

Before a superannuation fund trustee like Sunsuper Pty Ltd enters into a life insurance contract in respect of your life, it has a duty to tell the insurer anything that it knows, or could reasonably be expected to know, that may affect the insurer's decision to provide the insurance and on what terms.

The trustee entering into the contract has this duty until the insurer agrees to provide insurance. The trustee has the same duty before it extends, varies or reinstates the contract. The trustee does not need to tell the insurer anything that reduces the risk of the insurance, or is common knowledge, or the insurer knows or should know as an insurer, or where the insurer waives the duty to tell them.

If you as a member of Sunsuper do not tell us or the insurer something

If you, as the person whose life is to be insured under the life insurance contract, do not tell us or the insurer something that you know, or could reasonably be expected to know, may affect the insurer's decision to provide insurance and on what terms, this may be treated as a failure by us to comply with our Duty of Disclosure. This could affect the insurance cover provided to you as described below.

If we do not tell the insurer something (because you didn't tell us or otherwise)

In exercising the following rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If the insurer does, it may apply the following rights separately to each type of cover.

If we do not tell the insurer anything we are required to, and the insurer would not have provided the insurance if it had been told, the insurer may avoid the contract within three years of entering into it.

If the insurer chooses not to avoid the contract, it may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if we had told the insurer everything we were required to. However, if the contract has a surrender value, or provides cover on death, the insurer may only exercise this right within three years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount of insurance provided, it may, at any time, vary the contract in a way that places the insurer in the same position it would have been in if we had told the insurer everything we were required to. However, this right does not apply if the contract has a surrender value, or provides cover on death. If the failure to comply with the Duty of Disclosure is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed. For further information please contact us.

NRMA Superannuation Plan

Personal health summary

Please read the important information

Important: Please provide us with as much information as possible. Please tick boxes where appropriate. Use **BLOCK** letters and dark ink when completing this form and ensure it is signed and dated. *DENOTES MANDATORY FIELD.
If you are under 18 please contact us before completing this form.

To access information about your plan online, visit sunsuper.com.au/nrma

Member number

if already a member

Office use only

C59394

1 Personal details

Title	First name*	Middle name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Last name*	Date of birth (DD/MM/YYYY)*	Gender*
<input type="text"/>	<input type="text"/>	<input type="radio"/> M <input type="radio"/> F
Street address/PO Box*		
<input type="text"/>		
Suburb/Town*	State*	Postcode*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Home phone number	Daytime phone number*	
<input type="text"/>	<input type="text"/>	
Personal email address	Mobile phone number*	
<input type="text"/>	<input type="text"/>	

Note: Unless you have elected to receive printed information, Sunsuper will confirm this change electronically if we can. We'll email or SMS you if you have information to view in *Member Online*. If you would prefer information is posted to you in the future, change your preferences in *Member Online*, the Sunsuper app or by contacting us.

2 Details of your occupation

2A	Are you at work?	YES <input type="radio"/> NO <input type="radio"/>	Note: This means you must be performing your normal paid duties for your employer.	Your occupation	<input type="text"/>	Degree/trade qualification	YES <input type="radio"/> NO <input type="radio"/>
	Industry (e.g. Mining, Manufacturing, Construction, Agriculture, Retail)	Name of your employer	Your annual Salary	<input type="text"/>	NRMA	\$ <input type="text"/>	Refer to your <i>Sunsuper for life Corporate Insurance guide</i> for the definition of 'Salary'.
List the principal duties of your occupation, and the percentage of time at work spent doing each (e.g. office work 20%, site inspection 80%)							
1	%	2	%	3	%		
List the primary locations of your occupation, and the percentage of time at each location (e.g. office 20%, home 30%, suburban driving 50%)							
1	%	2	%	3	%		
2B	What is your employment status?	Permanent full time <input type="checkbox"/>	Permanent part time <input type="checkbox"/>	Casual <input type="checkbox"/>			
2C	Hours that you work a week (on average):	Under 15 hours <input type="checkbox"/>	15 hours or more <input type="checkbox"/>	Please note: if you are working less than 15 hours per week you will not be eligible to apply for Income Protection.			

3 Details of insurance cover

I would like to apply for the following cover in excess of the Automatic Acceptance Limit (AAL):

Death and Total & Permanent Disability	<input type="checkbox"/>	Death only	<input type="checkbox"/>	Income Protection	<input type="checkbox"/>
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The maximum Income Protection amount available is 85% of your 'Salary' up to a maximum of \$50,000 per month. Refer to your *Sunsuper for life Corporate Insurance guide* for the definition of 'Salary'.

Please refer to the *Sunsuper for life Corporate Product Disclosure Statement (PDS)* and *Sunsuper for life Corporate Insurance guide* for insurance details, available on your employer's microsite.

Please return the form to Sunsuper via sunsuper.com.au/contact-us OR Reply Paid 2924 Brisbane Qld 4001

➔ Please continue over page



Request for insurance / personal statement

This form can be used to obtain or change your insurance cover.

Your Duty of Disclosure

When you apply for a life insurance policy, you have a duty to tell us anything that you know, or could reasonably be expected to know, may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

You have the same duty before you extend, vary or reinstate the policy.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If someone other than you will be the life insured under the policy, any failure by that person to comply with the above duty will be treated as failure by you.

If you request life insurance inside super, the Trustee obtains this insurance from us in relation to you. In this circumstance, we rely on the disclosures that you or the Trustee makes to us.

If you do not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate policies of life insurance. If they do, we may apply the following rights separately to each type of cover.

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the policy within 3 years of entering into it.

If we choose not to avoid the policy, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the policy provides cover on death, we may only exercise this right within 3 years of entering into the policy.

If we choose not to avoid the policy or reduce the amount you have been insured for, we may, at any time vary the policy in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the policy provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the policy as if it never existed.

Information about genetic tests

If you have had a genetic test, you only need to disclose this to us if your total insurance cover (including cover under superannuation or held with other life insurers as well as cover applied for) will be more than any one of the following:

- \$500,000 life cover, or
- \$500,000 Total and permanent disability cover (TPD), or
- \$200,000 critical illness (trauma) cover, or
- \$4,000 per month income protection cover, salary continuance cover or business expenses cover.

Your cover may have been arranged through a financial adviser or directly with a life insurance company or cover is held under a group arrangement.

If you have had a favourable (negative) genetic test result you can provide this information regardless of the amount of cover applied for.

SECTION A – INSURANCE DETAILS

Policy name

Policy number

Please specify the type of insurance cover being applied for:

- Death only cover Death and TPD
 Salary Continuance Trauma

SECTION B – ADVISER DETAILS

Adviser Name

Adviser Phone Number

 ()

Adviser Email

I agree to the Insurer or any one of their authorised representatives contacting the client directly if required to collect further information to assist with the completion of this application.

I am lawfully authorised to advise on, and deal in, MLC Group Insurance policies under an Australian Financial Services Licence. I do not provide these services on behalf of MLC Limited ABN 90 000 000 402 AFSL 230694.

Signature of the financial adviser listed above

X	Date (DD/MM/YYYY)							
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION C – PERSONAL DETAILS

1 Person whose life is to be insured

Title Surname (Family name)

Given names

Male Female Date of birth / /

Marital status

2 Contact address for notices

			Postcode	

Home telephone

()

Work telephone

()

Mobile phone number

Facsimile

()

Email address (Please provide your email so notices relating to your application can be sent to you)

SECTION D – EMPLOYMENT DETAILS

3 Current employer's name

4 What is your current occupation?

5 What professional or trade qualification do you have?

6 On what basis are you employed?

Full-time Part-time Casual
 Contractor Fixed-term employment

Date you started with your CURRENT employer.

/ /

7 What is your annual salary?

\$

SECTION E – ADDITIONAL DETAILS

8 Are you in receipt of or have you ever made a claim for any type of accident or sickness (including lump sum total and permanent disablement, workers' compensation or third party insurance benefit) or have you ever applied for unemployment, sickness or accident benefits or other Centrelink or Veterans' Affairs Benefits?

No

Yes Give details

9 Have you ever had an application for insurance on your life declined, postponed, cancelled, accepted with an exclusion or a higher than standard premium, or modified in any way?

No

Yes Give details

10 Are you covered by, or are you applying for other life, disability, critical illness, or income protection insurance with any company including the Insurer (other than this application) – including benefits under superannuation?

No

Yes Give details for each.

If there is not enough space here, please list at Question 29, page 5.

Type of Insurance	Commencement Date	
	/ /	
Company	Policy Number	
Sum Insured or Monthly Benefit	If income protection Waiting Period	Benefit Period
		Is this application replacing this insurance?
		No <input type="checkbox"/> Yes <input type="checkbox"/>

If you answered "Yes" to this question please ensure you cancel your insurance with the Insurer or another provider once this application has been accepted.

11 Do you now engage or do you intend to engage in any of the following activities?

	No	Yes
a Flying as a pilot or crew in an aircraft	<input type="checkbox"/>	<input type="checkbox"/>
b Motor car, motor cycle or motor boat racing	<input type="checkbox"/>	<input type="checkbox"/>
c Underwater diving	<input type="checkbox"/>	<input type="checkbox"/>
d Football, parachuting, hang-gliding	<input type="checkbox"/>	<input type="checkbox"/>
e Other hazardous pursuits, activities or sports (eg polo, competitive judo, mountain climbing, mountain biking, downhill mountain biking)	<input type="checkbox"/>	<input type="checkbox"/>

If you answered 'Yes' to any of these, complete the Supplementary Pastimes Questionnaire on page 11.

If you answered 'Yes' to any of these, give full details of each below.

If there is not enough space here, please list at Question 29, page 5

Activity
Location
Amateur <input type="checkbox"/> Professional <input type="checkbox"/> Events/Hours per year <input type="checkbox"/>
Other details

SECTION F – HEALTH AND MEDICAL HISTORY

12 What is the name and address of your usual doctor or medical centre? (If no usual doctor, then the doctor you last visited)

If you have known this doctor for less than 12 months, please also advise your previous doctor's details at question 29 on page 5.

This question must be completed.

Doctor's name or medical centre

Address

Postcode

Business Number ()

How long have you been attending this practice?
 years months

Please provide details of your last check-up or consultation.
 Date of last consultation Reason for last check-up or consultation
 / /

Result

Medication prescribed, referral given or tests ordered

13 Are you carrying the Human Immunodeficiency Virus (HIV) which causes AIDS, antibodies to that virus, or are you suffering from AIDS or any AIDS related condition?

No Yes

14 In the past three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? Note – HIV risk situations are situations in which you have been potentially exposed to HIV infection. These situations include but are not limited to, intercourse with someone you know or suspect to be HIV positive, intravenous drug use, or unprotected anal intercourse, (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years)

No

Yes

A confidential questionnaire will be sent out to you to complete and return to the Insurer's Chief Underwriter.

15 Have you ever had any of the following conditions?

If you answer 'Yes' to a, b, c, d, e and/or f, please complete and submit the relevant supplementary questionnaire from pages 12 to 16.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a Asthma (questionnaire on page 12) | <input type="checkbox"/> | <input type="checkbox"/> |
| b any cyst, mole or skin lesion requiring medical advice or treatment (questionnaire on page 12) | <input type="checkbox"/> | <input type="checkbox"/> |
| c a strained back, sciatica, whiplash, spondylitis or any other back, neck or spinal problem (if applying for GSC or TPD, questionnaire on page 15, otherwise give details at question 27) | <input type="checkbox"/> | <input type="checkbox"/> |
| d any disorder of the bones, joints or muscles, arthritis, gout or repetitive strain injury (questionnaire on page 16) | <input type="checkbox"/> | <input type="checkbox"/> |
| e treatment or counselling for depression, or any nervous, anxiety, stress or mental disorder (questionnaire on page 14) | <input type="checkbox"/> | <input type="checkbox"/> |
| f high blood pressure or high cholesterol (questionnaire on page 13) | <input type="checkbox"/> | <input type="checkbox"/> |

16 Further medical requirements may be necessary to assess your application (eg. Blood tests, Medical exam). Do you wish the Insurer to arrange these?

No You will be advised what requirements to organise.

Yes The Insurer's provider will contact you directly.

17 Do you drink alcohol?

No

Yes Number of standard drinks:
 per day or per week
 Note: 1 standard drink = 1 glass of beer/wine/nip of spirit

18 Have you smoked tobacco or any other substance or used any nicotine-containing product in the last 12 months?

No

Yes What type? eg cigarettes, gum, patch Daily quantity

19 What is your height/weight? cm kg

20 Do you currently have or have you ever had any of the following?

If you answered 'Yes' to any item in this question please give details at Question 27.

- | | No | Yes |
|---|--------------------------|--------------------------|
| Heart complaint a | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or any neurological disorder b | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke or vascular disorder c | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung complaint d | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes, bowel, kidney or bladder disorder e | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol or drug dependence f | <input type="checkbox"/> | <input type="checkbox"/> |
| Professional advice to reduce alcohol consumption g | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraine, persistent headache or chronic fatigue h | <input type="checkbox"/> | <input type="checkbox"/> |
| Disorder of the reproductive system (eg prostate, ovary), or sexually transmitted disease i | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer or leukaemia j | <input type="checkbox"/> | <input type="checkbox"/> |
| Haemophilia or blood disorder k | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid disorder l | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver disorder, hepatitis or test indicating past or present hepatitis infection m | <input type="checkbox"/> | <input type="checkbox"/> |
| Any allergies, skin disorder, or disorder of the eyes, ears, nose or throat n | <input type="checkbox"/> | <input type="checkbox"/> |
| Any other operation, disability, illness or injury, medical investigation or test* (eg biopsy, mammogram, ultrasound, ECG) not already mentioned o | <input type="checkbox"/> | <input type="checkbox"/> |

*Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing

21 Other than already stated, have you in the last 5 years:

No Yes

Taken any prescribed medication on a regular or ongoing basis? (Other than for colds or flu) **a**

Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist? **b**

If you answered 'Yes' to any item in this question please give details at Question 27.

22 Do you currently have any other disability, illness, injury or symptoms not already mentioned?

No Yes

If you answered 'Yes' to this question please give details at Question 27.

23 Are you contemplating seeking any medical advice, test*, investigation or treatment?

No Yes

**Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing.*

Males: Go to Question 27.

Females only

24 Have you had any complications of pregnancy or childbirth?

No

Yes **Give details at Question 27.**

25 Are you currently pregnant?

No

Yes Date due
 / /

26 Have you ever had an abnormal pap smear?

No

Yes When

 Treatment

 Date and result of most recent pap smear

27 Did you answer 'Yes' to any item in Questions 15(c), 20, 21, 22, 23 and 24?

No **Go to next question**

Yes **Give full and accurate details below of each instance. If you are completing any of the questionnaires at the back of this application, you do not need to give the same details here. If there is not enough space here, please list at question 29.**

Question number in Section F	Illness, injury, condition or test	Test results	When did it start?	When did it cease?	Type of treatment and when treatment ceased	How long off work?	Have you completely recovered?	Name and address of institution and attending person

28 Have any of your parents, brothers or sisters (living or deceased) suffered from any of the following?

- | | | | |
|----------------------------------|------------------------|-------------------------|---------------------------------|
| • Cancer (specify type and site) | • Diabetes | • Huntington's disease | • Familial polyposis |
| • Heart disease | • Kidney disease | • Motor neurone disease | • Any other hereditary disorder |
| • Stroke | • Rheumatoid arthritis | • Muscular dystrophy | • Multiple sclerosis |

No

Yes Please provide details below

Relationship	Medical condition	Cancer type and site	Age condition began	Age at death (if applicable)

29 Further information

You can use this space to provide further information. Please note the page and question number the additional information refers to.

Page Number	Question Number	Further Information

SECTION G – DECLARATION

Read this section carefully before signing.

My decision to apply for insurance under MLC Group Insurance is based on the Product Disclosure Statement and/or Policy Document for the relevant product that I have received and my understanding of the information it contains.

I understand and agree that:

- (a) I have read the Duty of Disclosure set out on page 1. I understand that, until the Insurer accepts this application, I have a duty to disclose every matter which I know, or could reasonably be expected to know, is relevant to the Insurer's acceptance of this application and that if I fail to comply with my duty of disclosure the Insurer may (as permitted by law) decline to pay, or reduce our liability to pay, the benefits under this policy;
- (b) The answers to the questions in this application and any other relevant personal statement(s) and questionnaires are true and complete, and the answers given form the basis of the contract;
- (c) If any answers to the application questions are not in my own handwriting, I certify that I have checked them and they are correct;
- (d) I consent to notices relating to my application to be sent to the email address or the mobile number provided by me and I acknowledge that my personal and sensitive information may be sent to that email address.
- (e) Where this application is for insurance cover under a superannuation fund, I will provide the Insurer or the trustee or any appointed adviser, intermediary or administrator with any information which relates to my membership of that fund which they may request;
- (f) This insurance application is not effective until the Insurer accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;
- (g) I was actively at work performing the normal duties of my occupation when I applied for this insurance;
- (h) All statements and declarations given by me on this form are true and correct; and
- (i) The information contained in this application may be released to the trustee which has arranged this group insurance, or to an adviser, intermediary or administrator appointed by the trustee for the purposes of administering this insurance or the superannuation fund under which it is provided.

I authorise the Insurer to:

- (a) Provide my personal, financial and medical information (whether provided in this application or otherwise subsequently collected by the Insurer with my consent) to any medical professional, medical facility, reinsurer, assessor, adviser or any other confidential service provider, now or at any time in the future, for the purpose of issuing or administering this insurance, and assessing any claim made in respect of this insurance; and
- (b) Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undertaken in connection with this application to my usual doctor or medical centre as nominated at Question 12 of Section F, Health and Medical History; and
- (c) Provide a copy of the HIV Antibodies test to my usual doctor or medical centre as nominated at Question 12 of Section F, Health and Medical History unless I have nominated an alternative doctor to receive the results, in which case I authorise the results to be provided to the alternative doctor specified.

I also authorise the Insurer and any third party referred to in paragraphs (a), (b) and (c) of this authority, to transfer any such information outside the State, Territory or jurisdiction in which the information was collected in order to give effect to this authority.

Privacy

I acknowledge that I have access to the Insurer's privacy policy and agree that the Insurer may collect, use, disclose and handle my

personal information in a manner set out in the Group's privacy policy available on mlcinsurance.com.au

I acknowledge that where my Employer (or former Employer) or the trustee of my superannuation fund has appointed an adviser, intermediary or administrator to arrange and/or administer the group insurance policy on their behalf, my personal information, including my pastime activities, occupation and financial status will be provided to the Insurer for the purpose of expediting the assessment of this application for insurance.

Consent

I consent that where my application is declined, loaded and/or an exclusion is applied, the Insurer may disclose any personal medical information or finding that resulted in my application being declined, loaded and/or having an exclusion applied, to the adviser, intermediary or administrator providing services in relation to this group insurance.

I understand that I can withdraw this consent at any time by contacting the Insurer on **1800 652 447** or email enquiries.group@mlcinsurance.com.au

Where, in the Insurer's opinion, your medical information or our findings are of a personal or sensitive nature, the Insurer reserves the right to withhold disclosure of this information to the appointed adviser, intermediary or administrator.

Signature of Life to be Insured

X

Date

/ /

YOU MUST SIGN THE MEDICAL AUTHORITY ON PAGES 7 and 8.

Have you completed or were you requested to complete any questionnaires in this application form?

No Please return pages 1 to 9 of the completed form.

Yes Please return pages 1 to 16 of the completed form INCLUDING any completed questionnaires.

SEND TO:

Mail:

MLC Group Insurance
PO Box 23455
Docklands Vic 3008

Phone:

1800 652 447

Email:

enquiries.group@mlcinsurance.com.au

Website:

mlcinsurance.com.au



(DO NOT DETACH)

Authority to Release Medical Information

(to be completed in All cases)

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **MLC Life Insurance**, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth).

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Send us your form

Please mail your completed, signed and dated form to us at:

MLC Life Insurance
PO Box 23455
Docklands VIC 3008

If you have any questions, please call us on **1800 652 447** between 8.30am and 6pm (Melbourne/Sydney time) Monday to Friday or email us on enquiries.group@mlcinsurance.com.au.

MLC Limited ABN 90 000 000 402 AFSL 230694 (the Insurer) uses the MLC brand under licence. MLC Limited is part of the Nippon Life Insurance group and not a part of the NAB group of companies. Any references to 'we', 'us' and 'our' means MLC Limited.

Authority to Release Medical Information - Authority 1

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **MLC Life Insurance**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **MLC Life Insurance** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **MLC Life Insurance** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MLC Life Insurance** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

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Signature of Life Insured

X	Date (DD/MM/YY)					
	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>					

Authority to Release Medical Information – Authority 2

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **MLC Life Insurance**, or to third parties they engage, only if **MLC Life Insurance** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **MLC Life Insurance** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MLC Life Insurance** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

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Signature of Life Insured

X	Date (DD/MM/YY)					
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Pathology Request for Insurance

This must be completed when a blood test is required.

LIFE INSURANCE



Life to be Insured's Details

Title	Surname (Family Name) (please print)	Given Names	Sex	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Policy name	Family doctor or hospital – name and address			
<input type="text"/>	<input type="text"/>			
Policy number	Postcode			
<input type="text"/>	<input type="text"/>			

Report and account to Collection date and time Tests required

Chief Medical Officer PO Box 23455 Docklands Vic 3008 Phone: 1800 652 447	Date of appointment <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Multiple Biochemical Analysis 20 (Chol. (HDL & LDL), Trigs., Glucose, Creat., Uric acid, LFTs, Electrolytes), and Hepatitis B and C serology
	Time of appointment <input type="text"/> am/pm	<input type="checkbox"/> HIV Antibodies
		<input type="checkbox"/> Other (specify) <input type="text"/>

Life to be Insured's consent (not to be signed prior to attendance)

I give my consent to the tests nominated above including any reflex testing for Hepatitis B and C to be performed. Where one is for the presence of antibodies to the AIDS virus (HIV). I acknowledge that I have read the material provided by the Insurer (see over) on the implication of the test and understand its significance. I authorise the sending of a copy of the test results to the Insurer and to my family doctor as shown above.

No

Yes

Signature of Life to be Insured

X Date / /

HIV Antibody Blood Test

In accessing this application for insurance we may ask you to have a blood test to check your overall health, and to test for HIV. This is because we need to understand your state of health when taking out a life insurance policy.

The test can be done by your own doctor, by appointment with a doctor or paramedical nurse arranged by us, or directly with the pathology laboratory.

This test is voluntary, however, if you choose not to have the test, it could affect our decision to accept this application based on the other information you have provided to us.

AIDS/HIV

- Acquired Immune Deficiency Syndrome (AIDS) is a viral disease caused by the Human Immunodeficiency Virus (HIV).
- HIV weakens and destroys some of the white blood cells in our bodies – these cells help protect our bodies against infection and cancer.
- Evidence suggests that the virus will be in the body indefinitely but there are now effective treatment options available called antiretroviral therapy (ART).

A negative result

A negative result means you have not been infected or you have been infected recently but your body is not yet displaying the infection.

A positive result

A positive result means you have been infected by HIV.

Knowing that you are HIV positive has legal consequences which vary across all States and Territories. Because the long-term outlook for HIV and developing AIDS is unknown, most insurance is unlikely.

What happens to the results?

- You'll be asked to nominate your family doctor – or an alternative – to be sent the result by us and provide you the counselling.
- This will be in the consent declaration in the Application Form attached to this brochure.
- If the test is arranged by us the result is sent to us, MLC, confidentially to protect your privacy.
- If it's positive, you will receive proper counselling from a doctor.

Your choice

There may be several reasons you choose not to have this test including the impact of a potentially positive result on the HIV test.

If you may need more information before deciding, you are advised to seek advice from your own doctor, or a specialist HIV counsellor. Government and community organisations provide counselling services.

Supplementary Pastimes Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

UNDERWATER DIVING

- 1** Do you hold a diving qualification?
No
Yes Type of qualification and time held
- 2** How many dives do you make per year?
- 3** What is the average depth of dives? metres
- 4** What is the maximum depth of dives? metres
- 5** Do you ever dive alone?
No
Yes
- 6** Do you dive in caves, potholes, or at night?
No
Yes Give details
- 7** Do you use mixed gases to dive?
No
Yes Give details
- 8** Have you ever had an accident whilst diving or suffered an injury?
No
Yes Give details

MOTOR CAR, CYCLE OR BOAT RACING

- 9** What vehicle type do you race?
- 10** In what events and categories do you race?
(Please use CAMS category descriptions where applicable)
- 11** What is the engine size?
- 12** What maximum speed is reached?
- 13** How many times do you race per year?

AVIATION

- 14** Do you hold an aviation licence?
No **Go to Question 16**
Yes Type of licence and period of time held
- 15** Do you intend to change the scope of your licence, or engage in any other form of aviation other than as shown in question 16 below?
No
Yes Give details, including the qualifications you intend to obtain
- 16** Please complete number of flying hours in the following table
- | | Last year | | Future average | |
|---------------------------|-----------|-----------|----------------|-----------|
| | Crew | Passenger | Crew | Passenger |
| Commercial Airline | | | | |
| Charter | | | | |
| Private | | | | |
| Aero club / Flying school | | | | |
| Agriculture | | | | |
| Ultralight | | | | |
| Helicopter | | | | |

Return to Question 11 on page 2

Supplementary Asthma Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

- 1 When did you have your first episode?
- 2 How frequently do you need to use medication (inhalers, tablets, etc.)?
- 3 Approximately how many episodes occur per year?
- 4 When was your most recent episode?
- 5 How much time have you lost from work due to asthma in the past 12 months?
- 6 Have you ever been hospitalised for this condition or needed to attend a hospital, casualty or doctor's surgery for urgent treatment?
No
Yes Please provide names of hospitals, doctors and dates
- 7 Have you consulted any other doctor for this condition?
No
Yes Please provide names of hospitals, doctors and dates
- 8 Are you now taking medication or have you used any medication (including steroids) within the last 12 months?
No
Yes Please provide name of drug, daily dosage and date ceased (if applicable)
- 9 Do you record your own peak flow levels?
No
Yes Please provide details of how often you record your own peak flow levels and on average what the results are.

Return to Question 15(a) on page 3.

Supplementary Cyst / Mole / Skin Lesion Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

- 1 Site
- 2 Date diagnosed / /
- 3 Type
- 4 Was the cyst/mole/skin lesion removed?
No
Yes When?

By what method? (eg surgically, freezing or otherwise)
- 5 Were any special tests, investigations or treatments required?
No
Yes Please provide details
- 6 Was the growth reported to be malignant or benign by your treating doctor?
 Malignant Benign
Please forward copies of any histopathology reports you have.
- 7 Have you been or are you required to attend for any further treatment or follow-up since the original removal including re-excision of the lesion?
No
Yes Please provide details of date(s) and what was advised
- 8 Name and address of doctor consulted

 Postcode

Return to Question 15(b) on page 3.

Supplementary High Blood Pressure / High Cholesterol Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 (a) What was your last blood pressure/cholesterol reading, and when was this taken?

Blood pressure

Systolic	Diastolic	Date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Cholesterol

Reading	Date
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

(b) Is this reading consistent with others when checked?

No What is your typical reading?

Yes

2 When are you due for your next checkup?

3 How often are you required to attend your doctor for review/checkups?

Monthly Twice yearly
Quarterly Annually

4 When were you first told you had raised blood pressure/raised cholesterol levels?

5 Are you currently taking medication for your blood pressure/cholesterol levels?

No **Go to Question 7**

Yes Please provide names of medication and daily dosage

6 Has your treatment (type or dosage) been changed within the last 12 months?

No **Go to Question 8**

Yes When was it changed?

What was changed?

Why was it changed?

7 Have you ever been prescribed medication for blood pressure/cholesterol?

No How has the condition been managed?

Yes When and why did you cease taking this?

8 What was your last blood pressure/cholesterol reading at the time of diagnosis?

Blood pressure (eg 120/80)

Systolic	Diastolic
<input type="text"/>	<input type="text"/>

Cholesterol

Reading
<input type="text"/>

9 Have you ever undergone or been referred for any other investigations: eg ECG (resting or exercise stress), Echocardiogram, 24 hr Holter monitoring, urinalysis?

No

Yes What were the results?

Who holds the results of any investigations (eg GP)?

10 Has an underlying cause been found for your raised blood pressure/cholesterol?

No

Yes Please provide full details

Return to Question 15(f) on page 3.

Supplementary Mental Health Questionnaire

Complete this questionnaire only if requested to do so. To be completed by the Life to be Insured.

If there is not enough space here please complete additional details at Question 29, page 5.

- 1** Please indicate the conditions you have had or received treatment for?
- Anxiety including generalised anxiety, panic or phobia disorder
 - Eating disorder including Anorexia nervosa, bulimia
 - Depression including major depression, dysthymia
 - Manic depressive illness, bi-polar disorder
 - Alcohol or other substance abuse or addiction
 - Post traumatic stress
 - Schizophrenia or any other psychotic disorder
 - Stress, sleeplessness, chronic tiredness
 - Other Please describe

- 2** Please describe your symptoms including the date they started and how long they lasted
-

- 3** Has any reason for your condition been identified?
- No
- Yes Please provide details
-

- 4** When was your condition first diagnosed?

- 5** Have you had any recurrences of this condition?
- No
- Yes How many times? When?

- 6** Have you ever received any counselling or treatment for this condition? (eg medication, CBT, hospitalisation)
- No
- Yes **Please provide details below**
- | Type of treatment | Date commenced | Date ceased |
|-------------------|----------------|-------------|
| | | |
| | | |
| | | |
| | | |

- 7** Are you currently receiving treatment?
- No / /
- When did you cease treatment? / /
- Yes Please advise details:
-

- 8** Please provide the names and addresses of doctors you have consulted including the date first and last consulted. Please complete additional details at Question 29, page 5.
- Doctor's Name

Address

Postcode

Date first consulted / /

Date last consulted / /

- 9** Has your condition ever caused you to lose time from work?
- No
- Yes Please advise details:
-

- 10** Are you limited in your ability to work or to perform your activities of daily living as a result of this condition?
- No
- Yes Please advise details:
-

- 11** Do you continue to experience symptoms?
- No **Go to Question 12**
- Yes **Go to Question 13**

- 12** When did you last experience symptoms?
-

- 13** Describe your symptoms?
-

Return to Question 15(e) on page 3.

Supplementary Back/Neck Disorder Questionnaire

Complete this Questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 When did you first suffer from a back/neck disorder?

2 What is the cause of your back/neck disorder?

3 What is/was the exact nature of the back/neck disorder including symptoms?

4 What area of your back/neck is affected?

5 Please advise the names and addresses of any doctor, physiotherapist or chiropractor consulted and approximate dates.

Name	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Approximate dates	<input type="text"/>

Name	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Approximate dates	<input type="text"/>

6 Have you undergone any x-ray, scan or other test?

No

Yes Please provide details and results

7 What treatment have you had? (eg physiotherapy, medication, brace, surgery)

8 Are you still undergoing treatment?

No When did treatment cease? / /

Yes

9 When did you last experience symptoms?

10 Do you continue to experience symptoms?

No **Go to Question 13**

Yes

11 What are your current symptoms?

12 How often do you experience symptoms?

13 Have you lost time from work due to this disorder?

(a) In the last 12 months?

No **Go to (b)**

Yes

From	To
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

(b) Prior to the last 12 months?

No

Yes Please provide full details of all periods of time off work including dates

Return to Question 15(c) on page 3.

Supplementary Joint/Musculoskeletal Questionnaire

Complete this Questionnaire only if requested to do so.
To be completed by the Life to be Insured.

1 Which joint(s) or area(s) of the body are affected?
(Advise if left or right joint, where applicable)

2 What is/was the nature of the joint disorder, including symptoms?

3 What is the cause of the disorder?

4 When did the symptoms first occur?

5 When did you last experience symptoms?

6 Do you continue to experience symptoms?
No **Go to Question 9**
Yes

7 What are your current symptoms?

8 How often do you experience symptoms?

9 What treatment have you had?

10 Are you still undergoing treatment?
No When did treatment cease? / /
Yes

11 Have you had an x-ray or other test?
No
Yes Please provide details, including dates and results

12 Please advise the names and addresses of any doctor, physiotherapist or chiropractor consulted.

Name

Address

Postcode

Name

Address

Postcode

13 Have you lost time from work due to this disorder?

(a) In the last 12 months?

No **Go to (b)**
Yes

From	To
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

(b) Prior to the last 12 months?

No

Yes Please provide full details of all periods of time off work including dates

Return to Question 15(d) on page 3.