Resolution Life

Personal Statement

Information sheet

When to use this form

Use this form to apply for insurance cover with Resolution Life Australia.

Your privacy

Protecting your personal and sensitive information (your information) is important to us. Your information will be handled in compliance with our Privacy Policy and relevant laws.

We collect information to provide our products and services, including managing your insurance. We only collect information from you, authorised individuals, or as required by law.

In some cases, we may need sensitive information, like health details, to assess insurance applications. This information is used or disclosed for its primary purpose or related purposes, such as processing claims, with your express consent.

We may also disclose your information to third parties involved in these processes, including:

- financial advisers
- brokers
- parent or guardians (if under 18)
- insurers and reinsurers
- claims handlers and investigators
- legal and professional advisers, regulators and related companies.

Some of these third parties may be located in the EU, UK, India, New Zealand, Bermuda or USA.

Our Privacy Policy explains how we handle your information and how you can access, correct and complain about your information. You can only access or correct other people's information if authorised.

By providing your information, you consent to our collecting, using, storing, and disclosing it in compliance with our Privacy Policy. Without the requested information we may not be able to offer our services or process your insurance application. For more details, visit **resolutionlife.com.au/privacy**.

What you need to tell us

Before issuing insurance, we need to understand the risk and likelihood of a claim. This includes underwriting, where we determine if we can cover you, and on what terms and cost. We will ask about your personal circumstances, including health and medical history, occupation, income, lifestyle, pastimes, and insurance history. Your responses are crucial to our decision.

Your Duty to Take Reasonable Care Not to Make a Misrepresentation

When applying for insurance, you must ensure all information provided is true, accurate and complete. This duty continues until your application is accepted. A misrepresentation is a false, partially true or misleading answer.

If your information changes or you recall additional details during the application process, you must update us. This duty also applies when changing, extending or reinstating your insurance.

You are responsible for all answers, even if assisted. If a policy covers another person, their misrepresentation is treated as your failure to meet this duty. Therefore, you must ensure all information is accurate, whether you are the policy owner or the insured.

If you do not meet your legal duty

If you make a misrepresentation it can seriously impact your insurance. We may investigate the truthfulness of information provided, especially when a claim is made.

The *Insurance Contracts Act 1984* (Cth) includes remedies where a misrepresentation is made or you fail to comply with your legal duty, aiming to restore our position as if the duty had been met. Consequences include:

- treating the contract (or cover) as if it never existed
- reducing the insured amount to reflect the correct premium. For Death cover this reduction only applies within three years of your cover starting
- varying your cover to account for undisclosed information, affecting waiting periods, exclusions or premiums (excluding Death cover).

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These remedies depend on various factors, including:

- whether reasonable care was taken not to misrepresent, considering the clarity of our questions and information provided
- what actions we would have taken if the duty had been met
- whether the misrepresentation was fraudulent, and
- the time elapsed since the cover started.

Before we apply any remedies, we will inform you of our reasons and the supporting information, giving you an opportunity to explain or dispute our decision.

Changes before your cover starts

Before your insurance starts, we may ask you about any changes in your health or other circumstances 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 insurance starts, you think you may not have met your duty, please contact us immediately.

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 financial adviser), please check every answer and make corrections if needed before the application is submitted.

It may also be helpful for you to:

- have access to information about your medical history
- have a copy of the previous two years' tax returns for income reporting purposes.

How to submit your application

If you have a financial adviser: If you have been working with your adviser please send this directly to them.

Email: insurance@resolutionlife.com.au

We're here to help

It's important that you understand your obligations and the questions that are being asked. Please contact us for help if you have difficulty understanding the process of obtaining insurance or answering any questions.

Please also let us know if you're having difficulty due to a disability, understanding English or for any other reason – we're here to help and can provide additional support.

With My Resolution Life, you have easy digital access to your policy. Manage your policy online, anytime, and keep your payment and contact details updated through My Resolution Life. Login or register today at **resolutionlife.com.au**.

If you need help or more information, please speak to your financial adviser or contact us via our live chat at **resolutionlife.com.au** from 9:00am to 5:00pm (Sydney time) Monday to Friday. You can also call us on 133 731.

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

902026 08/25

Resolution Life

Personal Statement

Part A: Personal details

To be completed by the person to be insured.

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

Title | Given name(s) | Surname

Address

Gender

☐ Male ☐ Female

Date of birth

D D M M Y Y Y Y

Phone number | Email address

Declarations and consent

Plan/policy number (if altering existing policy)

Before you sign this personal statement, you should:

- Be aware that your financial adviser or Resolution Life is obliged to have provided you with the product disclosure statement (PDS) for the product(s) you are applying for.
- Read the PDS because it contains important information to help you understand the product and to decide whether it is appropriate to your needs.
- Read and understand the section in the information sheet entitled **'Your Duty to Take Reasonable Care Not to Make a Misrepresentation'** and note that any cover issued by us will be based on the answers you provide to questions in this form and any other questions that are asked before we advise you in writing that we have issued a policy. If someone has assisted you to complete the form (such as your financial adviser) you have checked every answer (and if necessary, made corrections) before this form is submitted.
- Read and understand the section in the information sheet entitled **'Your privacy'** which details how we collect, store, use and may disclose your personal information.

Honesty declaration

I confirm that I have answered all questions truthfully and to the best of my knowledge. I understand that providing accurate information helps Resolution Life offer appropriate insurance coverage and ensures a smooth claims process.

I acknowledge that deliberately providing false information may result in the denial of future claims.

Signature of person to be insured

Signature

✘

Date signed

D D M M Y Y Y Y

Part A: Personal details (continued)

Section 1: Residency and travel

1. Are you an Australian citizen or permanent resident of Australia or New Zealand?

☐ Yes ☐ No, provide visa and citizenship details below

2. In the next 12 months do you intend to travel or live outside Australia or New Zealand?

☐ Yes, complete the table below ☐ No

Where	When	Duration	Purpose

Section 2: Insurance details and claims history

3. Do you have or are you applying for Life, Total & Permanent Disablement, Income Protection/Salary Continuance or Trauma insurance with any insurer? This includes any Resolution Life cover or insurance within a superannuation fund or through your employer.

☐ Yes, complete the table below ☐ No

Insurer	Type of insurance (e.g. Life cover)	Date started	Insurance amount ($)	Waiting/ benefit period (if applicable)	Policy number	To be replaced?
		/ /				☐ Yes ☐ No
		/ /				☐ Yes ☐ No
		/ /				☐ Yes ☐ No

If this application is a conversion or replacement of insurance listed above:

- **When you are notified that your application for insurance has been accepted, you must cancel the benefits being transferred. If you do not cancel the existing insurance listed, any claim you make to Resolution Life for the insurance applied for and accepted may not be considered.**
- **If the existing insurance is held with Resolution Life, by completing question 3, you authorise us to cancel that insurance effective the date that the new insurance commences.**

4. Have you ever claimed or received benefits, or do you intend to claim, for any illness, injury or medical condition? This includes claims for Income Protection, Total and Permanent Disablement, Trauma or Critical Illness Insurance, Salary Continuance Cover, Workers' Compensation, NDIS, Pensions and/or Veterans' Affairs.

☐ Yes, complete the table below ☐ No

Company/ benefit type	Reason	Insurance amount	Date claim finalised/closed	Time off work
			/ /	

5. Has any life insurer ever indicated they would not issue you with insurance, or would apply a loading, modify, restrict, or exclude your insurance in any way?

☐ Yes, provide details below ☐ No

Section 3: Personal habits and lifestyle

Individual habits and lifestyle choices are an important part of our lives and can impact our health. These questions will help us understand you and your lifestyle.

6. a. In the last 12 months, have you smoked cigarettes, tobacco or cigars?

☐ Yes, complete b. below ☐ No

b. How frequently do you smoke cigarettes, tobacco, or cigars on average?

☐ 31 or more per day ☐ 11–30 per day ☐ 1–10 per day ☐ Less than 7 per week

7. In the last 12 months, have you used e-cigarettes, vapes or nicotine replacement products? For example, patches, gum or mints.

☐ Yes ☐ No

Part A: Personal details (continued)

Section 3: Personal habits and lifestyle (continued)

8. a. How many standard alcoholic drinks do you consume on average?

For reference

1 standard drink =	1 nip of spirits (30ml)	1 small glass of wine (100ml)	1 middy/half pint/pot of beer (285ml)
2 standard drinks =	2 nips of spirits (60ml)	1 large glass of wine (200ml)	1 pint of beer (568ml)

Enter the quantity below:

☐ Per day, or ☐ Per week, or ☐ Per month, or ☐ Per year, or

☐ I don't drink alcohol

b. How often do you have three or more standard drinks on any one occasion?

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once a month ☐ Never

c. Have you ever been advised by a medical professional to reduce or stop drinking alcohol?

☐ Yes, provide details below ☐ No

Many Australians have tried recreational drugs or drugs not prescribed by a doctor at some time in their lifetime.

9. a. In the last 15 years, have you used recreational drugs or substances such as, cocaine, marijuana, ecstasy, heroin,or speed

☐ Yes, provide details below ☐ No

Substance	How often / Frequency of use (Daily, weekly, monthly, once only etc)	Date last used
		/ /

b. Have you received advice, counselling or treatment for drug use or dependence?

☐ Yes, provide details below ☐ No

Facility or treating doctor	Date started	Date ceased
	/ /	/ /

Section 4: Height and weight details

10. a. What is your current:

Height (cm) ☐ Weight (kg) ☐

b. Have you lost over 5kgs in the last 12 months?

☐ Yes, provide how much and reason for the weight loss in box below

☐ No

c. Have you undergone surgery or are you using any medications to reduce your weight?

☐ Yes, provide details, including type of surgery or medication, date of surgery, any complications, and how much weight you have lost, in box below

☐ No

If there were any questions in Part A that you weren't able to answer completely, please provide more information below.

Part B: Personal health history

The following questions will help us understand your mental and physical wellbeing.

It is important to answer these questions accurately and completely to avoid your insurance policy being altered or cancelled in the future, which could potentially result in a claim not being paid.

Depending on the answers you provide we may need to obtain further information from you or your doctor. Before obtaining information from your doctor, we will ask for your consent and let you know each time we have used that consent.

Section 5: Doctor's details

11. Please provide the name and contact details of your usual doctor (if you do not have a usual doctor, then the last doctor that you saw). If you have seen more than one GP in the last two years, please provide details of your previous doctor(s).

Doctor/Medical Centre	Address and phone number	Dates of attendance
		/ /
		/ /
		/ /

Section 6: Mental health

Many Australians experience symptoms of mental illness. The following questions will help us understand your mental health and wellbeing so we can assess your application. If you answer yes to any of the following, please complete the mental health questionnaire in Part C of this form.

12. At any point in your life have you had, received advice for or experienced symptoms of the following:

a. Depression, adjustment disorder, post-natal depression, or any mood disorder ☐ Yes ☐ No

b. Panic attacks, anxiety, post-traumatic or other stress disorder ☐ Yes ☐ No

c. Obsessive compulsive disorder (OCD), attention deficit disorder (ADD/ADHD) ☐ Yes ☐ No

d. Eating disorder or personality disorder ☐ Yes ☐ No

e. Bipolar disorder, schizophrenia or any other mental health disorder ☐ Yes ☐ No

Section 7: Physical health

The following questions will help us understand your health and physical wellbeing so we can assess your application. If you answer yes to any of the following, please complete the relevant detailed questionnaire in Part C of this form.

13. Do you have or have you ever had:

a. High blood pressure or raised cholesterol ☐ Yes ☐ No
If yes, complete the **High blood pressure or raised cholesterol questionnaire**

b. Diabetes and/or sugar in the urine or raised blood sugar levels ☐ Yes ☐ No
If yes, complete the **Diabetes questionnaire**

c. Melanoma, squamous cell carcinoma (SCC), basal cell carcinoma (bcc) or any skin cancer ☐ Yes ☐ No
If yes, complete the **Skin lesion questionnaire**

d. Back or neck pain, injury or condition ☐ Yes ☐ No
If yes, complete the **Back or neck condition questionnaire**

e. Joint, bone, muscle or ligament injury or condition (other than minor strain/sprain requiring less than 1 week off work) ☐ Yes ☐ No
If yes, complete the **Disorder of the joints, muscles, ligaments, bone questionnaire**

f. Asthma ☐ Yes ☐ No
If yes, complete the **Asthma questionnaire**

Part B: Personal health history (continued)

Section 7: Physical health (continued)

14. Do you have or have you ever had:

a. Heart disease, heart condition or chest pain ☐ Yes ☐ No
b. Anaemia, or a bleeding or blood clotting condition ☐ Yes ☐ No
c. Multiple sclerosis, Parkinson's disease, muscular dystrophy or motor neurone disease ☐ Yes ☐ No
d. Brain injury, transient ischaemic attack (TIA) or stroke ☐ Yes ☐ No
e. Alzheimer's or other forms of dementia ☐ Yes ☐ No
f. Seizures or epilepsy ☐ Yes ☐ No
g. Tremors or any alteration in mobility or sensation ☐ Yes ☐ No
h. Cancer or a tumour (malignant or benign) ☐ Yes ☐ No
i. Chronic pain or chronic fatigue ☐ Yes ☐ No
j. Rheumatoid, psoriatic or any other arthritis ☐ Yes ☐ No
k. Osteoporosis ☐ Yes ☐ No
l. Reflux, hernia or other stomach condition ☐ Yes ☐ No
m. Crohn's disease, colitis or other bowel condition ☐ Yes ☐ No
n. Hepatitis, cirrhosis or other liver condition ☐ Yes ☐ No
o. Thyroid condition or pancreatitis ☐ Yes ☐ No
p. Sleep apnoea, lung or breathing condition ☐ Yes ☐ No
q. Psoriasis or other skin condition ☐ Yes ☐ No
r. Visual impairment or other eye condition not corrected by glasses/contact lenses ☐ Yes ☐ No
s. Hearing loss, ringing in the ears or other ear condition ☐ Yes ☐ No
t. HIV or AIDS ☐ Yes ☐ No
u. Kidney, urinary or bladder condition ☐ Yes ☐ No
v. Prostatitis, prostate disorder or abnormal Prostate Specific Antigen (PSA) ☐ Yes ☐ No
w. Ovarian or uterine condition ☐ Yes ☐ No
x. Abnormal pap smear/cervical screening ☐ Yes ☐ No
y. Covid-19 with symptoms of ongoing fatigue, complications and/or required hospitalisation ☐ Yes ☐ No
z. Have you had complications of pregnancy in the past and are currently pregnant?

☐ Yes, provide details below, including due date if currently pregnant ☐ No

If you answered yes to anything in question 14, provide details below:

Question	Condition	Date started	Date of last symptom	Treatment	Tests done and results	Time off work	Name and address of doctor, hospital or health professional consulted if other than your usual GP listed in question 11
		/ /	/ /				
		/ /	/ /				
		/ /	/ /				
		/ /	/ /				
		/ /	/ /				
		/ /	/ /				

Part B: Personal health history (continued)

Section 7: Physical health (continued)

15. Other than what you've already told us, in the last 12 months, have you experienced any of the following even if you have not seen a doctor about it:

a. Unexplained weight loss, loss of appetite or drenching night sweats ☐ Yes ☐ No

b. Persistent unexplained pain or abnormal bleeding ☐ Yes ☐ No

c. Lumps, thickened area or unexplained pain in or around testicles, breast area, armpit or neck ☐ Yes ☐ No

d. A crusty, bleeding or non-healing mole, new mole or skin lesion changing in colour, thickness or shape ☐ Yes ☐ No

e. Persistent changes in bowel motions and/or blood in the stools ☐ Yes ☐ No

f. Increased frequency of urination or blood in urine ☐ Yes ☐ No

g. Unexplained numbness, pins and needles, dizziness, visual disturbances or headaches ☐ Yes ☐ No

h. Persistent fatigue, stress or sleeplessness ☐ Yes ☐ No

If you answered yes to anything in question 15, provide details below:

Question	What have you experienced?	Date started	Date of last symptom	Treatment	Tests done and results	Time off work	Name and address of doctor, hospital or health professional consulted if other than your usual GP listed in question 11
		/ /	/ /				
		/ /	/ /				

Section 8: Investigations and treatment

You do not need to tell us about check-ups where the results were normal, or minor illnesses like cold or flu, or over the counter medication taken for these.

16. Other than what you have already told us, in the last **five** years, have you:

a. Seen a doctor or other health professional? For example, a psychologist, osteopath, physiotherapist, or chiropractor ☐ Yes ☐ No

b. Had any investigations? For example, blood test, x-ray, mammogram, colonoscopy, MRI/CT scan, ECG or biopsy ☐ Yes ☐ No

c. Had any symptoms or are you currently experiencing any symptoms or complaint for which you have not consulted a doctor? ☐ Yes ☐ No

d. Had any treatment or taken regular medication? ☐ Yes ☐ No

e. Had surgery, or attended hospital for an accident or medical condition? ☐ Yes ☐ No

f. 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? ☐ Yes ☐ No

If you answered yes to anything in question 16, provide complete details below:

Question	Condition	Date started	Date of last symptom	Treatment	Tests done and results	Time off work	Name and address of doctor, hospital or health professional consulted if other than your usual GP listed in question 11
		/ /	/ /				
		/ /	/ /				
		/ /	/ /				

Part B: Personal health history (continued)

Section 8: Investigations and treatment (continued)

17. a. Are you awaiting a doctor or specialist appointment, medical test, treatment, or surgery?

☐ Yes, provide details below ☐ No

b. Are you waiting for any results, or have you been advised to have further investigations, treatment or to see another doctor?

☐ Yes, provide details below ☐ No

Section 9: Family history

18. a. Has any first-degree blood related family member (father, mother, brother, sister, or children) been diagnosed or suffered from any of the following?

☐ Yes, cross all that apply and provide details below ☐ No, unknown/adopted, continue to question 19

- ☐ 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 other cancer or heart condition
- ☐ Prostate Cancer
- ☐ Polycystic kidney disease, kidney cancer
- ☐ Stroke
- ☐ Cardiomyopathy
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Huntington's disease
- ☐ Any hereditary disorder or condition that runs in families

Relationship to you	Condition	If cancer, type/site	Age at diagnosis	Age at death (if applicable)

b. Have you been recommended to have any tests or investigations regarding your family history?

☐ Yes, provide details below ☐ No

Part B: Personal health history (continued)

Section 10: Sports and pastimes

19. Do you intend to take part in any of the following activities?

a. Flying as a pilot or crew in an aircraft ☐ Yes ☐ No

b. Motor racing (car, bike or boat) ☐ Yes ☐ No

c. Motor bike riding, including quad bike riding, trail bike riding and commuting ☐ Yes ☐ No

d. Other hazardous sport or activity. For example, contact sport, recreations involving heights or underwater, mountain biking, hang-gliding, ocean racing or competitive horse riding ☐ Yes ☐ No

If you answered yes to anything in question 19, provide details of each activity below.

	Activity 1	Activity 2
i) Name of activity		
ii) How long have you participated in this activity?		
iii) Are you a certified instructor?	☐ Yes ☐ No	☐ Yes ☐ No
iv) In the last 12 months how many events, trips, climbs, jumps did you participate in?		
v) How many hours did you engage in this activity in the last 12 months?		
vi) Where do you participate in this activity geographically?		
vii) If your activity is diving do you ever dive alone, or in caves, wrecks, pot holes or at night?		
viii) Do you have any plans to become a professional in this pursuit?	☐ Yes ☐ No	☐ Yes ☐ No
ix) Please disclose maximum heights, speeds, depths (if applicable)		
x) Please give full details Including the engine size, boats or other vehicles/equipment used.		
xi) Are you involved in any record attempts?	☐ Yes ☐ No	☐ Yes ☐ No
xii) What qualifications do you hold?		

If there were any questions in Part B that you weren't able to answer completely, please provide more information below.

Part C: Detailed questionnaires

Complete the relevant health questionnaires if you answered yes to any items in questions 12 and 13.

Section 11: Back or neck disorder questionnaire

20. a. Please describe your back or neck condition and what caused the symptoms

b. If you have a back condition, what part of the back was or is affected (select all that apply):

☐ Neck ☐ Middle ☐ Lower

Have you experienced any of the following?

– Radiation or spread of pain down either the leg or arm ☐ Yes ☐ No

– Loss of strength/limb weakness ☐ Yes ☐ No

– Pins and needles/loss of feeling ☐ Yes ☐ No

c. When did you first have symptoms?

D D M M Y Y Y Y

d. When did you last have symptoms?

D D M M Y Y Y Y

e. How often have you had symptoms?

☐ Ongoing ☐ Yearly ☐ Weekly ☐ Monthly ☐ Once only ☐ Other, provide details below

f. When you have symptoms how long do they last?

☐ Ongoing ☐ Several weeks ☐ One week ☐ One day ☐ A couple of hours

g. Has this condition ever interfered with, or restricted your lifestyle activities, normal occupational duties, or working hours?

☐ Yes, provide details below ☐ No

h. Have you ever taken time off work because of your back/neck condition?

☐ Yes, provide details below ☐ No

i. Have you had any investigations? For example, X-ray, CT scan or MRI.

☐ Yes, provide details below ☐ No

Date	Tests done	Result/diagnosis	Part of body (e.g. lower back)
/ /			
/ /			

j. Have you received treatment from a surgeon, doctor, chiropractor, physiotherapist, osteopath, or acupuncturist?

☐ Yes, provide details below ☐ No

Name	Address	Date of last consult
		/ /
		/ /

k. Have you been treated with medication, surgery, or injections?

☐ Yes, provide details below ☐ No

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

Part C: Detailed questionnaires (continued)

Section 12: Disorder of the joints, muscles, ligaments, or bone questionnaire

21. a. Please describe your condition and what caused the symptoms

b. Affected area (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 or area of the body:

c. Have you experienced any of the following?

- Radiation or spread of pain ☐ Yes ☐ No
- Loss of range of movement ☐ Yes ☐ No
- Swelling ☐ Yes ☐ No
- Loss of strength/limb weakness ☐ Yes ☐ No
- Pins and needles/loss of feeling ☐ Yes ☐ No

d. When did you first have symptoms?

D D M M Y Y Y Y

e. When did you last have symptoms?

D D M M Y Y Y Y

f. How often have you had symptoms?

☐ Ongoing ☐ Yearly ☐ Weekly ☐ Monthly ☐ Once only ☐ Other, provide details below

g. When you have symptoms how long do they last?

☐ Ongoing ☐ Several weeks ☐ One week ☐ One day ☐ A couple of hours

h. Has this condition ever interfered with, or restricted your lifestyle activities or normal occupational duties or working hours?

☐ Yes, provide details below ☐ No

i. Have you ever taken time off work because of your joint, muscle, or ligament disorder?

☐ Yes, provide details below ☐ No

j. Have you had any investigations? For example, X-ray, CT scan, MRI or ultrasound.

☐ Yes, provide details below ☐ No

Date	Tests done	Result / diagnosis
/ /		
/ /		

k. Did you receive treatment from a surgeon, doctor, chiropractor, physiotherapist, or osteopath?

☐ Yes, provide details below ☐ No

Name	Address	Date of last consult
		/ /
		/ /

Part C: Detailed questionnaires (continued)

Section 12: Disorder of the joint, muscle, or ligament disorder questionnaire (continued)

l. Have you been treated with medication, surgery, or injections?

☐ Yes, provide details below ☐ No

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

Section 13: Mental health disorder questionnaire

22. a. Which of the following have you experienced (select all that apply):

☐ Depression, mood disorder or post-natal depression
☐ Adjustment disorder
☐ Post-traumatic stress disorder
☐ Anxiety, stress or panic disorder
☐ Obsessive compulsive disorder
☐ Attention deficit disorder
☐ Eating disorders
☐ Personality disorder
☐ Bipolar disorder or manic episodes
☐ Schizophrenia
☐ Other, provide details

b. Please describe your symptoms. For example, feeling anxious, feeling down or poor concentration.

c. When did your symptoms start?

D D M M Y Y Y Y

d. When did you last experience symptoms?

D D M M Y Y Y Y

e. How often have you experienced these symptoms (select the most relevant option):

☐ Daily ☐ Weekly ☐ Monthly ☐ A few times a year ☐ Recurring every few years

f. What was the cause of your symptoms?

g. Have you needed to stop work, take time off, or reduce/change the number of hours you work?

☐ Yes, provide details below ☐ No

h. Have there been any impacts to your social life? For example, an impact on your relationships, withdrawal from family or friends, or your ability to exercise or play sport.

☐ Yes, provide details below ☐ No

i. Have you consulted a health professional about your condition? For example, your general practitioner, a counsellor, psychologist, or psychiatrist.

☐ Yes, provide details below ☐ No

Name	Address	Date of last consult
		/ /
		/ /

Part C: Detailed questionnaires (continued)

Section 13: Mental health disorder questionnaire (continued)

j. Have you received any counselling, medication, or treatment for this condition?

☐ Yes, provide details below ☐ No

Details of the medication/counselling/therapy/treatment	Date started	Date stopped
	/ /	/ /
	/ /	/ /

k. If you have stopped your treatment, was this decision supported by your health professional? ☐ Yes ☐ No

l. Have you been admitted to hospital or clinic because of your condition?

☐ Yes, provide details below ☐ No

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

m. Have you ever thought of harming yourself or taking your own life?

☐ Yes, provide the name and contact details of your doctor that would have the details, if one was consulted ☐ No

Doctor	Address	Phone number

n. Have you ever acted on these thoughts?

☐ Yes, provide the name and contact details of your doctor if one was consulted ☐ No

Doctor	Address	Phone number

Section 14: High blood pressure or raised cholesterol questionnaire

23. a. Which of the following apply to you? ☐ High blood pressure ☐ Raised cholesterol ☐ Both

b. When was your blood pressure and/or cholesterol first raised and what was your reading/level at that time?

/ Blood pressure reading ☐ Not sure

D D M M Y Y Y Y Date ☐ Not sure

Cholesterol reading ☐ Not sure

D D M M Y Y Y Y Date ☐ Not sure

c. What was your most recent blood pressure/cholesterol reading and when was this taken?

/ Blood pressure reading ☐ Not sure

D D M M Y Y Y Y Date ☐ Not sure

Cholesterol reading ☐ Not sure

D D M M Y Y Y Y Date ☐ Not sure

d. How often are you required to see a doctor for reviews/check-ups?

☐ Annually ☐ Twice yearly ☐ Quarterly ☐ Monthly ☐ Other

e. Have you taken medication for your condition? ☐ Yes, provide details below ☐ No

Medication	Date started	Date ceased	Daily dose
	/ /	/ /	
	/ /	/ /	

Part C: Detailed questionnaires (continued)

Section 14: High blood pressure or raised cholesterol questionnaire (continued)

f. Have you had or been referred for any investigations? For example, resting or exercise ECG, 24hr holter monitor, urinalysis or echocardiogram.

☐ Yes, provide details below ☐ No

g. Has any cause been found for your raised blood pressure or raised cholesterol?

☐ Yes, provide details below ☐ No

Section 15: Skin lesion questionnaire

24. a. Please complete the table below (list all):

Type of skin lesion	Location	Has the lesion been removed?	Date removed	How was it removed? (e.g. frozen/burnt off, lasered, cut out)	Pathology result (benign/ malignant)	Name of treating doctor
			/ /			
			/ /			
			/ /			

b. Are any follow ups required?

☐ Yes, confirm details including the date of your last follow-up and how frequently follow-ups are required (for example, monthly, twice yearly, annually) ☐ No

Section 16: Diabetes questionnaire

25. a. Which of the following best describes your condition?

☐ Type 2 diabetes ☐ Type 1 diabetes ☐ Glucose intolerance ☐ Insulin resistance ☐ Not sure

(If you cross yes to one of the above, continue to question b.)

OR

☐ Gestational Diabetes – **only answers to i, ii & iii are required.**

i) Number of times diagnosed with gestational diabetes?

ii) Date of last diagnosis? D D M M Y Y Y Y

iii) Have your blood sugar values returned to normal since pregnancy? ☐ Yes ☐ No

b. When were you diagnosed with this condition?

D D M M Y Y Y Y

c. How is this condition treated? (Select all that apply)

☐ Diet ☐ Medication ☐ Insulin

Name of medication	Daily dose

d. Do you have any complications due to your diabetes?

☐ Yes, cross all that apply below ☐ No

☐ Eye problems ☐ Kidney problems/protein in the urine ☐ Diabetic neuropathy (nerve pain/tingling/numbness)
☐ High blood pressure ☐ Vascular/blood vessel disease

e. Have you suffered from a diabetic coma, or required hospitalisation due to your diabetes?

☐ Yes, provide details below ☐ No

f. If you have had a HbA1c (glycosylated haemoglobin) test in the last 6 months please confirm the result below:

☐ 8.1% or more ☐ 6.1% to 8.0% ☐ 6% or less ☐ Don't know

Part C: Detailed questionnaires (continued)

Section 16: Diabetes questionnaire (continued)

g. If you have had a fasting glucose test in the last six months please confirm the result below:

☐ 8.1% or more ☐ 6.1% to 8.0% ☐ 6% or less ☐ Don't know

h. Please provide the name and address of your doctor and the date of your last visit:

Doctor	Address	Date
		/ /
		/ /

Section 17: Asthma questionnaire

26. a. When was your asthma diagnosed? D D M M Y Y Y Y

b. When did you first have symptoms? D D M M Y Y Y Y

c. When did you last have symptoms? D D M M Y Y Y Y

d. Approximately how many times per year do you or did you get symptoms? ☐

e. Does the environment in which you work or perform your normal daily duties, exacerbate or cause your symptoms of asthma? For example, dust, sawdust, pollen or grass.

☐ Yes, provide details below ☐ No

f. In the last 12 months have you taken time off work or been unable to perform your normal daily activities because of your asthma?

☐ Yes, provide details below ☐ No

g. Please provide details of the treatment for your asthma, including dosage of drugs taken and frequency. For example, aerosol spray, tablets or injections, amounts and number of times per day.

h. Have you ever been treated for your asthma with steroids? For example, prednisone.

☐ Yes, provide details below ☐ No

i. Have you ever attended a hospital emergency room or been admitted to hospital because of your asthma?

☐ Yes, provide details below ☐ No

j. In the last three years, have you had or been advised to have a chest X-ray or respiratory function test?

☐ Yes, provide details below ☐ No

k. Have you ever had any complications or other conditions related to your asthma?
For example, cardiac or respiratory arrest, heart disease or chest deformities.

☐ Yes, provide details below ☐ No

l. i) Please provide details of the doctor you consult for your asthma:

ii) When did you last consult this doctor for asthma?

D D M M Y Y Y Y

Part C: Detailed questionnaires (continued)

If there were any questions in Part C that you weren't able to answer completely, please provide more information below.

Part D: Occupation and income

Handy hint: Having your last two tax returns on hand might make this section easier for you to complete.

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

Please disclose your insurable income to 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.

Section 18: Occupation

27. Please provide details of your current and previous occupation or jobs over the last five years. If you have a second occupation please provide details in question 38.

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

28. What are the main duties of your current principal occupation?

Duties **For example, admin/computer work, sales, supervision, manual work, hazardous duties, handling explosives**	**Time per day on each duty (%)**	**Main location** **For example, office, on-site, driving, underground, offshore, underwater, at heights, or at home**	**Time per day at each location (%)**
	100%		100%

Only complete this section if you are applying for Total and Permanent Disability, Income Insurance or Business Expenses Insurance

29. In the last five years did you stop working for reasons other than holidays? For example, unemployment or end of contract.

☐ Yes, provide details below ☐ No

30. Have you changed the type of work you perform or your work hours in the last two years?

☐ Yes, provide details below ☐ No

31. How many hours per week do you work in your principal occupation?

32. How many weeks per year do you work in your principal occupation?

Part D: Occupation and income (continued)

Section 18: Occupation (continued)

33. What qualifications do you have? For example, diploma, degree or trade certificate.

34. Do you intend to change your principal occupation, occupation duties, hours worked and/or employment status in the next 12 months?

☐ Yes, provide details below ☐ No

35. Do you intend to take parental or extended leave in the next 12 months?

☐ Yes, provide details below ☐ No

36. a. Have you ever been bankrupt, entered into a personal insolvency arrangement or your business been liquidated or placed under administration?

☐ Yes, provide details below ☐ No

b. Date of discharge

D D M M Y Y Y Y

c. Any pending legal proceedings ☐ Yes ☐ No

d. Outstanding financial commitments ☐ Yes ☐ No

37. Have there been any complaints or disputes which have prevented you from practicing your profession and/or led to the cancellation of your licence to practice?

☐ Yes, provide details below ☐ No

38. Do you have a second occupation or job?

☐ Yes, provide details including specific duties below ☐ No

a. Number of hours per week worked and annual income derived from this occupation or job

Hours per week:

Income:

If you are applying for Income Insurance or Business Expenses Insurance complete the following applicable sections.

If you are only applying for Total and Permanent Disability Insurance, complete question 39 if you are self-employed and 46 – 47 if you are an employee.

Section 19: For self-employed (sole trader, partnership, employee of own company or trust)

39. 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 from past profits, capital, or loans.

Tax year ending	Gross income	Less all expenses	Equals net business income before tax	Wages or salary	Drawings or director fees paid to you	Your total income
30/06/	$	$	$	$	$	$ 0.00
30/06/	$	$	$	$	$	$ 0.00

40. Did your business contribute to a complying superannuation fund on your behalf?

☐ Yes, provide how much in the last financial year or what percentage below ☐ No

Part D: Occupation and income (continued)

Section 19: For self-employed (sole trader, partnership, employee of own company or trust) (continued)

41. a. What percentage of the business do you own? ☐

b. Is your income split for tax purposes with your spouse? ☐ Yes, provide details below ☐ No. Please complete 41c if you are not 100% owner

Number of hours per week your spouse works in the business: ☐

Nature of work performed ☐

c. Please provide percentage ownership and roles/duties of the other owners.

☐

42. a. How many people do you employ? ☐ b. How many generate income for you? ☐

43. What proportion of total business income is from your personal exertion? ☐

44. Do you receive any income from any other sources? For example, rental income or dividends.

☐ Yes, provide details below ☐ No

Source	Net income per year after expenses but before tax
	$

45. If you were to become disabled, would any of your income continue? For example, investment income, ongoing business income or renewal commission.

☐ Yes, provide details below ☐ No

Type of income	Amount	If an investment property – negatively or positively geared?	Date income would stop (If applicable)
	$		/ /
	$		/ /

Section 20: For employees i.e you do not have any ownership in your employer's business

46. What is your employment status?

☐ Permanent full-time ☐ Permanent part-time ☐ Contractor ☐ Casual or non-permanent ☐ Not currently employed

47. What is your total pre-tax income from all sources?

	Current	Last financial year	Previous financial year
Salary	$	$	$
Bonus	$	$	$
Commission	$	$	$
Regular overtime	$	$	$
Superannuation	$	$	$
Total	$ 0.00	$ 0.00	$ 0.00

48. What rate of superannuation guarantee is your employer contributing on your behalf? ☐ %

49. Do you expect to receive any income from any other sources? For example, rental income or dividends.

☐ Yes, provide details below ☐ No

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

50. If you were to become disabled, would any of your income continue? For example, salary, personal leave more than 100 days or investment income.

☐ Yes, provide details below ☐ No

Type of income	Amount	Date income would stop (if applicable)
	$	/ /
	$	/ /

Part D: Occupation and income (continued)

Only complete this section if you are applying to increase an existing Business Expenses Insurance Plan

Section 21: Business Expenses Insurance

51. Business structure:

☐ Company ☐ Partnership ☐ Trust ☐ Sole trader

Date the business was purchased/started:

D D M M Y Y Y Y

52. Business name and address:

Business name	**Address**

53. Employees:

	Full-time	**Part-time**
Number of income producing employees		
Number of non-income producing employees		

54. If partnership/company, number of partners/directors: ☐

55. Percentage of business income derived from your personal work/exertion: ☐ %

56. If you were to become disabled, what would be the reduction in business income? ☐ %

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

57. 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) Telephone	$
(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 (for example, superannuation contributions) for employees who do not generate revenue.	$
(xi) Net locum cost* only for medical practitioners or dentists classified as occupation category MP or AA	$
(xii) Other fixed expenses (provide details below)	$
(xiii) **Total monthly expenses** (Total of (i) to (xii) above)	**$** 0.00
(xiv) Percentage of expenses in (xiii) above that you are responsible for	%

Details of other expenses

*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.

If there were any questions in Part D that you weren't able to answer completely, please provide more information below.

Part E: Authorities

Section 22: Medical authority

Please read: **'Your privacy'** section of the product disclosure statement.

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.

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

Section 23: Financial authority

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

I, Family name | Given name(s) | Date of birth (D D M M Y Y Y Y)

authorise my accountant/financial adviser to release to the insurer (Resolution Life Australasia 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

What you need to know

Any insurance cover for your product is issued by Resolution Life Australasia Limited ABN 84 079 300 379, AFSL No. 233671 (Resolution Life). This product is issued by either Resolution Life, Equity Trustees Superannuation Limited ABN 50 055 641 757, AFSL No. 229757, RSE Licence No. L0001458 (Trustee) as trustee of either the National Mutual Retirement Fund ABN 76 746 741 299, RSE 1056310 or the Super Retirement Fund ABN 40 328 908 469, RSE 1067361 (each a 'Fund') or N.M. Superannuation Proprietary Limited ABN 31 008 428 322, AFSL No. 234654, RSE Licence No. L0002523 (Trustee) as trustee of either the AMP Super Fund ABN 78 421 957 449, RSE 1056433 or the Wealth Personal Superannuation and Pension Fund ABN 92 381 911 598, RSE 1071481 (each a 'Fund').
If Resolution Life is the issuer of life insurance policies to the Trustee for your product, the Trustee, as owner of the life insurance policies, will receive the applicable benefit from Resolution Life, and in turn provides the benefit to eligible Fund members.

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