

Application for Insurance Cover Form



Please complete this Form using **CAPITAL** letters and a blue or black pen. Please complete the relevant sections of this Form if you want to increase insurance cover for Death and Total and Permanent Disablement (TPD) and/or apply for or increase your existing level of Income Protection insurance cover.



Member

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Retirement

- TAL will be treating this Form as a 'consumer insurance contract'
- Please answer all the questions truthfully, accurately and completely, and provide additional information wherever requested.
- The person to be insured must complete and sign this application and initial any changes.
- As part of your application, you may be required to undergo additional medical tests.
- As part of the overall assessment process TAL will contact you if further information is required.

Privacy – Use and disclosure of personal information

Your privacy with TAL Limited ABN 70 050 109 450 AFSL 237848 ('TAL' or the 'Insurer')

The personal information you provide in the form is necessary for TAL to provide you with the products and services you have requested from TAL. You do not have to provide TAL with your personal information, but if you do not do so TAL may not be able to provide you with the products or services. TAL complies with the *Privacy Act 1988* and the principles laid out in its Privacy Policy which details information about the entities that TAL usually discloses personal information to (including overseas recipients), how you may access or seek correction of your personal information, how we manage that information and our complaints process.

The way in which TAL collects, uses, secures and discloses your information is set out in the TAL Privacy Policy available at www.tal.com.au/Privacy-Policy or free of charge on request to TAL by telephoning **1800 666 136**.

Duty to take reasonable care not to make a misrepresentation – Important information before commencing this application

There is a duty to take reasonable care not to make a misrepresentation when applying for insurance. Before answering the questions in this application form it is important that the person answering the questions carefully reads the 'Duty to take reasonable care not to make a misrepresentation' section on page 5 of this form which explains the duty, the consequences of not complying with the duty, and guidance for answering the questions. If the duty is not complied with, TAL may be able to avoid or change cover; this means a benefit may not be able to be claimed or the amount TAL pay may be reduced.

Section 1 | Your personal details

Title	Member number	Account number (if known)	Date of birth (DD/MM/YYYY)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname				
<input type="text"/>				
Given name(s)			Sex (M/F) – assigned at birth	
<input type="text"/>			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Residential address				
<input type="text"/>				
Town/Suburb/City			State	Postcode
<input type="text"/>			<input type="text"/>	<input type="text"/>
Postal address <input type="checkbox"/> (Tick box if same as above)				
<input type="text"/>				
Town/Suburb/City			State	Postcode
<input type="text"/>			<input type="text"/>	<input type="text"/>

Continued over the page

Section 1 | Your personal details (continued)

Telephone (home)

Telephone (work)

Mobile number

Email

Preferred contact number

Home

Work

Mobile

Preferred time of contact

Morning (9am-12pm)

Afternoon (12pm -6pm)

Any time

Section 2 | Death and Total and Permanent Disablement (TPD) Insurance or Death only cover

OPTION 1: UNITISED COVER

Please nominate the **total** number of Death units required:

units

Please nominate the **total** number of TPD units required:

units

Note: This includes any units of cover you already have with First Super.

OR

OPTION 2: FIXED COVER

Please indicate the **total** level of cover you require including your existing cover:

Death cover

Maximum cover: Unlimited

TPD cover

Maximum cover: \$2 million

- > Any increase in cover is subject to your application being accepted.
- > If the Insurer accepts your application, the cover requested will replace the cover you currently hold with First Super.
- > You cannot hold a combination of unitised and fixed cover at the same time.

Section 3 | Income Protection insurance

I wish to apply for Income Protection insurance cover.

Please select a waiting period:

30 days

60 days

90 days

Income Protection benefit required: (number of \$100 units per month)

Note: Your monthly benefit and superannuation benefit combined is subject to a maximum of 85% of your monthly salary at the time of claim.

What is your current occupation?

Are you working on a permanent full-time or part-time basis?

No

Yes

Note: If you are not employed on a permanent basis, that is you are unemployed or employed on a casual basis, you are not eligible for Income Protection insurance cover.

If 'No', please specify:

Section 3 | Income Protection insurance (continued)

Do you work at least 15 hours a week?

No Yes

Note: If you work less than 15 hours per week on average, you will not be eligible for Income Protection insurance cover.

What is your annual income before tax (excluding mandated superannuation guarantee contributions)?

Note: If you are self-employed this means income after business expenses but before tax.

\$ per year

Section 4 | White Collar/non-manual or Professional cover

If you are engaged in a 'White Collar/non-manual' or 'Professional' occupation, you may be eligible for lower insurance premiums by answering the following questions.

WHITE COLLAR/NON-MANUAL

- > Are you solely engaged in a professional, managerial, marketing, accounting or clerical occupation on a permanent full-time or part-time basis? No Yes
- > Do you spend at least 80% of your working time in an office environment? No Yes
- > Are you actively working and able to perform your usual duties and are not undergoing any rehabilitation program? No Yes

If you have answered 'Yes' to all the above questions you are eligible for White Collar/non-manual premium rates.

PROFESSIONAL

In addition to the requirements set out for 'White Collar/non-manual' premium rates, please answer the following to apply for professional:

- > Are your duties entirely undertaken within an office environment? No Yes
- > Do you earn more than \$125,000 per annum from your occupation? No Yes
- > Do you hold a senior management role **OR** hold tertiary qualifications relevant to your profession **OR** are you a member of a professional institute or registered government body related to your profession? No Yes

If you have answered 'Yes' to all the questions in both White Collar/non-manual and Professional Section you are eligible for Professional premium rates.

Section 5 | Your insurance and claim history

1. Apart from this application, do you have or are you applying for any other Life, Total and Permanent Disablement (TPD) or Income Protection (IP) insurance? (Please include cover held or applied and/or applied for through TAL or under superannuation.) No Yes
2. Are you claiming or have you ever claimed a benefit from any source e.g. Total and Permanent Disablement benefit from any superannuation fund, workers' compensation, disability pension, Veterans' Affairs or any other insurance cover providing accident or illness benefits? No Yes
3. Has an application for life, disability, trauma, accident or illness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? No Yes

If yes to 1, 2 or 3, please provide full details below.

NAME OF COMPANY	COVER TYPE	SUM INSURED/ MONTHLY BENEFIT	DATE OF APPLICATION OR CLAIM	STATE ANY LOADINGS/ EXCLUSIONS	REASON FOR DECISION/ CLAIM	DURATION OF CLAIM	RECOVERY	IS COVER TO BE REPLACED?
		\$	DD/MM/YYYY				%	<input type="checkbox"/> No <input type="checkbox"/> Yes
		\$	DD/MM/YYYY				%	<input type="checkbox"/> No <input type="checkbox"/> Yes
		\$	DD/MM/YYYY				%	<input type="checkbox"/> No <input type="checkbox"/> Yes

Before deciding to replace any existing cover, you should compare and consider the policy terms and conditions to work out if the insurance cover is right for you. If you decide to replace existing cover you hold with another superannuation fund or insurer, please do not cancel your existing cover until we have told you that your application has been accepted, and on what terms. This is because there are some risks associated with replacing your existing cover, such as:

- > If you have experienced any new health issues you may not be covered for these under your new replacement cover. But these health issues may be covered under your existing cover, depending on when they arose and your policy terms.
- > You may be subject to new or restarted waiting periods before you can make a claim on the new replacement cover.
- > If you make a misrepresentation in your application for the replacement cover, the new insurer may avoid your cover (treat it as if it never existed) or vary the cover provided (including reducing the cover amount).

Section 6 | Your habits and activities

1. Have you smoked, vaped, used tobacco or nicotine replacement products in the last 12 months?

- No ➔ Go to question 2.
- Yes ➔ Please advise substances smoked or vaped, frequency of use, date first smoked or vaped and when last smoked or vaped.

SUBSTANCE SMOKED/VAPED	FREQUENCY	DATE FIRST SMOKED	DATE LAST SMOKED
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

Section 6 | Your habits and activities (continued)

2. In the last five years have you smoked any substance other than tobacco or nicotine products?

No Yes ➤ Please advise substances smoked, frequency of use, date first smoked and when last smoked.

SUBSTANCE SMOKED/VAPED	FREQUENCY	DATE FIRST SMOKED	DATE LAST SMOKED
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

3. Do you drink alcohol?

No Yes ➤ Please answer the following:

- a) What is the most number of standard drinks that you would drink in a day?
- b) How often would you drink this amount?
- c) How many standard drinks do you have per day on average?

Note One standard drink is: 1 glass of wine, 1 full-strength beer, 1 nip of spirits. Please round to the nearest whole number. If between 0 and 1 units, please enter 1.

4. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare-paying passenger on a commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing?

No Yes ➤ State activity/ies performed, frequency of participation, level of participation (e.g. amateur or professional), maximum depth/speed, equipment used and location (if applicable).

5. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months?

No Yes ➤ State where, when, duration and reason.

6. Are you an Australian citizen, a New Zealand citizen residing in Australia, a holder of an Australian permanent visa or a person who resides in Australia on an approved working visa?

Yes No ➤ State type of visa you hold, expiry date, plans for applying for permanent residency and nationality/current citizenship.

Section 7 | Medical details

1. Please state your: Height cm Weight kg

Should we require further medical information from your health providers we will seek your consent via requesting you to complete a "Consent for accessing health information".

2. Name and address of your usual doctor or medical centre

Doctor's last name

Doctor's given name

Doctor's address

Town/Suburb/City

State

Postcode

3. Details of last medical consultation with your usual doctor or medical centre

Date (DD / MM / YYYY)

Reason

Outcome/results

4. If you have attended that doctor for less than 12 months, state name and address of previous doctor

Doctor's last name

Doctor's given name

Doctor's address


Town/Suburb/City

State

Postcode

Section 8 | Your family history

1. Has any of your immediate family (mother, father, brother or sister) been diagnosed with any of the following conditions before the age of 65: Heart disease (e.g. angina or heart attack), stroke, cardiomyopathy, cancer, diabetes, mental illness, Alzheimer's disease, multiple sclerosis, muscular dystrophy, Parkinson's disease, polycystic kidney disease, Huntington's disease or any other inherited blood or neurological disorder?

No Yes  Provide details in the table below.

RELATIONSHIP TO MEMBER	MEDICAL CONDITION (e.g. breast cancer, heart attack, type 2 diabetes)	AGE WHEN DIAGNOSED	AGE AT DEATH (if applicable)

Section 9 | Your medical history

Please provide details for all 'Yes' answers in the general medical questionnaire at section 10.

1. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?

- a) Chest pain, high blood pressure, raised cholesterol or any heart / circulatory disorder? No Yes
- b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition? No Yes
- c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder? No Yes
- d) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)? No Yes
- e) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout? No Yes
- f) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition? No Yes
- g) Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind? No Yes
- h) Drug dependence or abuse (either prescribed or non-prescribed), or alcohol dependence or abuse? No Yes
- i) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhoea, or gastro where these were short, isolated episodes from which you have made a full recovery)? No Yes
- j) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus? No Yes

2. Have you been infected with the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?

No Yes

3. Apart from treating any condition already disclosed, have you in the last year had medication prescribed by a medical practitioner that is intended to be used for three months or longer (excluding contraceptives)?

No Yes

4. Apart from any condition already disclosed, do you plan to seek or are you awaiting medical advice, investigation or treatment for any other current health condition or symptoms?

No Yes

5. Apart from any condition already disclosed, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full-time basis (for at least 30 hours per week), even if your actual employment is on part-time or casual basis?

No Yes

6. Apart from any condition already disclosed, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last 3 years?

No Yes

Section 10 | General medical questionnaire

Please provide details for all 'Yes' answers in Section 9, Q's 1a-j and Q's 2-6. Please complete on a separate sheet if you need to provide additional information.

	QUESTION NUMBER <input type="text"/>	QUESTION NUMBER <input type="text"/>	QUESTION NUMBER <input type="text"/>
1. Date symptoms first started and description of symptoms	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
2. What was the condition and which part and side of the body was affected (if applicable)?			
3. What was the medical diagnosis including results of x-rays and investigations?			
4. What was the frequency (daily, weekly, etc.) of attacks or symptoms?			
5. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			
6. How long were you unable to work or perform your normal duties/activities?			
7. If a hospital visit was required, please provide date and duration of your stay.			
8. What advice/treatment did you receive?			
9. Are you still receiving treatment? If so, please advise nature and frequency of treatment.			
10. Date treatment/ medication ceased (if applicable).			
11. When did you last suffer from any symptoms?			
12. Degree of recovery (%).			

The duty to take reasonable care

When you apply for insurance, you are treated as if you are applying for cover under an individual consumer insurance contract. A person who applies for cover under a consumer insurance contract has a legal duty to take reasonable care not to make a misrepresentation to the Insurer before the contract of insurance is entered into.

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

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

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. Under the *Insurance Contracts Act 1984 (Cth)* there are a number of different remedies that may be available to the Insurer. They are intended to put the Insurer in the position it would have been in if the duty had been met. For example, the Insurer may:

- > avoid the cover (treat it as if it never existed);
- > vary the amount of the cover; or
- > vary the terms of the cover.

Whether the Insurer can exercise one of these remedies depends on a number of factors, including:

- > whether reasonable care was taken not to make a misrepresentation. This depends on all of the relevant circumstances.
- > what the Insurer would have done if the duty had been met – for example, whether it 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 any of these remedies are exercised, the Insurer will explain the reasons for its decision, how to respond and provide further information, and what you can do if you disagree.

Guidance for answering the questions in this Form

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

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

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

Changes before your cover starts

Before your cover starts, the Insurer may ask you whether the information that has been given as part of your application for insurance remains accurate or whether there has been a change to any of your circumstances. As any changes might require further assessment or investigation, it could save time if you let us or the Insurer know about any changes when they happen.

If you need 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.

Section 12 | Declaration

- > I have read and understand the Duty to take reasonable care not to make a misrepresentation on page 9 and understand that this duty applies any time I answer TAL's questions as part of an application for insurance.
- > My answers to the questions are true, complete and accurate.
- > I have read and understood the Privacy Disclosure Statement entitled 'Privacy – Use and Disclosure of personal information' on page 1 of this form. I consent to the collection, use and disclosure of my personal (including sensitive) information in accordance with these terms.
- > I understand that cover under a policy does not begin until acceptance by the insurer, of which I will be notified in writing and provided my member account has adequate funds to meet the premium payable. I understand that increases or changes to insurance premiums may apply.
- > I have read the insurance section of the current Product Disclosure Statement relevant to my Division, including the Member Guide Supplement: Insurance Guide.
- > I understand that if my First Super account has not received any contributions or other amounts for a continuous period of 16 months (inactive), superannuation legislation will prohibit First Super from providing me with insurance cover unless I make an appropriate election (opt-in).
- > I understand First Super will not be permitted to provide insurance cover from 1 April 2020, if my superannuation account has not had a minimum balance of at least \$6,000 (low balance) and/or I am under 25 years of age, unless I make an appropriate election (opt-in).
- > I direct First Super to accept this application as an election to be provided with insurance cover even if my account is inactive, has a low balance or I am under 25 years of age.
- > I understand this election will apply to all insurance cover through my account, including any cover for death, total and permanent disablement and income protection that I already hold in my account and that I am applying for by this application.
- > I understand this election will continue to apply to my insurance cover, unless and until it is withdrawn by me in writing. I understand that I can withdraw my election at any time.
- > I also understand that I can, at any future time, decrease or cancel my insurance cover.

Signature of applicant

Date (DD/MM/YYYY)

Full name

This application MUST be received within 30 days of the date you sign it.

Please return this completed form by:


 First Super, PO Box 666, Carlton South, VIC 3053

 claims@firstsuper.com.au

Want to know more? We're here to help.

 1300 360 988

 mail@firstsuper.com.au

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 firstsuper.com.au

