resistance ☐ ▶ **Go to c**

b. Have your blood sugar levels returned to normal after the delivery of your baby?

☐ Yes ☐ No

c. At what age were you diagnosed with this condition?

d. In the last 6 months, have you had an HbA1c (Glycosylated haemoglobin) or Fasting blood sugar/glucose level test?

Yes ☐ ▶ **Please complete below**

No ☐

HbA1c (Glycosylated haemoglobin) (please tick (✔) the appropriate box)

☐ Up to 6.0% ☐ 6.1% to 8.0% ☐ 8.1% or more ☐ Don't know

Fasting blood sugar (please tick (✔) the appropriate box)

☐ Up to 6.6 mmol ☐ 6.7 to 8.0 mmol ☐ 8.1 mmol or above ☐ Don't know

e. As a result of your condition, have you ever experienced complications such as eye problems, numbness or tingling in your legs or feet, a diabetic or insulin coma?

Yes ☐ ▶ **Please complete below**

No ☐

Please specify the complication and the date this occurred. (dd/mm/yyyy)

f. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode Country

Phone number

3. Cysts/Moles/Sunspots/Skin lesions questionnaire

a. Please tick (✔) the appropriate box

☐ Cyst/Mole ☐ BCC (Basal cell carcinoma) ☐ Dysplastic naevi

☐ Sunspot ☐ SCC (Squamous cell carcinoma) ☐ Melanoma

☐ Other (please specify)

b. Location of growth(s) e.g. face, back, right arm

c. Date of treatment(s) (dd/mm/yyyy)

/ / / /

d. Have you been advised that your growth(s) or skin lesion(s) were cancerous or malignant?

☐ Yes ☐ No

e. How many growth(s) or skin lesion(s) did you have?

f. Have all your growth(s) or skin lesion(s) been removed or treated?

Yes ☐

No ☐ ▶ **Please complete below**

(i) How many were treated?

(ii) Why were they not all removed or treated?

Section M – Specific questionnaires (continued)

g. Were any of your growth(s) or skin lesion(s) removed surgically, cut out or scraped off?

Yes ☐

No ☐ ▶ **Please complete below**

(i) How many? ☐

h. Were any further tests, investigations, treatments, wider excisions or follow-ups recommended?

Yes ☐ ▶ **Please provide details below**

No ☐

i. What was the date of your last skin check? (dd/mm/yyyy)

/ /

j. What was the result of your last skin check?

k. Is your treating doctor different from the last doctor you consulted?

Yes ☐

No ☐ ▶ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

State Postcode Country

Phone number

4. Joint/Musculoskeletal questionnaire

a. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone, dislocated shoulder

b. What part of the body was affected e.g. lower back, neck, left or right limb

c. Is the nature of the condition arthritic, degenerative or a disc problem?

☐ Yes ☐ No

d. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

How often has condition occured?

e. When did your symptoms first occur? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ 2-5 years ago ☐ 12-24 months ago

☐ 6-12 months ago ☐ 3-6 months ago ☐ more than 5 years ago

f. Has this condition caused you to lose time off work?

Yes ☐ ▶ **Please complete below**

No ☐

Total number of days you have had off work ☐

Section M – Specific questionnaires (continued)

g. Are you experiencing symptoms or have any residual restrictions or limitations to your work duties?

Yes ☐ ▶ **Please complete (i) below**

No ☐ ▶ **Please complete (ii) below**

(i) Please provide details of any symptoms, residual restrictions or limitations to your work duties

(ii) Please provide details of any symptoms, residual restrictions or limitations to your work duties

☐ Within the last 3 months ☐ 2-5 years ago ☐ 12-24 months ago

☐ 6-12 months ago ☐ 3-6 months ago ☐ more than 5 years ago

h. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode Country

Phone number

5. Mental health questionnaire

a. Are you currently suffering from, or have you previously experienced symptoms of or sought advice or treatment for any of the following:

Single episode of depression (including adjustment disorder, postnatal depression or grief reactions)	☐ Yes	☐ No
Chronic or recurrent depression	☐ Yes	☐ No
Anxiety disorder(s) (including generalised anxiety, obsessive compulsive, phobic/panic anxiety, or post traumatic stress)	☐ Yes	☐ No
Bipolar I or II disorder, or cyclothymia	☐ Yes	☐ No
Schizophrenia or other psychotic disorder(s) (including drug-induced delusional disorder)	☐ Yes	☐ No
Eating disorder(s) (including anorexia nervosa or bulimia)	☐ Yes	☐ No
Attention deficit disorder (including ADD/ADHD)	☐ Yes	☐ No
Other (please specify diagnosis)	☐ Yes	☐ No

b. Have any reasons or causes for the condition been identified?

Yes ☐ ▶ **Please complete below**

No ☐

If 'Yes' advise details including cause, and if the cause is still persisting

c. When were you first diagnosed with the condition? (dd/mm/yyyy)

/ /

d. Are there any physical/other medical conditions contributing to or associated with your condition? (such as chronic pain)

Yes ☐ ▶ **Please provide details below**

No ☐

Section M – Specific questionnaires (continued)

e. Please describe your symptoms, including the date they started (dd/mm/yyyy)

/ /

f. When did you last experience these symptoms? (Or specify if ongoing, (dd/mm/yyyy))

/ / ☐ Ongoing

g. Did your symptoms include suicidal thoughts or ideation?

Yes ☐ ▶ **Go to Question h**

No ☐ ▶ **Go to Question i**

h. If 'Yes', have you ever attempted suicide?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Provide details including dates (dd/mm/yyyy)

	/ /
	/ /

i. Have you had any recurrences of these symptoms?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Provide details including dates (dd/mm/yyyy)

	/ /
	/ /

j. Please complete the table below with details of all treatments prescribed, recommended or received for your condition (including medications, counselling and alternative/ complementary therapies)

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received (dd/mm/yyyy)

/ /

Date treatment ceased (or specify if ongoing, (dd/mm/yyyy))

/ / ☐ Ongoing

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received (dd/mm/yyyy)

/ /

Date treatment ceased (or specify if ongoing, (dd/mm/yyyy))

/ / ☐ Ongoing

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received (dd/mm/yyyy)

/ /

Date treatment ceased (or specify if ongoing, (dd/mm/yyyy))

/ / ☐ Ongoing

k. Are you limited in your ability to work or perform your activities of daily living as a result of this condition?

Yes ☐ ▶ **Please provide details below**

No ☐ ▶

l. Does your usual doctor have knowledge of this condition?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode Country

Phone number

6. High blood pressure and raised cholesterol questionnaire

a. Please tick (✔) the appropriate box(es)

☐ High blood pressure*

☐ Raised cholesterol#

b. When were you first diagnosed with this condition? (please tick (✔) the appropriate box)

☐ Within the last 12 months

☐ More than 12 months ago

c. Do you have any problems or complications resulting from this condition? (e.g. heart disease, kidney disorder)

☐ Yes ☐ No

d. Are you taking regular medication for this condition?

☐ Yes ☐ No

***Additional questions for high blood pressure**

e. Is your blood pressure being monitored by your doctor and considered to be well controlled? (e.g. less than 140/90)

☐ Yes ☐ No

f. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Name of doctor

Doctor/medical centre/hospital address

State Postcode Country

Phone number

#Additional questions for raised cholesterol

g. When was your last cholesterol reading? Please tick (✔) the appropriate box(es)

☐ Within the last 12 months

☐ More than 12 months ago

h. What was your last cholesterol reading? Please tick (✔) the appropriate box(es)

☐ 2.0 to 6.5 mmol ☐ 6.6 to 7.5 mmol

☐ 7.6 mmol or above ☐ Don't know

Section M – Specific questionnaires (continued)

i. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Name of doctor

Doctor/medical centre/hospital address

State Postcode Country

Phone number

Section N – Pastimes and activities questionnaires

If you answered 'Yes' to:
Section K a on page 13, then please complete **Flying** questionnaire below
Section K b on page 13, then please complete **Underwater diving** questionnaire **on page 23**
Section K c on page 13, then please complete **Football of any code** questionnaire **on page 23**
Section K d on page 13, then please complete **Motor sports of any kind** questionnaire **on page 23**
Section K e to h on page 13, then please complete **Other sports or hazardous activities** questionnaire **on page 24**

1. Flying questionnaire

a. What type of aerial device/aircraft do you fly? (please tick (✔) the appropriate aircraft(s))

		Number of hours flown in the last 12 months	Number of hours in the next 12 months
Fixed wing (Private/recreational/commuter travel)	☐		
Helicopter (Private/recreational/commuter travel)	☐		
Fixed wing (Charter flying)	☐		
Helicopter (Charter flying)	☐		
Fixed wing and Helicopter (Agriculture/crop/mustering)	☐		
Helicopter, fixed wing – occupation i.e aerial surveyor, photographer etc.	☐		
Ballooning	☐		
Gliding	☐		
Ultra-light/gyroplane	☐		
Aerobatics/stunts	☐		

b. Do you hold any licence that allows you to fly any aircraft (but not including remotely piloted aircraft) e.g. recreational pilot licence, private pilot licence, commercial pilot licence, air transport pilot licence, etc.?

☐ Yes ☐ No

c. Do you intend to change the scope of your present licence?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Please state the change in scope of your present licence

Section N – Pastimes and activities questionnaires (continued)

d. Have you ever had an accident or been charged with violating civil aviation regulations?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Please provide details

e. Do you intend to engage in any form of aviation other than already mentioned?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Please provide details on the other form of aviation

f. Do you ever use unauthorised landing areas?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Please provide details

g. Please advise the make and model of the aircraft that you fly/pilot

Make Model

2. Underwater diving questionnaire

a. At what level do you participate? (please tick (✔) the appropriate box)

☐ Recreational only (non-competiton)

☐ Recreational only (with competition)

☐ Semi-professional/professional

b. How many times per year do you participate in this activity?

c. Do you ever dive:

alone? e.g. without a buddy ☐ Yes ☐ No

over 40 meters in depth? ☐ Yes ☐ No

in wrecks, caves or potholes? ☐ Yes ☐ No

If 'Yes' to any above, please provide details

d. What type of qualification do you hold? (please tick (✔) the appropriate box)

☐ No qualification ☐ PADI ☐ BSAC

☐ NAUI ☐ Other (please specify)

3. Football of any code questionnaire

a. What type of football code do you participate in? (please tick (✔) the appropriate box)

☐ Rugby League ☐ Australian Rules ☐ American football

☐ Rugby Union ☐ Touch football/Oztag ☐ Soccer

b. At what level do you participate? (please tick (✔) the appropriate box)

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

Section N – Pastimes and activities questionnaires (continued)

c. In the last two years have you had a sporting injury to your shoulder, leg, knee or ankle that required any time off work?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Please provide details

d. Do you receive an income from participating in this activity?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

How much do you earn from this activity per year?

$

4. Motor sports of any kind questionnaire

a. What type of vehicle or motor activity do you engage in?

b. At what level do you participate? (please tick (✔) the appropriate box)

☐ Recreational only (non-competiton) ☐ Semi-professional/professional

☐ Recreational only (with competition) ☐ Record attempts or prototype testing

c. Have you ever been involved in any accidents whilst practising, testing or racing?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Provide details of when this occurred and whether you have any restrictions of your work duties or activities as a result (dd/mm/yyyy)

d. Do you hold a CAMS license and/or are you a member of a motor racing club or organisation?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

Please provide details

e. Which events do you race in? (e.g. circuit racing, drag racing) Please provide details including class of racing event

f. Please advise the following details

Number of times per year that you participate in this activity

Vehicle type including make

Engine size

What maximum speed is reached?

5. Other sport or hazardous activity questionnaire

a. What type of activity do you engage in?

b. At what level do you participate? (please tick (✔) the appropriate box)

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

Section N – Pastimes and activities questionnaires (continued)

c. How many times per month do you play, jump / launch or participate in this activity?

d. Do you receive an income from participating in this activity?

Yes ☐ ▶ **Please complete below**

No ☐ ▶

How much do you earn from this activity per year?

$

Section O – Active account election

If your superannuation account is, or becomes, inactive for a continuous period of 16 months then under superannuation legislation we are required to cancel your insurance cover unless you provide an election. If you do not want your insurance cover to cease please tick the box below.

• I elect that all insurance cover already applying, or to be provided, for me under insert fund name

☐ ('My insurance') is to continue to apply for me even if my account in the product is, or becomes, inactive for a continuous period of 16 months under superannuation legislation

Section P – General declaration

The following declarations apply to all policy owner(s):

1. I understand that the insurance applied for will not become effective unless and until the Application is accepted by Resolution Life and Resolution Life is under no liability until acceptance is effected.
2. I acknowledge that the Resolution Life Australasia Limited and its subsidiaries (other than Resolution Life to the extent provided for in this document) do not guarantee the obligations or performance of Resolution Life Australasia Limited ABN 84 079 300 379, AFSL No. 233671 (Resolution Life) or the products it offers.
3. I confirm that the declarations and answers to all questions in this application are true and correct including those not in my own handwriting (for a life insured, this confirmation relates to answers and declarations about them).
4. I have read and understood my Duty to take reasonable care as set out in this application and I am aware of the consequences of non-disclosure. I understand my duty to take reasonable care continues after this application has been submitted until the application has been accepted in writing.
5. I have read and understood the Privacy Collection Statement on **page 2** of this application form.
6. I hereby authorise Equity Trustees Superannuation Limited and Resolution Life Australasia Limited to deduct premiums for this cover from my account and acknowledge that any benefits or other moneys payable by Resolution Life with respect to this cover will be credited to that account.

Name of life insured

Signature of life insured

✗

Date (dd/mm/yyyy)

/ /

Customer contact authority

Resolution Life Australasia Limited ABN 84 079 300 379, AFSL No. 233671 (Resolution Life).

Only complete this section if you are happy to be contacted by a representative of Resolution Life Australasia Limited for more information in order to speed up the assessment process.

Name of life insured

I,

agree that Resolution Life or an authorised representative may contact me in respect of my insurance application or policy.

Signature of life insured

✗

Date (dd/mm/yyyy)

/ /