

Application for insurance (or to increase your current insurance benefit)



This Application is made by you under a life insurance policy issued to the Trustee of First State Super by TAL Life Limited, ABN 70 050 109 450 (the insurer). It will be used by the insurer to assess your application.

Subject to your occupation, you can use this form if you are:

- A **new employer sponsored member** and you would like to apply for additional cover over and above the automatic cover you may be entitled to, or income protection cover. Premiums for additional cover are payable in addition to the premiums payable for automatic cover.
- A **new personal member** of First State Super and would like to apply for death and total and permanent disablement (TPD) cover, death only cover or income protection cover.
- An **existing member** and you would like to apply to increase your current level of cover.

To see how your occupation affects your application for insurance, or increase in insurance, please refer to the Member Booklet Supplement applicable to your membership.

Please use a dark pen and CAPITAL letters. Insert (X) when you have to choose an option. You can also fill in this form online, print it and send it to us. Forms are located on our website at firststatesuper.com.au/forms.

If you have any questions, please call us on **1300 650 873**.

i **Definition of a casual worker:**
Casual means you are not employed on a permanent basis, nor do you have a contractual agreement to provide services for a specific period of time or task.

1. Your personal details

Member number	Account number	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Title	Last name	
<input type="text"/>	<input type="text"/>	
Given name(s)		
<input type="text"/>		
Address		
<input type="text"/>		
<input type="text"/>		
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Daytime contact number	Mobile number	M F
<input type="text"/>	<input type="text"/>	<input type="text"/>
Can the insurer contact you directly to clarify or gather information in relation to this application?		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Email (for security reasons, please ensure that your nominated email address is your personal email address and not a role-based email address such as <code>employee_title@company.com.au</code>)		
<input type="text"/>		

2. Your occupation

Are you employed? If not, you may only apply for additional death and TPD cover. Yes No

Are you employed as a casual worker (see definition at left)? Yes No

Are you in paid employment for more than 30 hours per week? Yes No

What is your occupation?

Name of employer or government department you work for

Gross annual salary (include packaged items but not bonuses/commissions) \$, , OFFICE USE ONLY – Employer Code

What duties do you perform at work? Please be as specific as possible, including percentage of time performing each duty, because this information will be used to assign an occupational rating (if applicable).



i **Death and TPD or death only cover**

You can nominate a fixed dollar amount, a number of units, or a combination of both. Your total cover (which includes any automatic cover) is subject to a maximum of \$5 million for TPD/terminal illness. There is no limit on the amount of additional death cover you can apply for. To apply for this cover, complete Sections 1, 2, 3, 6 and 9.

3. Death and TPD or death only cover

Please complete this section to apply for or increase your **death and TPD** cover or your **death only** cover.

I currently have			I want my new cover to be <i>(show the total amount of cover you would like, including any existing cover that you may have)</i>		
	Unitised cover	AND /OR Fixed cover		Unitised cover	AND /OR Fixed cover
Death and TPD cover	<input type="text"/>	\$ <input type="text"/>	Death and TPD cover	<input type="text"/>	\$ <input type="text"/>
	units of death and TPD cover	of death and TPD cover		units of death and TPD cover	of death and TPD cover
Death only cover	<input type="text"/>	\$ <input type="text"/>	Death only cover	<input type="text"/>	\$ <input type="text"/>
	units of death only cover	of death only cover		units of death only cover	of death only cover

i **Income protection cover**

Subject to your occupation, this cover provides you with a monthly income benefit (not a lump sum) for 2 years, 5 years or to age 65. If you are absent from work as a result of an illness or injury, payment does not start until your nominated waiting period has expired. You may apply to be covered for an insured amount of 75% or 50% of your income. To apply for this cover, complete Sections 1, 2, 4, 6, and 9.

4. Income protection cover

Subject to your occupation, complete this section if you **DO NOT** currently have income protection cover. You must also complete Section 6 the Personal Health Statement. You must be working at least 15 hours per week to apply for income protection cover.

I would like to apply for a benefit of 75% OR 50% of my monthly income

In addition to the % of monthly income indicated, I would like a 10% superannuation contribution benefit paid to my First State Super account Yes No

I would like a benefit period of 2 years 5 years To age 65

My current gross monthly income is \$, .

(For definition of monthly income, please refer to the Member Booklet Supplement applicable to your membership)

(DD-MM-YYYY)

The effective date of my current gross monthly income is - -

I would like a waiting period of 14 days 30 days 60 days 90 days

Important: A 14-day waiting period is only available for a **two year benefit period**.

Complete this section if you DO currently have income protection cover. You must also complete Section 6 Personal Health Statement

I would like to increase the percentage of my current gross monthly paid as a benefit from 50% to 75%

My current gross monthly income has increased to \$, .

The effective date (DD-MM-YYYY) of my current gross monthly income is - -

I would like to reduce my waiting period From 30 days 60 days 90 days
To 14 days 30 days 60 days 90 days

In addition to the % of monthly income indicated, I would like a 10% superannuation contribution benefit paid to my First State Super account Yes No

I would like a benefit period of 2 years 5 years To age 65

i **Basic Plus insurance category**

If you are eligible, you can apply to have both new and existing cover rated at the Basic Plus insurance category. To apply for the Basic Plus insurance category on your existing cover, complete Sections 1, 2, 5 and 9.

i **Further information**

Depending on the answers provided in this application and the amount of cover you have applied for, the insurer may require further information regarding your health, lifestyle, pastimes and personal information.

5. Basic Plus insurance category application

Please answer these questions if you wish to apply to be rated for the Basic Plus insurance category. You must be able to answer YES to each of the questions in this section to be eligible for the Basic Plus insurance category. If you are accepted for this category, it will apply to all your insurance cover.

Are the duties of your occupation limited to professional, managerial, administrative, clerical, secretarial or similar white collar-type tasks which are of a sedentary nature and do not involve manual work and are undertaken entirely within an office environment (excluding travel time from one office environment to another) Yes No

Are you earning in excess of \$80,000 (including superannuation) per annum from this occupation? Yes No

Do you hold a tertiary qualification relevant to your current occupation OR are you a member of a professional institute or registered member of a government body OR are you engaged as a senior member of your employer's management/executive team? Yes No

6. Personal health statement

1. Please state your Height Weight

2. a. Have you ever had an application for life, disability, trauma, accident or illness insurance on your life declined, deferred or accepted with a loading, exclusion or special terms? Yes No

b. Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Worker's Compensation or Motor Vehicle Third Party? Yes No

c. Do you have, or are you applying for other life or disability cover? Yes No

If you answered YES to a, b and/or c, please provide details below (attach a separate page if you need more space):

Name of company	Cover type	Sum insured/ Monthly benefit	Date of application or claim	Decision	Reason for decision/claim	Duration of claim	Recovery %	Is other cover to be replaced?
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>
								Yes <input type="checkbox"/> No <input type="checkbox"/>

6. Personal health statement (continued)

3. Habit and activities

a. Do you drink alcohol?

Yes No

If yes, state type and daily quantity

b. Have you smoked in the past 12 months?

Yes No

If yes, state form and quantity

c. Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs?
(If yes, the insurer may ask you to complete an additional questionnaire)

Yes No

d. 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 travelling recognised routes) motor racing, diving, football, parachuting, hang gliding or any other sport? (If yes, the insurer may ask you to complete an additional questionnaire)

Yes No

e. Do you intend travelling outside Australia in the next two years?

Yes No

If yes, please provide details below (where, when, duration and reason)

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

Last name

Given name

Address

State

Postcode

5. Details of last medical consultation

Date

Reason

Outcome – including degree of recovery

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

Last name

Given name

Address

State

Postcode

6. Personal health statement (continued)

7. a. Within the last three years have you consulted, been examined, treated by or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation, or taken any medication, drugs, stimulants, sedatives or tranquilisers? Yes No
- b. Have you ever had an ECG, X-ray, ultrasound, mammogram, surgery or any other investigation? Yes No
- c. Have you ever had any blood tests which revealed an abnormality, e.g. raised blood sugar, liver function or kidney function results, or anemia, etc? Yes No
- d. Do you contemplate seeking any medical examination, advice, treatment or surgery, for any current health condition, in the future? Yes No

If you answered YES to a, b, c or d please provide details below:

Question	Dates – from/to	Name/address of doctor, hospital or clinic	Condition, medications, treatments, and time off work	Recovery %

8. Have you ever had, been advised that you had, or received treatment for any of the following:
- a. High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder? Yes No
- b. Bowel, stomach or intestinal problem, gallbladder, hepatitis or liver disease? Yes No
- c. Epilepsy, stroke, paralysis, multiple sclerosis or fainting attacks? Yes No
- d. Depression, anxiety, panic attacks, stress, chronic fatigue, fibromyalgia or any other mental or nervous condition? Yes No
- e. Diabetes, sugar in urine, pancreatic or thyroid problem? Yes No
- f. Cancer, tumour, melanoma, sunspots, mole or growth of any kind? Yes No
- g. Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis? Yes No
- h. Impairment of sight, hearing or speech? Yes No
- i. Asthma, bronchitis, sleep apnoea, or any lung complaint? Yes No
- j. Leukaemia, hemochromatosis, anaemia, or any blood problem? Yes No
- k. Kidney, prostate, or bladder problem? Yes No
- l. Psoriasis, eczema, or any skin problem? Yes No
- m. Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury? Yes No
- n. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? Yes No
- o. Have you ever engaged in any activity/ies reasonably accepted to having an increased risk of exposure to the HIV/AIDS virus? Yes No

6. Personal health statement (continued)

FEMALES ONLY

p. Have you ever had any gynaecological conditions (e.g. endometriosis, abnormal pap smear, etc.)? Yes No

q. Have you ever had any complications of pregnancy or childbirth? Yes No

r. Are you currently pregnant? Yes No

If yes, what is expected delivery date?

s. Have you ever had a breast lump (even if you have not seen a doctor about it)? Yes No

Please provide details for all 'Yes' answers to Q8 a to s in the space provided at Q9.

9. General medical questionnaire

Please provide details for all answers to Q8 a to s. Place the question number with the Yes answer at the top of the column (such as 8a) and then answer the questions (a) to (n) in the table below. You may provide details on a separate sheet if required. If the question in the table does not apply to your condition, please write not applicable.

Question	Q	Q	Q	Q
a. Date symptoms first started and description of symptoms?				
b. What was the condition and which part of the body was affected?				
c. What was the medical diagnosis and date?				
d. What tests or investigations have you had and what were the results?				
e. What was the frequency (daily, weekly, etc) of attacks or symptoms?				
f. What was the severity (mild, moderate, severe) and duration of attacks or symptoms?				
g. How long were you unable to work or perform your normal duties/activities?				
h. If a hospital visit was required, please provide date and duration of your stay.				
i. What advice/treatment did you receive?				
j. Are you still receiving treatment? If so, please advise nature and frequency of treatment?				
k. Date treatment/medication ceased.				

6. Personal health statement (continued)

Question	Q	Q	Q	Q
l. When did you last suffer from any symptoms?				
m. Degree of recovery (% symptoms)?				
n. Please supply the name and address of all doctors, hospitals or other practitioners consulted.				

10. Family history

Have any of your immediate family, (living or deceased) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia, Huntington's Chorea or any hereditary disease before the age of 60? Yes No

If **Yes**, please give details of your family medical history. Please note, immediate family means your father, mother, brother or sister.

Relationship to member	Medical condition (eg breast cancer, diabetes)	Age when diagnosed	Age at death (if applicable)

7. Your duty of disclosure to the insurer – TAL Life Limited

Before you enter into a life insurance contract, you have a duty to tell the insurer anything that you know, or could reasonably be expected to know, that may affect the insurer's decision to insure you and on what terms.

You have this duty until the insurer agrees to insure you.

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

You do not need to tell the insurer anything that:

- reduces the risk that the insurer insures you for; or
- is common knowledge; or
- the insurer knows or should know as an insurer; or
- the insurer waives your duty to tell them about.

If you do not tell the insurer something

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

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

If the insurer chooses not to avoid the contract, the insurer 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 them everything you should have. However, if the contract has a surrender value, or provides cover on death, the insurer may only exercise this right within 3 years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount you have been insured for, the insurer may, at any time vary the contract in a way that places them in the same position they would have been in if you had told them everything you should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If your failure to tell the insurer is fraudulent, they may refuse to pay a claim and treat the contract as if it never existed.

8. Privacy

Your privacy with the insurer – TAL Life Limited

The privacy of TAL's customers is important and they are bound by obligations imposed by current privacy laws including the Australian Privacy Principles. The way in which TAL collects, uses, secures and discloses information relating to their customers is set out in the privacy policy available at www.tal.com.au/Privacy-Policy or available on request.

Collection and use of personal information

The insurer collects personal information, including your name, age, gender, contact details, health information, salary, and employment information so that they may assess and administer products and services to you. In certain circumstances, such as applications for life insurance products and claims, the insurer may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, the insurer may not be able to provide products and services to you or pay the claim.

The insurer may take steps to verify the information they collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or they may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Disclosure of personal information

The insurer discloses relevant personal information to external organisations that help to provide their services and may also disclose some of your personal information to other parties, when required to do so to provide their products and services to you, such as the following:

- claims assessors and investigators, claims managers and reinsurers;
- medical practitioners (to verify or clarify, if necessary, any health information you may provide);

- any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- other insurers;
- for members of superannuation funds where TAL is the insurer, to the trustee, or administrator of the superannuation fund; and
- other organisations to whom the insurer outsources certain functions during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where the insurer may also disclose your personal information in circumstances where it is:

- required by law (such as to the police or Australian Tax Office), and
- authorised by law (e.g. under court orders or statutory notices).

Your privacy with First State Super

The personal information you provide on this form is collected by and held for First State Super by the fund administrator, Mercer Administration, in accordance with the Australian Privacy Principles of the *Privacy Act 1988 (Cth)*, for the purpose of administering your account and providing you with services associated with your fund membership. For further information about how your personal information is handled, please phone us on 1300 650 873 or visit firststatesuper.com.au/privacy to view the privacy policy (a hard copy of the policy may also be provided on request). The policy contains information about how you may access and seek correction of your personal information, how you may complain about a breach of your privacy and other important information about how your personal information is collected, used and disclosed.

9. Declaration

I declare that:

- I have read and understand my duty of disclosure and that this duty applies until formal notification of acceptance.
- The answers to the questions are true, and I have not deliberately withheld any information material to the proposed insurance.
- I agree to be bound by the terms and conditions attached to this cover as set out in the life insurance policy issued to the Trustee by the insurer.
- I consent to the collection, use and disclosure of personal information by the insurer and its service providers in order to assess my application and any claim under the policy.
- I have read and understood the above privacy statements and agree to the collection, use and disclosure of personal information as described in those statements.
- I consent to the insurer seeking medical information from any doctor who at any time I have consulted

prior to the date hereof. A photocopy of this authority is as valid as the original to the extent that all professional confidence and privilege is waived.

- I understand that cover under any policy accepted does not begin until acceptance by the insurer of which I will be notified in writing.
- I have read and understand the insurance section of the current First State Super *Member Booklet* relevant to my Division, including (for employer-sponsored, Police Blue Ribbon and Ambulance Officers' Super members) the *Member Booklet Supplement: Insurance*.

Medical authority

I agree that any Medical Practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not, will be hereby authorised and directed by me to divulge to TAL Life Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Signature

Date (DD-MM-YYYY)

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Please sign and date form here.

Send the form to this address.

10. Where to send your completed form

Return the completed form to **First State Super PO Box 1229 WOLLONGONG NSW 2500**. If you have any questions, please call us on **1300 650 873**.