# Increase/Alteration/Addition Application

Information sheet

## Important information for applicants

Please read these instructions carefully before starting this application.

This application form should be completed if you are applying for an increase, alteration or addition to the following for your existing Elevate insurance Plan:

- life
- trauma
- total and permanent disablement (TPD)
- income insurance, or
- business expense.

This includes benefits under Superannuation.

Before you sign this application form, be aware that if this application is for an alteration or addition to an existing plan, the current **product disclosure statement** may not be relevant and there may have been changes to the policy terms for the benefit you are requesting to add or amend. Please refer to your **plan document** together with any subsequent updates we've provided to you for the terms and conditions of your plan. You can also obtain a consolidated list of updates by contacting your adviser. This information will help you to understand the product and to decide whether it is appropriate to your needs.

Where this application form is for an addition of a new plan, please refer to the current **product disclosure statement**. We will then provide you with a **plan document** relating to the plan you purchase.

The following are not available when adding an option to a plan:

- Addition of an option or plan to pre August 2009 policies (inception date of Elevate),
- PremierLink and FlexiLink options,
- The addition of a TPD Own Occupation option to an Elevate Super plan or SMSF plan, and
- Addition of a TPD Any Occupation option to an Elevate Super or SMSF plan commencing prior to 1 July 2014.

In this application form, 'you' refers to the plan owner or the person insured under the plan, as indicated. 'We' refers to the underwriter, Resolution Life Australasia Limited. This applies except where declarations are signed in this application, in which case, 'I/we' refers to the proposed Plan owner or the person insured, as indicated.

### We rely on what you tell us

Before we decide to increase or alter your cover or add a new type of cover, 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 have consented to have if the total combined sum insured with all life insurers for the insurance being applied for is over:

• $500,000 life cover

• $500,000 total and permanent disability cover (TPD)

• $200,000 trauma / critical illness cover, or

• $4,000 a month income protection cover, salary continuance cover or business expenses cover.

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 Moratorium on Genetic Tests. A copy of the moratorium is available in the Life Insurance Code of Practice **cali.org.au/life-code**.

## Privacy – use and disclosure of personal information

The privacy of your personal information is important to you and also to us. We may collect personal information directly from you or your financial adviser. We may also collect personal information if it is required or authorised by law, including the *Superannuation Industry (Supervision) Act 1993*, the *Corporations Act 2001* and the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006* (AML/CTF).

Our main purpose in collecting personal information from you is so we can establish and manage your plan. If you choose not to provide the information necessary to process your application, then we may not be able to process it. We may also use this information for related purposes—for example, enhancing customer service and product options and providing you with ongoing information about opportunities that may be useful for your financial needs through direct marketing. These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services that may be made available by us, other members of the Resolution Life Group, or by your adviser.

Please contact us if you do not want your personal information used for direct marketing purposes.

If you are applying for the Life Insurance Superannuation Plan or the Income Insurance Superannuation Plan, we will also use this information to assess your application for, and manage your membership of, the National Mutual Retirement Fund or the Wealth Personal Superannuation and Pension Fund. We will only use information about your dependants in the event of your death.

We usually disclose information of this kind to:

- other members of the Resolution Life Group
- your adviser or broker (if any)
- the owner of the plan
- your parent or guardian, if you are under age 18
- external service suppliers who may be located in Australia or overseas, who supply administrative, financial or other services to assist the Resolution Life Group in providing you with services. A list of countries where these providers are likely to be located can be accessed via our privacy policy.
- the Australian Transaction Reports and Analysis Centre (AUSTRAC) where required by our anti-money laundering compliance plan
- the Australian Taxation Office (ATO) to conduct searches on the ATO's lost member register for lost super
- anyone you have authorised or if required by law.

If sensitive information, such as health information is collected in relation to this financial product, then additional restrictions apply. Resolution Life may collect health information using a third party provider. The primary purpose for obtaining this health information is for the insurer, Resolution Life to assess your application for new or additional insurance. Resolution Life may also use this information for directly related purposes —for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims. Resolution Life may disclose your health information to:

- the adviser or broker responsible for the plan
- your parent or guardian, if you are under age 18
- the trustee
- the owner of your personal insurance plan (if applicable)
- Resolution Life reinsurers
- medical practitioners
- any person Resolution Life considers necessary to help either assess claims or resolve complaints
- anyone you have authorised or if required by law.

If you are an insured person, aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

If you are an insured person, Resolution Life and/or its health screening provider may also speak to a third party for the sole purpose of arranging a health screening appointment. This third party may include a spouse, family member, personal assistant, adviser or other relevant party.

Under the current Resolution Life privacy policy you may access personal information about you held by the Resolution Life Group. The Resolution Life privacy policy sets out the Resolution Life Group's policies on management of personal information, including information about how you can access your personal information, seek to have any corrections made on inaccurate, incomplete or out-of-date information, how you can make a complaint about privacy, and information about how we deal with such complaints. The Resolution Life privacy policy can be obtained online at **resolutionlife.com.au** or by calling our Customer Service Centre.

## 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).





07270_RL 03/25

To be completed for all applications.

Resolution Life

# Application Details

If altering a non-superannuation or SMSF plan, please complete the Non-superannuation or SMSF application sections on pages 37 to 42. If altering the Life Insurance Superannuation Plan or the Income Insurance Superannuation Plan, please complete the Superannuation application sections on pages 43 to 48.

**Note:** If this application is for an alteration to an existing plan, the current **product disclosure statement** may not be relevant. Please refer to your plan document together with any subsequent updates we've provided to you for the terms and conditions of your plan. A consolidated list of updates is also available by contacting us on 133 731.

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

## 1. Increase/Alteration/Addition summary

☐ Review loading/exclusion ☐ Increase benefit period ☐ Addition of an option or plan[1]
☐ Increase sum insured ☐ Decrease waiting period ☐ Any other (please provide details in Adviser notes)

Existing Plan number | | | | | | | | | | | Date proposal signed D D M M Y Y Y Y

### Person insured

Is the Person insured also the: ☐ Plan owner ☐ Payer of insurance premium

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

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

Occupation title and the industry that the Person insured works in:

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

Please refer to the definitions of insurable income, in the income details section on page 32.

### Residential address of person insured

Address

Suburb | State | Postcode | Country

Home number | Business number | Mobile number

Email address

1 Please include the quote you wish to proceed with along with this completed application form.

## 1. Increase/Alteration/Addition summary (continued)

### Correspondence details

! Only complete this section if the addressee or correspondence address is different to the person insured.

Is the addressee for correspondence different to the person insured? ☐ No ☐ Yes

Company/SMSF

C/O (eg company title/department)

Title

Given name(s)/Trustee name(s)

Family name

Is the address for correspondence different to the residential address of the person insured? ☐ No ☐ Yes

Address

Suburb

State

Postcode

Country

Home number

Business number

Mobile number

Email address

### Plan owner(s)

! Only complete this section if plan owner is a company, trustee of an SMSF or an individual other than the person insured.

☐ Plan owner is payer of insurance premium (only if not being paid by person insured)

| Title | Family/Company/SMSF | Given name(s)/Trustee name(s)(i) | Date of birth | Plan/PremierLink name |
|---|---|---|---|---|
| | | | / / | |
| | | | / / | |
| | | | / / | |
| | | | / / | |
| | | | / / | |
| | | | / / | |

(i) The names of all trustees should be listed.

Only provide an Australian business number (ABN) if the plan owner is to be a company or a trustee:

Company ABN

**The plan owner(s) will need to complete the non-superannuation or SMSF application sections on pages 37 to 42.**

To be completed for all applications.

## 1. Increase/Alteration/Addition summary (continued)

### Life/Total and Permanent Disablement/Trauma

Product name

Existing Plan number[1]

| | Existing cover | Proposed cover (including increase, alteration or addition) |
|---|---|---|
| Sum insured | $ | $ |
| Premium structure | ☐ Stepped ☐ Level ☐ Blended | ☐ Stepped ☐ Level ☐ Blended |
| Optional benefit(s) | Name of option | Name of option |
| | Sum insured / Yearly premium | Sum insured / Yearly premium |
| | $ / $ | $ / $ |
| | Name of option | Name of option |
| | Sum insured / Yearly premium | Sum insured / Yearly premium |
| | $ / $ | $ / $ |
| Smoker | ☐ No ☐ Yes | ☐ No ☐ Yes |
| Exclusions or loadings | | |
| Total yearly premium (including plan fee) | | $ |

1 Not required if adding a plan.

## 1. Increase/Alteration/Addition summary (continued)

### Income Insurance/Business Expenses

Product name

Existing Plan number[1]

| | Existing cover | | Proposed cover (including increase, alteration or addition) | |
|---|---|---|---|---|
| Weekly benefit | $ | | $ | |
| Monthly benefit | $ | | $ | |
| | Injury | Sickness | Injury | Sickness |
| Benefit period | | | | |
| | Days | Weeks | Days | Weeks |
| Waiting period | | | | |
| Premium structure | ☐ Stepped ☐ Level | | ☐ Stepped ☐ Level | |
| | Name | | Name | |
| Optional benefit(s) | | | | |
| | Sum insured | Yearly premium | Sum insured | Yearly premium |
| | $ | $ | $ | $ |
| | Name | | Name | |
| Optional benefit(s) | | | | |
| | Sum insured | Yearly premium | Sum insured | Yearly premium |
| | $ | $ | $ | $ |
| Smoker | ☐ No ☐ Yes | | ☐ No ☐ Yes | |
| Exclusions or loadings | | | | |
| Total yearly premium (including plan fee) | **$** | | **$** | |

1 Not required if adding a plan.

To be completed for all applications.

## 2. Payment details

We'll need the following from you to refund any insurance premiums to you (if applicable):

- Super account—your super fund details
- Non super account—your bank account details

☐ **Deposit in my bank/building society/credit union account**

Bank/building society/credit union name

Bank/building society/credit union address | Suburb | State | Postcode

BSB number | Account number | Payee account name

☐ **Transfer to an external fund (excluding transfers to a Self Managed Super Fund (SMSF)**

Name of fund[1] | Name of fund administrator

Postal address

Administrator's phone number | Membership number[1] | Unique Superannuation Identifier (USI)

ABN | Product name

☐ **Transfer to a Self Managed Super Fund (SMSF)**

Name of SMSF fund[2] | Fund phone number[2] | ABN

Account name | BSB | Account number

For EFT payments, you must provide us with a certified copy of your SMSF bank statement.

1 Required if transfer is to a super fund. Please obtain from the receiving fund. If these details are not quoted, we may not be able to process your application.

2 If these details are not quoted, we may not be able to process your application.

To be completed by the person insured.

Resolution Life

# Personal Statement

**'You' refers to the person insured.**

## 3. Personal details

**Important:** 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.

### Contact details for person insured

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

| Daytime number | Hours you can be contacted |
|---|---|
| | |
| **After hours 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 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, please advise the date you can make that 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 to go and live in another country? ☐ No ☐ Yes

If **'yes'**, please provide details:

| Where | Duration |
|---|---|
| | |
| | |
| | |

## 3. Personal details (continued)

**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 |
|---|---|---|
| | | |
| | | |
| | | |

### 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:

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.

**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 |
|---|---|
| | / / |

**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? ☐ No ☐ Yes

If **'yes'**, please provide details:

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

## 3. Personal details (continued)

### Personal habits

**8.** a. Have you ever been a smoker or used any sort of tobacco products (including e-cigarettes or nicotine replacement products)?

☐ No > go to question 9 ☐ Yes

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: ____

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

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

ii. What strength are they? ____ mgs

b. If you have stopped, when? ____ month ____ year

c. Have you ever been advised by a health care professional to reduce your smoking because of a medical condition? ☐ No ☐ Yes

If 'yes', please advise the name of the condition and any treatment received:

Condition ____ Treatment ____

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

**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 the 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.) ☐ No ☐ Yes

If **'yes'**, please give details, including the type of drug and the date(s) used:

## 4. Your health details

### Doctor details

**12.** 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 two years, please provide details of the previous doctor.

| Name | Address | Phone number |
|---|---|---|
| | | |
| | | |

**13.** Date of last consultation with any doctor

D D M M Y Y Y Y

## 4. Your health details (continued)

### Doctor details (continued)

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

**15.** Please advise reason for your last consultation

**16.** Please advise results/outcome of your last consultation

**17.** Were you referred for further tests, investigations or referred to a specialist? ☐ No ☐ Yes

If **'yes'**, please provide full details

### Personal health history

**18.** 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

**19.** 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** (eg a disorder or injury of the ankle, elbow, hip, knee, wrist or shoulder) ☐ No ☐ Yes

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

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

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

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

g. **Schizophrenia, psychotic or personality disorder, manic or bipolar disorder** or any other **mental health disorder** ☐ 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

## 4. Your health details (continued)

### Personal health history (continued)

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

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

ac. HIV or AIDS ☐ No ☐ Yes

! If you answered **'no'** to all items, go to 20. If you answered **'yes'** to any of the items in 19, please provide details in the table below, **except** for any condition in bold text for which you need to complete the relevant health questionnaire in section **7**.

| 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 (%) |
|---|---|---|---|---|---|
| | / / | | | | |
| | / / | | | | |
| | / / | | | | |
| | / / | | | | |
| | / / | | | | |

**20.** 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 20, please provide details in the table below **except** for any condition in bold text for which you need to complete the relevant **health questionnaire** in section **7.**

| 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 (%) |
|---|---|---|---|---|---|
| | / / | | | | |
| | / / | | | | |
| | / / | | | | |
| | / / | | | | |

## 4. 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 you answered **'yes'** to **e** or **f**, please provide details in the table below.

| Item number | Date | Reason | Results | Follow up required | Name of doctor | Pending follow up | When |
|---|---|---|---|---|---|---|---|
| | / / | | | ☐ No ☐ Yes | | | / / |

**21.** 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? **Important:** Please refer to the **genetic test approach** in the **information sheet** when answering this question. ☐ No ☐ Yes

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 three consecutive days? ☐ No ☐ Yes

If you answered **'yes'** to any of the items in 21, 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 (%) |
|---|---|---|---|---|---|---|
| | / / | | | / / | | |
| | / / | | | / / | | |
| | / / | | | / / | | |

## 4. Your health details (continued)

### Personal health history (continued)

**22.** 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 a, b or c above please provide details:

| |
|---|
| |
| |
| |

### Family history

**23.** 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 question.

☐ 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) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 4. Your health details (continued)

### Family history (continued)

**24.** 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, brothers or your children).

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 |
|---|---|---|---|---|
| | | / / | | |
| | | / / | | |
| | | / / | | |
| | | / / | | |
| | | / / | | |

**25.** Are any tests or investigations pending? ☐ No ☐ Yes

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

## 5. Sports and pastimes details

**26.** 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 **'no'** to all items above, go to section **8** – Occupation details. 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 please complete the Detailed sports and pastimes questionnaire(s) overleaf.

| 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 |
| | | | | ☐ Amateur ☐ Professional | ☐ Competitive ☐ Non-competitive |

## 6. Detailed sports and pastimes questionnaires

Only complete the relevant sections of this question if you answered **'yes'** to section **5**, 26a, b or c above.

### 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 **'no'**, 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:
   a. in total as a pilot
   b. in the last 12 months
   c. 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:

### 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?

## 6. Detailed sports and pastimes questionnaires (continued)

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

**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

   If **'yes'**, please provide details:

To be completed by the person insured.

## 7. Health questionnaires

! Only complete the relevant health questionnaires, if you answered '**Yes**' to any items in bold text in **19**, **20** and **22**.

### a. 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',** 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 any of the above, please provide details:

## 7. Health questionnaires (continued)

### a. Back or neck disorder questionnaire (continued)

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 to 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 any of the above 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:

e. 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 |
|---|---|---|---|
| | | | / / |
| | | | / / |
| | | | / / |

## 7. Health questionnaires (continued)

### a. Back or neck disorder questionnaire (continued)

b. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes

If **'yes',** please provide the 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 the details:

### b. 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? (select all that apply):

☐ Shoulder ☐ right ☐ left ☐ Elbow ☐ right ☐ left
☐ Wrist ☐ right ☐ left ☐ Hip ☐ right ☐ left
☐ Knee ☐ right ☐ left ☐ Ankle ☐ right ☐ left
☐ Other – please advise which joint right/left:

3. Have you experienced any of the following? (select all that apply): ☐ No ☐ Yes

c. ☐ Radiation or spread of the pain
d. ☐ Loss of feeling or strength
e. ☐ Loss of range of movement
f. ☐ Pins and needles
g. ☐ Weakness or instability
h. ☐ Swelling or
i. ☐ Other – please advise:

If **'yes',** please provide the 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)?

## 7. Health questionnaires (continued)

### b. Disorder or injury of the joints questionnaire (continued)

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–iii 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 to 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
iv. ☐ pain Other

If you selected any of the above 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 **'yes',** please provide the details:

e. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes

If **'yes',** please provide the details:

## 7. Health questionnaires (continued)

### b. Disorder or injury of the joints questionnaire (continued)

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

| 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.

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 the 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:

| |
|---|
| |
| |

## 7. Health questionnaires (continued)

### c. 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?

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?

## 7. Health questionnaires (continued)

### c. Mental health disorders questionnaire (continued)

9. Have you ever received any treatment for this condition? ☐ No ☐ Yes

If **'yes',** please provide the 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 the 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:

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. Have any first-degree blood related family members (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).

If **'yes',** please provide details:

## 7. Health questionnaires (continued)

### d. 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 go to the **Mental health disorders questionnaire** on section **6c**.

   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
   - ☐ 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 selected 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?
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):

## 7. Health questionnaires (continued)

### e. 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 | | |

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:

## 7. Health questionnaires (continued)

### f. 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):
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 three 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

## 7. Health questionnaires (continued)

### g. Cyst, mole, skin lesion questionnaire

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

- ☐ Mole or naevi
- ☐ Hyperkeratosis, solar keratosis or Squamous Cell Carcinoma (SCC)
- ☐ Melanoma
- ☐ Other lesions (please describe below):
- ☐ Basal Cell Carcinoma (BCC)
- ☐ Sebaceous cyst/lipoma/fatty cyst just under the skin

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

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 |
|---|---|---|
| / / | | |

### h. 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? ☐ Yes ☐ No

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 screening or pap smear test? ☐ Yes ☐ No ☐ Awaiting follow up

If 'Yes', please provide all dates and results since the abnormal result?

## 7. Health questionnaires (continued)

### h. 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?

### i. Diabetes questionnaire

1. Which of the following best describes your condition: (select all that apply)

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

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

3. How is this condition treated? (select all that apply)

☐ 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)? ☐ No ☐ Yes

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? ☐ No ☐ Yes

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?

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 |
|---|---|---|
| / / | | |
| / / | | |
| / / | | |

## 7. Health questionnaires (continued)

### j. COVID-19 (coronavirus) questionnaire

1. Which of the following apply to the potential risks you've been exposed to within the last month (select all that apply)?

   ☐ Travelled overseas

   ☐ Had contact with someone who has recently returned from overseas

   ☐ Was exposed to someone who suffered and was later diagnosed with COVID-19

2. When did you or the other person return from overseas or when were you exposed?

   D D M M Y Y Y Y

3. Have you completed the required 14 days of self-quarantine/isolation? ☐ No ☐ Yes

4. Have you developed any symptoms such as fevers, sore throat, cough, headaches or shortness of breath? ☐ No ☐ Yes

   If **'yes',** please provide details:

5. i. If you've been tested for COVID-19 what was the result?

   ☐ Negative

   ☐ Positive

   ii. If you tested **'positive'** did you have a following COVID-19 test result which was negative? ☐ No ☐ Yes

   iii. If you tested **'positive'** were you hospitalised? ☐ No ☐ Yes

   If **'yes',** please provide details in the table below:

| Period in hospital | Hospital name and address | Treatment received | Did you spend time in intensive care? |
|---|---|---|---|
| / / to / / | | | ☐ No ☐ Yes<br>If **'yes'**, number days ____ days |

6. If you had symptoms or tested **'positive'** to COVID-19, have you fully recovered with no continuing or residual symptoms or complications? ☐ No ☐ Yes

   If **'yes',** please provide details:

## 8. Occupation details

! Only to be completed by the person insured if altering Income Insurance, Business Expenses Insurance or Total and Permanent Disability Insurance. If you are not applying for these proceed to section **11**. Medical and financial authorities.

**27.** 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 37.

| | 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 **39**.

**28.** 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:

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

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

**31.** 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%** |

## 8. Occupation details (continued)

**32.** 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:

**33.** 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:

**34.** Do you intend to change your occupation or employment status? ☐ No ☐ Yes

If **'yes'**, please provide details below:

**35.** 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.

**36.** 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.

**37.** Do you have any other occupations or jobs? ☐ No ☐ Yes

If **'yes'**, please provide details below including specific duties:

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

! Only complete **39** if you work in the mining or oil and gas industry.

**39.** 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 two 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 | | |

## 9. Insurable income details

**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.

### 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.

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 below: ☐ No ☐ Yes

## 9. Insurable income details (continued)

### 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:

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:

## 10. Business expense details

! To be completed by the Person insured only if applying for Business Expenses Insurance. If you are not applying for these proceed to section **11**. Medical and financial authorities.

### 40. Business structure

☐ Company ☐ Partnership ☐ Trust ☐ Sole proprietor

Date the business was purchased/started D D M M Y Y Y Y

### 41. Business details

Business name

Business address | Suburb | State | Postcode

### 42. Employees

Number of income producing employees: Full-time | Part-time

Number of non-income producing employees: Full-time | Part-time

**43.** If a partnership/company, number of partners/directors

**44.** Percentage of business income derived from your personal exertion %

**45.** If you were to become totally disabled, what would be the reduction in business income? %

Please provide a brief explanation of what would happen to the business if you were to become disabled:

## 10. Business expense details (continued)

**46. Monthly** expenses of the business over the last 12 months

| | | **Monthly expenses ($)** |
|---|---|---|
| i. | Rent or mortgage interest payments | |
| ii. | Electricity, gas, water, heating | |
| iii. | General insurance premiums | |
| iv. | Cleaning | |
| v. | Phone | |
| vi. | Leasing of equipment or motor vehicles | |
| vii. | Property rates and taxes | |
| viii. | Dues to professional bodies | |
| ix. | Accountant's fees | |
| x. | Salaries and associated costs (eg superannuation contributions) for employees who do not generate revenue | |
| xi. | Other fixed expenses (please provide details below)[1] | |
| xii. | **Total** monthly expenses (Total of (i) to (xi) above) | **$** |
| xiii. | Percentage of expenses in (xii) above that you are responsible for | % |

1 Details of other expenses.

| |
|---|
| |
| |

**For qualified registered medical practitioners or dentists classified as MP or AA only.**

**47. Net Locum Cost**[2] $

2 Net Locum Cost is the estimated cost of engaging a locum to replace you while you are totally disabled and unable to work due to sickness or injury, less any income this person generates. Only complete this question if you estimate locum expense will exceed income generated by the locum.

To be completed by the person insured.

Resolution Life

# Medical and financial authorities

## 11. Medical authority

! Before you complete this page please read the privacy disclosure statement 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 insured

✗ _____ Date signed 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 Limited ABN 84 079 300 379 (Resolution Life) and to any other person or company acting on Resolution Life's behalf), 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 insured

✗ _____ Date signed D D M M Y Y Y Y

Accountant/financial adviser name _____ Accountant/financial adviser contact number _____

Accountant/financial adviser address _____

**Issue date:** March 2025

Resolution Life

# Non-superannuation or SMSF application

**Use this form** if you are applying for an increase, alteration or addition to non-superannuation or SMSF insurance (including FlexiLink plans and/or PremierLink) not paid from a North, Summit, Generations or iAccess account.

## 12. Non-superannuation or SMSF payment authorities

! **Before you complete this page**, please read the 'Paying your premiums' section in the general terms and conditions in the **product disclosure statement**.

### Payment method

Select method of payment:

☐ Direct debit by credit card (please list insurance plans paid by credit card below and complete **option 1**)

| | | |
|---|---|---|
| | | |
| | | |

☐ Direct debit by bank account (please list insurance plans paid through bank account below and complete **option 2**)

| | | |
|---|---|---|
| | | |
| | | |

☐ Receive payment due notices (only available for quarterly, half-yearly and yearly payments)

### Option 1: Direct debit by credit card

! Only complete this section to pay your insurance premiums by credit card.

Authority to deduct arrears: ☐ No ☐ Yes (**Note:** We will only deduct if arrears are applicable.)

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by credit card, you may choose a date for deduction, between 1st to 28th only

Credit card type: ☐ MasterCard ☐ Visa

Credit card number | Expiry date | Name as shown on credit card

Cardholder's signature

✗

Date signed D D M M Y Y Y Y

**If your credit card details change (eg card number or expiry date) we may be unable to process your payment. To update your credit card details, please call us on 133 731.**

## 12. Non-superannuation or SMSF payment authorities (continued)

### Option 2: Direct debit by bank account

Only complete this section to pay your insurance premiums by direct debit.

**Note**: Please refer to your financial institution to check your account offers direct debiting.

Authority to deduct arrears: ☐ No ☐ Yes (**Note:** We will only deduct if arrears are applicable.)

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by bank account, you may choose a date for deduction, between 1st to 28th only

BSB number

Account number

Bank/financial institution name

Bank/financial institution branch name

Account in name of (name in full)

If company account Australian business number (ABN)

**Account holder signature(s)**

Signature—account holder 1

✗

Date signed

D D M M Y Y Y Y

Signature—account holder 2 (if applicable)

✗

Date signed

D D M M Y Y Y Y

## 13. Nomination of beneficiaries (non-super)

! To be completed if you are applying for an increase, alteration or addition to a Life Insurance plan, including plans where the insurance will be paid from a North, Summit, Generations or iAccess investment account.

**'You' refers to the plan owner** (ie the person who has the authority to decide how the benefit is dispersed).

**Nominate beneficiaries – only for Life Insurance Plan. Do not complete if you are applying to alter the Life Insurance SMSF Plan.**

You can choose who and how your death benefit is paid in the event of the death of the Person insured.

Do you wish to make a nomination? ☐ No ☐ Yes

If **'yes'**, please nominate the beneficiaries to receive the payment of benefits below.

**1.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number ( ) | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**2.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number ( ) | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**3.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number ( ) | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**4.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number ( ) | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**5.** Title | First name | Family name | Gender ☐ Male ☐ Female | Date of birth / /

Address

Phone number ( ) | Relationship of the nominated person to the plan owner | % of death benefit[1] %

**Total percentage** **100%**

1 Percentages must be whole numbers.

## 13. Nomination of beneficiaries (non-super) (continued)

### Plan owner declaration

Plan owner family name | Given name(s)

I/We _____ _____ ,
the plan owner(s), nominate the person(s) named above to receive any proceeds that may become payable under this plan, as a result of the death of the person insured.

I understand that:

- payment of benefits will be made on the basis of the latest nomination received in writing by Resolution Life
- if there is no nomination, or the nomination has been revoked, benefits will be paid to the plan owner (or their estate)
- nominated beneficiaries should seek advice from their taxation adviser regarding the potential taxation implication of any benefit received
- if a nominated beneficiary predeceases the person insured, then that nominated beneficiary's benefit will be paid to the plan owner (or their estate)
- the plan owner may vary the nomination at any time by completing a Nomination of beneficiary form and forwarding it to Resolution Life.

Signature of the plan owner

✗

Date signed

D D M M Y Y Y Y

## 14. Non-superannuation or SMSF insurance application and signature (Declaration and consent)

Plan number

**Before you sign this application form, you should:**

- **read the product disclosure statement** provided by your adviser when you took out your original plan, or if adding a new plan you should read the current **product disclosure statement**. It contains important information to help you understand the product and to decide whether it is appropriate to your needs, and
- 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, and
- read the Privacy – use and disclosure of personal information section in the **Information sheet** and understand the terms outlined.

### Access to information

I authorise:

- any other insurers or other professional, such as a financial adviser or accountant, to disclose any information they may possess about me, whether held in hard copy or in any other format, to Resolution Life, and
- Resolution Life to collect any information they have on my health, medical history, pastimes, work history or anything else that Resolution Life considers to be relevant to assessing or underwriting this cover or assessing any claim under it.

Where I hold other policies or plans within the Resolution Life Group, I authorise the use of any information obtained under this authority in connection with those policies or plans.

### Signature of person to be insured

**If the person to be insured is the same person as the plan owner, go to 'Signature of plan owner – only for individuals'.**

Print full name of person to be insured

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

### Signature of plan owners – only for individuals (including individual trustees of an SMSF)

Print full name of SMSF or trust (if applicable)

**For plan owners (must be aged 16 years or over)**

Print full name of plan owner/Trustee

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

Plan owner/Trustee (delete one)

Print full name of plan owner/Trustee

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

Plan owner/Trustee (delete one)

– For SMSFs, if there are more than two trustees required as signatories, please cross here ☐ and provide their full name(s) and signature(s) in the Adviser notes section on page 50.

## 14. Non-superannuation or SMSF insurance application and signature (Declaration and consent) (continued)

**Signatures of plan owners – only for companies** (including company trustees of an SMSF)

Company seal

Print full name of company

Signature 1

✗

Director/Sole Director
and Secretary (delete one)

Signature 2

✗

Director/Secretary
(delete one)

Date signed

/ /

Print full name of person signing for and on behalf of the above company

To be signed by:

- For any company, either two directors of the company or a director and company secretary, or
- For a proprietary company, one signature as 'sole director and secretary' where the company has only one director who is also the sole company secretary.

**Note:** If the company constitution mandates the use of a company seal then it must be provided along with the relevant signatures outlined above.

Resolution Life

# Superannuation application

**Use this form** if you are applying for an increase, alteration or addition to Life Insurance Superannuation or an Income Insurance Superannuation Plan held through National Mutual Retirement Fund (NMRF).

Where a FlexiLink plan and/or PremierLink option is applied for and linked to North, Summit, Generations or iAccess, please also complete the Non-superannuation payment authorities.

## 15. Superannuation payment authorities

**Before you complete this page**, please read the 'Paying your premiums' section in the general terms and conditions in the **product disclosure statement**.

### Payment method

Select method of payment:

☐ Direct debit by credit card (please list insurance plans paid by credit card below and complete **option 1**)

| | | |
|---|---|---|
| | | |
| | | |

☐ Direct debit by bank account (please list insurance plans paid by bank account below and complete **option 2**)

| | | |
|---|---|---|
| | | |
| | | |

☐ Receive payment due notices (only available for quarterly, half-yearly and yearly payments)

☐ Partial rollover from a complying super fund (please complete and return the **Enduring rollover authority** form—eligibility criteria applies)

### Option 1: Direct debit by credit card

Only complete this section to pay your insurance premiums by credit card.

Authority to deduct arrears: ☐ No ☐ Yes (**Note:** We will only deduct if arrears are applicable.)

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by credit card, you may choose a date for deduction, between 1st to 28th only

Credit card type: ☐ MasterCard ☐ Visa

Credit card number | Expiry date | Name as shown on credit card

Cardholder's signature

✗

Date signed D D M M Y Y Y Y

**If your credit card details change (eg card number or expiry date) we may be unable to process your payment. To update your credit card details, please call us on 133 731.**

## 15. Superannuation payment authorities (continued)

### Option 2: Direct debit by bank account

Only complete this section to pay your insurance premiums by direct debit.

**Note**: Please refer to your financial institution to check your account offers direct debiting.

Authority to deduct arrears: ☐ No ☐ Yes (**Note:** We will only deduct if arrears are applicable.)

Frequency of ongoing premium deductions (cross one): ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

(Optional) If paying **monthly** direct debit by bank account, you may choose a date for deduction, between 1st to 28th only

BSB number | Account number

Bank/financial institution name | Bank/financial institution branch name

Account in name of (name in full) | If company account Australian business number (ABN)

**Account holder signature(s)**

Signature—account holder 1 | Signature—account holder 2 (if applicable)

✗ | ✗

Date signed | Date signed

D D M M Y Y Y Y | D D M M Y Y Y Y

**If the person insured is a member of the National Mutual Retirement Fund, binding death nominations are not available. Please contact our Customer Service Centre for the correct form if you wish to make a non-binding nomination.** If you are applying for membership through North, Summit, Generations or iAccess, your nomination of dependants for distribution of your death benefits requires the completion of the appropriate death benefit nomination form available under North, Summit, Generations or iAccess. Completion of the superannuation nomination of dependants form accompanying this application will be void if your policy is under North, Summit, Generations or iAccess.

## 16. Nomination of dependants (For National Mutual Retirement Fund (NMRF) members only)

! To be completed if you are applying for an increase, alteration or addition to a Life Insurance Superannuation Plan held through National Mutual Retirement Fund (NMRF).

! **Before you complete this page:**

- you should read the 'Holding your policy in superannuation' section of the **product disclosure statement**, and
- discuss your needs with your financial adviser.

**When making a nomination you must select one of the following**

☐ Non-binding death benefit nomination—complete sections **a and b**

– If you make a non-binding death benefit nomination, the Trustee will decide who will receive your benefit in the event of your death. We will generally pay your nominated beneficiary(ies), but may decide to pay your death benefit differently.

**OR**

☐ Binding death benefit nomination—complete sections **a, b and c**

– The trustee must pay your benefit in the event of your death to the person(s) or your legal personal representative/estate you have nominated, provided that your nomination is valid. You must have two witnesses sign and date your application in the witness declaration section.

**Note:** You can change your nomination at any time by notifying the Trustee of the NMRF in the approved form.

### A. Death benefit nomination

(Trustee must pay specific people you have selected, provided that your nomination is valid)

% of benefit

☐ My legal personal representative (eg the executor of your will) %

**AND/OR**

**1.** Title | First name | Family name | Gender ☐ Male ☐ Female

Address

Date of birth / / | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[1] ☐ Child | % of death benefit[2] %

**2.** Title | First name | Family name | Gender ☐ Male ☐ Female

Address

Date of birth / / | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[1] ☐ Child | % of death benefit[2] %

**3.** Title | First name | Family name | Gender ☐ Male ☐ Female

Address

Date of birth / / | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[1] ☐ Child | % of death benefit[2] %

1 Interdependency relationship.

2 Percentages must be whole numbers.

## 16. Nomination of dependants (For National Mutual Retirement Fund (NMRF) members only) (continued)

### A. Death benefit nomination (continued)

**4.** Title | First name | Family name | Gender ☐ Male ☐ Female

Address

Date of birth / / | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[1] ☐ Child | % of death benefit[2] %

**5.** Title | First name | Family name | Gender ☐ Male ☐ Female

Address

Date of birth / / | Relationship of the nominated person to the person insured ☐ Financial dependant ☐ Spouse ☐ IR[1] ☐ Child | % of death benefit[2] %

**Total percentage** **100%**

### B. Declaration, acknowledgment and signature

**Member declaration**

Do not sign this declaration unless in the presence of both witnesses.

I have read the information in the 'binding nominations' section of the **product disclosure statement** and understand that:

- in the event of my death, the Trustee will pay the death benefit in accordance with this nomination
- unless I revoke or amend it before it expires, this nomination will cease to be valid in three years time
- this nomination revokes any previous nomination that I may have made
- I declare that at the date of this application I have answered all questions accurately
- I am aware that if I do not make a valid binding nomination, the Trustee has the right to select the person or persons to whom to pay the benefit in the event of my death. I ask that the Trustee consider the preferred dependant(s) mentioned above when making a selection
- I acknowledge that a binding nomination is not valid unless completed to the satisfaction of the Trustee and received at the Customer Service Centre before the death of the member.

Print full name of member | Date of birth D D M M Y Y Y Y

Signature of member ✗ | Date signed D D M M Y Y Y Y

### C. Witness declaration

! Witness declarations—must be completed if making a binding nomination.

**Note**: Each witness must be an independent person and cannot be a nominated beneficiary.

I declare that:

I am 18 years of age or over, am not a person nominated above and that this nomination was signed by the member in my presence.

**Witness 1**—full name | Signature ✗ | Date signed D D M M Y Y Y Y

I am 18 years of age or over, am not a person nominated above and that this nomination was signed by the member in my presence.

**Witness 2**—full name | Signature ✗ | Date signed D D M M Y Y Y Y

1 Interdependency relationship.

2 Percentages must be whole numbers.

**To be completed if you are applying to increase or alter a life insurance superannuation plan and/or an income insurance superannuation plan.**

## 17. Superannuation insurance application and signatures (Declarations and consent)

Plan number

**Before you sign this application form, you should:**

- **read the product disclosure statement** provided by your financial adviser when you took out your original plan, or if adding a new plan you should read the current **product disclosure statement**. It contains important information to help you understand the product and to decide whether it is appropriate to your needs, and
- 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, and
- read the Privacy – use and disclosure of personal information section in the **Information sheet** and understand the terms outlined.

### Access to information

I authorise:

- any other insurers or other professional, such as a financial adviser or accountant, to disclose any information they may possess about me, whether held in hard copy or in any other format, to Resolution Life, and
- Resolution Life to collect any information they have on my health, medical history, pastimes, work history or anything else that Resolution Life considers to be relevant to assessing or underwriting this cover or assessing any claim under it.

Where I hold other policies or plans within the Resolution Life Group, I authorise the use of any information obtained under this authority in connection with those policies or plans.

### Superannuation membership

Are you applying for insurance through? ☐ North ☐ Summit ☐ Generations ☐ iAccess

If through North , Summit, Generations or iAccess please provide your existing account number

Are you applying for insurance through superannuation that is not attached to North, Summit, Generations or iAccess? This will be through the NRMF. ☐ No ☐ Yes

If **'yes'**, please complete questions 1 to 3

**1.** Current employment status

- ☐ Employee, go to question 2
- ☐ Self employed (sole trader, partnership)
- ☐ Employed by own company, go to question 3

**2.** Does your employer contribute to an existing superannuation fund on your behalf? ☐ No ☐ Yes

**3.** Have you selected an employer supported plan (ie your employer pays part or all of your premiums)? ☐ No ☐ Yes

If **'yes'**, please complete employer details below and question 4.

Company name

Company address

To be completed if you are applying to increase or alter a life insurance superannuation plan and/or an income insurance superannuation plan.

## 17. Superannuation insurance application and signatures (Declarations and consent) (continued)

### Superannuation membership (continued)

**4.** Please confirm that your employer has agreed to pay for premium increases due to indexation. ☐ No ☐ Yes

### 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 additional 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.

### To be completed by you (the person insured)

Print full name of person insured

Date of birth D D M M Y Y Y Y

Signature

✗

Date signed D D M M Y Y Y Y

Resolution Life

# Financial adviser and commission details

! To be completed by the adviser for all increases, alterations and additions.

## 18. Underwriting and financial requirements

Have you spoken to our underwriting department for pre-assessment advice? ☐ No ☐ Yes

If **'yes'**, who did you speak to (or contact), what did you discuss and on what date did this occur?

If you were provided with a Request ID or Service Request ID number, please provide this number.

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

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

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

## 19. Adviser details

Adviser name

Adviser/Account number

Business phone number

Mobile phone number

Email address

## 20. Adviser checklist

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

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

If this application is for agreed value income insurance, will the client be providing substantiating financial evidence in support of the monthly benefit proposed? ☐ No ☐ Yes

**Note:** If you have crossed '**no**' above, financial evidence will be required in the event of a claim and the client will receive written notification from us after the policy has commenced.

Has a quote been provided with this application? ☐ No ☐ Yes

Are there multiple payment methods? Examples include FlexiLink or PremierLink TPD option, life super paid via Summit, Generations or North and trauma by direct debit or credit card, or life super paid by credit card and income insurance (non-super) paid by direct debit. ☐ No ☐ Yes

If **'yes'**, please specify which benefits are to be paid by which payment method in the Adviser notes overleaf.

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

If **'yes'**, please cross: ☐ Children's Trauma Option Personal statement ☐ Financial questionnaire

☐ Other, please specify

## 20. Adviser checklist (continued)

Have the client and the person insured read 'The Duty to Take Reasonable Care Not to Make a Misrepresentation'? ☐ No ☐ Yes

Do you have a preferred or alternative contact method? ☐ No ☐ Yes
If 'yes', please provide details in adviser notes below.

Have you explained to the client and the person to be insured the possible implications on the contract if The Duty to Take Reasonable Care Not to Make a Misrepresentation is not complied with? ☐ No ☐ Yes

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

If **'yes'**, specify (refer to adviser notes section if extra space required)

## 21. Adviser notes

## Where to send this form

Email or mail this completed form (and any supporting documents) to:

Resolution Life Customer Service
GPO Box 5441
Sydney NSW 2001

askus@resolutionlife.com.au

**Any questions?**
133 731

Resolution Life

# Resolution Life administration

Plan number | | | | | | | | | | |

## Service centre only

| Deposit paid | Date | Amount ($) | Receipt number | Account/By |
|---|---|---|---|---|
| | / / | | | |
| | / / | | | |
| | **Total** | **$** | | |

## Previous business

☐ No ☐ Yes If **'yes'**, give details:

| | | | |
|---|---|---|---|
| Plan number | | | |
| Person insured | | | |
| Benefit symbol | | | |
| Code acceptance | | | |
| Assessment | | | |
| Special conditions | | | |
| Amount of risk | | | |
| Reinsurance | | | |
| Status and commencement date | | | |

| | | | |
|---|---|---|---|
| Plan number | | | |
| Person insured | | | |
| Benefit symbol | | | |
| Code acceptance | | | |
| Assessment | | | |
| Special conditions | | | |
| Amount of risk | | | |
| Reinsurance | | | |
| Status and commencement date | | | |

## Previous business (continued)

| | | | |
|---|---|---|---|
| Plan number | | | |
| Person insured | | | |
| Benefit symbol | | | |
| Code acceptance | | | |
| Assessment | | | |
| Special conditions | | | |
| Amount of risk | | | |
| Reinsurance | | | |
| Status and commencement date | | | |





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