

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

Full name and address of doctors consulted or hospitals attended:

Three empty text boxes for doctor/hospital details.

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

Other information: Three empty text boxes.

Which question did you answer yes to?

Illness, injury or tests: Three empty text boxes.

Main symptoms/cause: Three empty text boxes.

Date commenced: DD MM YYYY

Time off work:

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: Three empty text boxes.

Date of last symptom: DD MM YYYY

Further treatment recommended: Y N

If 'Yes', please give details: Three empty text boxes.

Full name and address of doctor or hospital consulted: Three empty text boxes.

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

Other information: Three empty text boxes.

- 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. You have the same duty to disclose those matters to the Insurer before you renew, extend, vary or reinstate a contract of life insurance.

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. If your non-disclosure is fraudulent, the Insurer may void the contract at any time.

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.

By signing below I acknowledge that:

- > I have read and carefully considered the questions in this application and all answers provided are true and correct;
- > cover is conditional upon me, as a potential or current insured member, disclosing all matters known to me that are relevant to the Fund's or the insurer's decision to issue cover, and acknowledge that if I do not comply with this condition, then the Fund or the insurer may cancel my cover and/or not pay a claim;
- > if I am accepted as an insured member, and I have not fully disclosed all known circumstances then the Fund or the insurer may not pay a claim arising out of, or in relation to, those circumstances;
- > I have read the Duty of Disclosure and understand my obligations under the Insurance Contracts Act 1984 as explained above;
- > I am not restricted by injury or illness from carrying out all of my normal work duties and I am working my normal hours;
- > If I do not complete this application correctly, or I do not sign and date this form, my application will be invalid and will not be considered by the Insurer;
- > I hereby authorise the release to the Insurer (OnePath Life Limited), or any other organisation duly appointed by OnePath Life Limited, of any medical information needed in connection with this application, including full details of my past medical history. A photocopy (or similar) of this authorisation will be as valid as the original;
- > Payment of benefits (including any insurance benefits) are subject to taxation legislation; and
- > I have read the Privacy Statement in the *More about First Super* document that forms part of the Product Disclosure Statement and hereby consent to the collection, use, storage and disclosure of my personal information as described therein.

Please sign here

Signature line with a red 'X' mark.

Date

DD MM YYYY date input boxes.

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

This application is part of the First Super Product Disclosure Statement and The Insurance Important Information Brochure dated 30 September 2011.