

5: Statement of personal health – part A

The Insurer will consider most applications using the information collected on this form. However, the insurer may require additional details such as financial information, a medical examination, medical reports and blood tests. Your cover will only commence once your application is approved by the insurer.

At any time in your life have you ever suffered from, experienced symptoms of, or been diagnosed with any of the following?

- a:** Heart trouble, murmur, high blood-pressure, high cholesterol, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? Y N
- b:** To the best of your knowledge, has the virus which causes AIDS (Acquired Immune Deficiency Syndrome) ever infected you or are you carrying antibodies of the virus? Y N
- c:** Disease related to kidney, bladder, prostate, bowel, stomach or liver (including hepatitis B & C)? Y N
- d:** Mental illness, depression, anxiety, chronic fatigue, nervous condition, stress or post traumatic stress disorder? Y N
- e:** Diabetes, thyroid or glandular trouble? Y N
- f:** Asthma, lung conditions and breathing disorder? Y N
- g:** Back, neck, shoulder or knee pain or strain, sciatica, whiplash, or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments cartilage or limbs, including broken bones? Y N

- h:** Disorder of the eyes, ears or skin (exclusion prescription glasses or contact lenses)? Y N
- i:** Are you currently off work, or unable to perform all your usual duties on a permanent full time basis, or are you receiving any form of medical treatment? Y N
- j:** To the best of your knowledge, have you taken more than a total of 7 days off your work over the past 12 months due to illness or injury (other than cold or flu)? Y N
- k:** Disease of the brain, nervous system, stroke or epilepsy? Y N
- l:** Cancer, leukaemia, tumour or any kind of blood disorder? Y N
- m:** If you have smoked tobacco in the last 12 months please advise the type and quantity per day:
 (i) Type _____
 Quantity _____ per _____ Day _____ Week _____ Month _____ Year
- (ii) Have you been advised by a medical practitioner to give up or reduce the amount of smoking on specific medical grounds, or have you been informed that you have a medical condition as a result of your smoking? Y N
- n:** (i) If you consume alcohol please state the type and quantity:
 Beer Wine Spirits Others _____
 Quantity _____ per _____ Day _____ Week _____ Month _____ Year
- (ii) Have you been advised by a medical practitioner to give up or reduce the amount of alcohol consumed on specific medical grounds, or have you been informed that you have a medical condition as a result of your alcohol consumption? Y N

5: Statement of personal health – part B

Note: you only need to fill in Section 5, part B if:

- you are applying for more than \$500,000 of Death Only and/or Death & TPD cover
- you are applying for more than \$4,000 per month Income Protection insurance cover
- you have answered Yes to any questions in part A.

Otherwise proceed to Section 6 (Declaration) at the end of the Form.

When you have completed Part A and (if required) Part B of this form, please sign the declaration at the end of the form.

- 1:** What is your height? I am cm; or feet and inches
- 2:** What is your weight?
 I weigh kg; or stone and pounds
 Has your weight varied by more than 10 kg (22 pounds) during the past 12 months? Y N
 If yes, provide details:

- 3:** Have any of your near relatives (i.e. your father, mother, brother or sister) been diagnosed prior to age 60 with hereditary disorders such as diabetes, cancer, heart disease, mental disorder, haemophilia or Huntington's chorea? Y N
 If you answered 'Yes' to this question, please advise relationship, condition and age diagnosed:

- 4:** Do you engage in, or intend engaging in (other than as a fare-paying passenger) any hazardous activity such as flying, motor racing, parachuting, hang gliding or diving? Y N
 If 'Yes', please provide details of the activity and the frequency with which you participate in this activity, including maximum speed / height / depth:

 I participate in this activity times per year.
- 5:** Have you ever had an application for life, disability, accident or sickness insurance declined, postponed, modified or accepted on special terms (eg. exclusions or loadings)? Y N
 If 'Yes', provide dates and details:

- 6:** Have you ever made a claim, or are any claims pending or intended for any type of accident or sickness, lump-sum total and permanent disablement, workers' compensation or personal injury insurance? Y N
 If 'Yes', provide dates and details:

- 7:** Have you ever had any of the following, or to the best of your knowledge, do you currently have any of the following:
- a:** Ill health or disability? Y N
- b:** Asthma, sleep apnoea, bronchitis, persistent cough or any other chest or lung troubles or allergy? Y N
- c:** Ulcers, bowel trouble or recurring indigestion? Y N
- d:** Epilepsy, fits or dizziness of any kind or persistent headaches? Y N
- e:** Stress, anxiety, depression, mental or nervous disorders, Alzheimer's disease or dementia? Y N
- f:** Kidney or bladder problems, renal colic or stones, nephritis, pyelitis or cystitis? Y N
- g:** Arthritis, gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, Chronic Fatigue Syndrome (Myalgic Encephalomyelitis)? Y N
- h:** Cancer, tumour, cyst, growths of any kind, or breast lumps (even if you have not seen a doctor)? Y N
- i:** Varicose veins, hernia or skin trouble? Y N
- j:** Any abnormality affecting eyesight, hearing, speech or physical mobility? Y N
- k:** Anaemia, haemophilia or any other disease of the blood? Y N
- l:** Bowel, liver, or gall bladder disease or hepatitis? Y N
- m:** Any other disease or condition or relevant symptoms lasting more than four weeks or of an ongoing nature? Y N
- n:** Coughing of blood or passing of blood from the bowel or in the urine? Y N
- o:** Are you currently receiving or considering receiving medical attention, or taking prescribed drugs (other than for contraceptive purposes)? Y N
- p:** Have you ever had any test for HIV (Human Immunodeficiency Virus) other than as a direct requirement of your employment, residency, pregnancy, being a blood donor or an application for insurance? Y N
- q:** i) Have you EVER worked as, or engaged in, sexual activity with a prostitute; or engaged in anal sexual activity? Y N
- ii) Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? Y N

8: a: Usual doctor or Medical Centre details

Full name of usual doctor:

Grid for full name of usual doctor

Telephone number:

Grid for telephone number

Address of usual doctor:

Street no: Street name:

Grid for street number and name

Suburb:

Grid for suburb

State:

Postcode:

Grid for state and postcode

How many years have you been attending this doctor?

Grid for years and months

Reason for your last consultation:

Text box for reason for last consultation

Date of your last consultation:

Grid for date of last consultation

Outcome:

Text box for outcome

b: If usual doctor known for less than 12 months, please advise name and address of doctor who has details of your medical history:

Full name of doctor:

Grid for full name of doctor

Telephone number:

Grid for telephone number

Address:

Street no: Street name:

Grid for street number and name

Suburb:

Grid for suburb

State:

Postcode:

Grid for state and postcode

Reason for your last consultation:

Text box for reason for last consultation

Date of your last consultation:

Grid for date of last consultation

Outcome:

Text box for outcome

c: If you have more than one usual doctor please provide details of additional doctors below:

Full name of additional usual doctor:

Grid for full name of additional usual doctor

Telephone number:

Grid for telephone number

Address of additional usual doctor:

Street no: Street name:

Grid for street number and name

Suburb:

Grid for suburb

State:

Postcode:

Grid for state and postcode

How many years have you been attending this doctor?

Grid for years and months

Reason for your last consultation:

Text box for reason for last consultation

Date of your last consultation:

Grid for date of last consultation

Outcome:

Text box for outcome

9: Do you currently have, or are you currently applying for, Death, Total and Permanent Disablement or Income Protection (salary continuance) insurance with any other superannuation fund or insurer? If yes please provide details.

Text box for insurance details

10: Females only. If these questions are not applicable please continue to "Details of personal health question".

a: Are you currently pregnant? Y N

If 'Yes', please provide due date:

Grid for due date

b: Have you ever had any complications with pregnancy or childbirth? Y N

If 'Yes', please advise details:

Text box for pregnancy details

c: Have you ever had an abnormal pap smear, breast ultrasound or mammogram? Y N

If 'Yes', please advise details:

Grid for medical history details

Text box for medical history details

Details of personal health questions

If you answered 'yes' to any questions in Part B, please complete the following section (photocopy if required):

Which question did you answer yes to? Grid

Illness, injury or tests:

Text box for illness, injury or tests

Main symptoms/cause:

Text box for main symptoms/cause

Date commenced: Grid

Time off work: Text box

Has the condition recurred? Y N

If 'Yes', state date range:

From: Grid

To: Grid

Have you fully recovered? Y N

If 'Yes', give date: Grid

If 'No', degree of recovery Grid %

Full details of treatment:

Text box for full details of treatment

Date of last symptom: Grid

Further treatment recommended: Y N

If 'Yes', please give details:

Text box for further treatment details

Full name and address of doctors consulted or hospitals attended:

Blank text area for doctor/hospital details.

Does your usual doctor have details of this condition? Y N

Other information: Blank text area.

Which question did you answer yes to?

Illness, injury or tests: Blank text area.

Main symptoms/cause: Blank text area.

Date commenced: DD MM YYYY

Time off work: Blank text area.

Has the condition recurred? Y N

If 'Yes', state date range:

From: DD MM YYYY

To: DD MM YYYY

Have you fully recovered? Y N

If 'Yes', give date: DD MM YYYY

If 'No', degree of recovery %

Full details of treatment: Blank text area.

Date of last symptom: DD MM YYYY

Further treatment recommended: Y N

If 'Yes', please give details: Blank text area.

Full name and address of doctor or hospital consulted: Blank text area.

Does your usual doctor have details of this condition? Y N

Other information: Blank text area.

I have completed Section 5, part B because:
- I am applying for more than \$500,000 of Death Only or Death & TPD cover
- I am applying for more than \$4,000 per month Income Protection insurance cover
- I have answered Yes to one or more questions in part A.
Now sign and date Section 6 (Declaration) at the end of the Form.

6: Declaration

Your duty of disclosure

Before you become insured under a contract of life insurance, you have a duty, under the Insurance Contracts Act 1984, to disclose to the Insurer every matter that you know or could reasonably be expected to know, is relevant to the Insurer's decision whether to accept the risk for the insurance and if so on what terms.

- Your duty does not require you to disclose any matter:
> that diminishes the risk undertaken by the Insurer;
> that is of common knowledge;
> that the Insurer knows or in the ordinary course of business ought to know; or
> to which the Insurer waives your duty of compliance.

Non-disclosure

If you fail to comply with your duty of disclosure, and the Insurer would not have entered into the contract on any terms if the failure had not occurred, the Insurer may void the contract within the first three years of entering into it.

An Insurer who is entitled to avoid a contract of life insurance may within three years of entering into it, elect not to avoid it, but reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the Insurer.

Please sign here: Blank line with a red 'X' mark.

Date: DD MM YYYY

This application MUST be received within 30 days of the date you sign it.
Please return this completed form to: First Super, PO Box 666, Carlton South VIC 3053
t: 1300 360 988 f: 1300 362 899 e: mail@firstsuper.com.au w: www.firstsuper.com.au