

## Your duty to take reasonable care not to make a misrepresentation

## About your duty

When you apply for life insurance as a member of Australian Retirement Trust, the insurer may conduct a process called underwriting. It's how the insurer decides whether it will cover you, and if so on what terms and at what cost. If your application is underwritten, you will be asked questions which the insurer needs to know the answers to. These will be about your personal circumstances and may include questions about your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you provide in response to the questions is vital to the insurer's decision.

## The duty to take reasonable care

When applying for insurance which is to be underwritten, you have a legal duty to take reasonable care not to make a misrepresentation before your application is accepted by the insurer. 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. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced. Please note that there may be circumstances where the insurer later investigates whether the information you provided was true. For example, the insurer may do this when a claim is made.

## **Guidance for answering questions**

When answering questions as part of an application for insurance cover, you should:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us or the insurer before you respond.
- Answer every question.
- · Answer truthfully, accurately and completely.
- If you are unsure about whether you should include information or not, you should include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), you should check every answer (and if necessary, make any corrections) before the application is submitted.
- You must not assume that Australian Retirement Trust or the insurer will contact your doctor for any medical information.

## Changes before your cover starts

Before your application is accepted, the insurer may ask about any changes that mean you would now answer the questions differently. 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 this information and the questions that you are asked. Ask us or the insurer for help if you have difficulty understanding the process of applying for insurance or answering our or the insurer's questions. If you're having difficulty due to a disability, understanding English or for any other reason, we are here to help and can provide additional support for anyone who might need it.

## What can the insurer do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to the insurer. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put the insurer in the position they 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 you took reasonable care 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 they 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 the insurer exercises any of these remedies, they will explain their reasons, how to respond and provide further information, including what you can do if you disagree.

Last name* Date of birth (DD/MM/YYY)* Gender*   M F   Street address / PO Box*   Suburb / Town* State*   Postcode* Home phone number    Date of birth (DD/MM/YYY)*  Gender* M   Personal email address    Mobile phone number*   Details of your occupation   20   Details of your occupation   21   Mote: This means you must be provide your documents, including statements and notices of changes to your account, electronically, We'll email or SMS you when information is ready to view in Member Online, the Australian Retirement Trust app, or by contacting us.   22   Details of your occupation   24   Are you at work?   Note: This means you must be presentable YES   Note: This means you must be presentable YES   No   YES   Mackay Sugar Limited   1   %   2   %   3   %   4	Mackay Sugar Superannuation Plan Chackay Sugar Superannuation Plan Chackay Sugar Superannuation Plan Description of the second secon						Retirement     Substantial     Substantia		
Street address / PO Box*         Suburb / Town*       State*       Postcode*       Home phone number       Daytime phone number*         Personal email address       Mobile phone number*       Mobile phone number*         Vote: Where we can we'll provide your documents, including statements and notices of changes to your account, electronically, We'll email or SMS you where information is ready to view in tember online, the Australian Retirement Trust app. or by contacting us.         2       Details of your occupation       Degree/trade qualification         2A       Are you at work?       Your occupation       Vers NO         Maters this means you must be you?       Yes NO       Vers NO       Vers NO         Industry (e.g. mining, manufacturing, construction, agriculture, retail)       Name of your employer       Your annual salary       Bifer to your Start dimine of tainy.         1       %       2       %       3       %         2B       Employment status:       Permanent       Permanent       Permanent       %       %         2C       Hours that you work work:       Under 14       14 hours       or more       %       %	Title	First name*			Middle name				
Suburb / Town* State* Postcode* Home phone number Daytime phone number*   Personal email address Mobile phone number* Mobile phone number* Mote: This means you would prefer information is posted to you, change your preferences in Member Online, the Australian Retirement Trust app, or by contacting us. Details of your occupation Are you at work? Mote: This means you must be YES NO Mote: This means you must be YES NO Mackay Sugar Limited Suburb / Sumps- Compare Mackay Sugar Limited Suburb duites of your occupation, and the percentage of time at work spent doing each (e.g. office work 20%, site inspection 80%) 1 96 2 96 3 28 Employment status: Permanent Permanent<	Last nan	le*				Date of	<b>birth</b> (DD	/MM/YYYY)*	
Personal email address       Mobile phone number*         Vote: Where we can well provide your documents, including statements and notices of changes to your account, electronically. Well email or SMS you when information is ready to view in Member Online. If you would prefer information is posted to you, change your preferences in Member Online. If you would prefer information is posted to you, change your preferences in Member Online. If you would prefer information is posted to you, change your preferences in Member Online. If you would prefer information is posted to you, change your preferences in Member Online. If you would prefer information is posted to your occupation         2A       Are you at work?       Your occupation         2A       Are you at work?       Your occupation         YES       NO       YES         Industry (e.g. mining, manufacturing, construction, agriculture, retail)       Name of your employer       Your annual salary         Industry (e.g. mining, manufacturing, construction, agriculture, retail)       Name of your employer       Your annual salary         1       %       2       %       3       %         List the principal duties of your occupation and the percentage of time at each location (e.g. office 20%, suburban driving 50%)       1       %       2         2       %       3       %       %         2       %       3       %         2       %       3       %         2 <td< th=""><th>Street ac</th><th>ldress / PO Box*</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></td<>	Street ac	ldress / PO Box*							
Are you at work?       Your occupation         2A       Are you at work?       Your occupation         YES       NO         Petails of your normal paid       YES       NO         Industry (e.g. mining, manufacturing, construction, agriculture, retail)       Name of your employer       Your annual salary         Mackay Sugar Limited       \$       Petrosonal duties of your occupation and the percentage of time at work spent doing each (e.g. office work 20%, site inspection 80%)       1       %         1       %       2       %       3       %         2B       Employment status:       Permanent full time       Permanent full time       Permanent part time       %         2C       Hours that you work       Under 14 hours or more       %       3       %	Suburb /	Town*	State*	Postcode*	Home phone number		D	aytime phone nu	mber*
Are you at work? Your occupation   2A Are you at work?   Note: This means you must be yets   YES   NO	Persona	email address					M	obile phone nun	nber*
Are you at work?       Your occupation       qualification         Note: This means you must be performing your normal paid duties for your employer.       YES       NO         Industry (e.g. mining, manufacturing, construction, agriculture, retail)       Name of your employer       Your annual salary       Befer to your Super Swings-Corporate Insurance Guide for the definition of salary.         1       Mackay Sugar Limited       \$       S       %         1       %       2       %       3       %         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%)       9         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%)       %         2B       Employment status:       Permanent full time       Permanent part time       Permanent part time       %         2C       Hours that you work a week (on average):       Under 14 hours or more       14 hours or more       %	Member	<b>Dnline</b> . If you would prefer information is poste							ng us.
duties for your employer.   Industry (e.g. mining, manufacturing, construction, agriculture, retail)   Mackay Sugar Limited     Mackay Sugar Limited     Mackay Sugar Limited     1   %   2   %   3     %     4     %     1     %     1     %     2     %     1     %     1     %     1     %     2     %     1     %     1     %     2     %     1     %     1     %     1     %     1     %     2     %     %     %     %     %     %     %     %     %     %     %     %     %     %     %     %     %     %<	2A	Note: This means you must be YES		occupation					qualification
Mackay Sugar Limited \$   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 %   2   4 %   2   4 %   3   4 %   4   4 %   3   4 %   4   4 %   3   4 %   3   4 %   4 5 6 7 7 7 7 8 8 8 9	Industry	duties for your employer.	agriculture, r	etail) <b>Name of yo</b>	ur employer				Savings – Corporate
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 %   2   4 %   2   4 %   2   4 %   3   9   2   4   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3   9   3 4 5 5 5 5 5 6 7 7 7 7 8 7 9				Mackay S	ugar Limited			\$	
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       Employment status:       Permanent full time       Permanent part time       9       3       %         2C       Hours that you work a week (on average):       Under 14 hours or more       14 hours or more       9       14 hours	List the	principal duties of your occupation and	the percent	age of time at wo	rk spent doing each (e.g.	office wor	k 20%, si	te inspection 809	%)
1     %     2     %     3     %       2B     Employment status:     Permanent full time     Permanent part time     9       2C     Hours that you work a week (on average):     Under 14 hours     14 hours or more	1		% 2			% 3			%
2B       Employment status:       Permanent full time       Permanent part time         2C       Hours that you work a week (on average):       Under 14 hours or more       14 hours or more	List the	primary locations of your occupation, a	nd the perce	entage of time at	each location (e.g. office 2	20%, home	e 30%, su	burban driving 5	0%)
2D     Employment status:     full time     part time       2C     Hours that you work a week (on average):     Under 14 hours     14 hours or more	1		% 2			% 3			%
a week (on average): hours or more	2B								
Please continue over page	2C								
								Please	continue over page

Australian

## 3 Insurance cover

**Important:** Before completing this section, please refer to your Super Savings – Corporate Product Disclosure Statement for Accumulation Account (PDS) and Super Savings – Corporate Insurance Guide for insurance details, available on your employer plan's microsite. Any increase in insurance cover will be subject to acceptance by the insurer and will apply from the date your cover is accepted by the insurer.

<b>3A</b> Would you like to change your level of s	Standard Death and Total & Permanent Disability	(TPD) cover?
Level 1 Level 2 (10%) (15%)	Level 3 (20%)	
If you'd like more than Level 3 cover, please complete s	ection 3B to apply for Additional cover.	
Note: If you're increasing your cover within 120 days of j		t need to complete the entire form; simply tick the
appropriate box and go to the last page to sign and date	h.	
	OR	
<b>3B</b> Would you like to apply for Additional of	cover?	
Death and Total & Permanent Disability (TPD)		
I would like to apply for the following amount of fi	xed cover1:	
Death cover \$	TPD cover \$	
The amount you specify will be in addition to your Stan		
1 Fixed cover means your amount of insurance stays the same but your prem	-	
	units win generary increase as you geconer.	
Income Protection		
Are you applying for Income Protection? YES N	0	
Monthly benefit required \$		
<b>Note:</b> To be eligible for Income Protection you must be e The maximum Income Protection amount available is 85 \$50,000 per month. Refer to your Super Savings – Corpo	% of your 'salary' (where 75% is paid as income and 10%	
If you are applying to increase your co joining your employer (3A), or applyin you must also complete the attached	g to increase your cover (3B),	If you don't need to complete the entire form, simply sign and date below and return to Australian Retirement Trust
4 Authorisation and declaration		
Privacy	<ul> <li>I have received, read and accept the Super Savings – Corporate Product Disclosure Statement for Accumulation Account (PDS) and</li> </ul>	Member to sign here*
By completing this form you consent to the collection, use and disclosure of any personal information, including information that may be of a sensitive nature we or the nominated insurer may collect about you and	Super Savings – Corporate Insurance Guide.     I understand all the conditions I must meet to be eligible to obtain	X
exchange with third parties located in Australia and overseas, in the manner outlined in our and the nominated insurer's respective privacy policies as updated from time to time.	Additional cover, I agree that my Additional cover will not commence until my application for Additional cover has been accepted by the insurer. I acknowledge insurance cover is provided by an external	Full name (print in BLOCK letters)*
A copy of our privacy policy can be obtained by visiting australianretirementtrust.com.au/privacy. A copy of the nominated	<ul> <li>I understand the cost of cover will be based on the applicable</li> </ul>	
insurer's privacy policy can be obtained by visiting their website directly. These policies are consistent with the requirements of the <i>Privacy Act 1988</i> .	premium rates applying under the relevant membership division of Australian Retirement Trust and will reflect your occupation category, any employer funded arrangements (if applicable), and	Date (DD/MM/YYYY)*
I declare that: I acknowledge and have read my Duty to Take Reasonable Care Not	any premium loadings or exclusions that may apply. • By signing this Change of Insurance Cover form, I consent to the	
to take a Misrepresentation and all of my details on this Change of Insurance Cover form are correct.	collection and disclosure of information about me for the purposes shown above.	Please return the form to Australian Retirement Trust Reply Paid 2924 Brisbane Qld 4001 OR via australianretirementtrust.com.au
		/contact-us

We are committed to respecting the privacy of personal information you give us. If you would like a copy of Australian Retirement Trust's Privacy Policy, visit **australianretirementtrust.com.au/privacy** or call **13 11 84**.

Australian Retirement Trust Pty Ltd ABN 88 010 720 840 AFSL No. 228975 Trustee of Australian Retirement Trust ABN 60 905 115 063



## Group Risk Personal statement

#### **IMPORTANT NOTICE**

Zurich is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you:

- you are proposing to become an insured member under the policy and your benefits are subject to assessment by Zurich
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by Zurich.

Zurich requires this Personal Statement and other health information to assist us in making a decision on your proposed insurance cover. This Personal Statement is confidential. Please refer to the Privacy Statement in the Product Disclosure Statement.

You may wish to seal it in an envelope and send it to:

Zurich, GPO Box 4129, Sydney NSW 2001

#### Duty to take reasonable care not to make a misrepresentation

## When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer when applying for insurance. To meet this duty, you must also take reasonable care not to make such a misrepresentation.

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

Not meeting your legal duty can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

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

#### About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can provide cover, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information given to us in response to our questions is vital to our decision.

When you apply for insurance benefits through a superannuation fund, or ask to extend or make changes to existing insurance benefits, the fund trustee may pass on to us personal information you provide to them. You also therefore need to take reasonable care not to make a misrepresentation when providing this information to the fund trustee.

#### Guidance for answering our questions

You are responsible for the information you provide to us. When answering our questions, you should:

- think carefully about each question before answering. 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. Please don't assume we will ask others such as your doctor
- review your application carefully. If someone else helped prepare your application, please check every answer (and if necessary, make any corrections).

#### Changes before your cover starts

Before your cover starts, please tell us about any changes that mean you would now answer our questions differently. It could save time if you let us know about any changes as and when they happen. This is because any changes might require further assessment or investigation.

#### Notifying the insurer

If, after the cover starts, you think you may not have met your duty, please tell us immediately and we'll let you know whether it has any impact on the cover.

#### Telephone contact

After you submit your application, we may contact you by phone to collect any information missing from your application. The information you provide will be recorded and used in the assessment of your application for insurance cover. The need for you to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into also applies during any phone contact with us.

#### If you need help

It's important that you understand this information and the questions we ask. Ask us for help if you have difficulty answering our questions or understanding the application process.

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 for anyone who might need it. You can have a support person you trust with you.

#### What can we do if the duty is not met?

If you do not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth). They are intended to put us in the position we would have been in if the duty had been met.

For example, we may do one of the following:

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

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

- whether you took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we provided on the duty was
- what we would have done if the duty had been met for example, whether we would have offered cover, and if so, on what terms
- · whether the misrepresentation was fraudulent
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, and what you can do if you disagree.

#### Type of Fund/Plan

Please select the appropriate box O Group Life	e O Group Salary Continuance
Policy number (if known)	
Name of Fund/Plan	
Type of cover	Amount of required benefit/cover
O Death Only	\$
O Total and Permanent Disablement (TPD)	\$
O Group Salary Continuance (monthly benefit)	\$

1. Personal details

Title O Mr O Mrs O Ms O Miss O Doctor	O Other
Surname	Given name(s)
Date of birth (dd/mm/yyyy) / /	O Male O Female
Residential address (this cannot be a PO Box) Street	
Suburb	State Postcode
Country	
Home phone Work phone	Mobile phone
Email	
<ul> <li>May one of our underwriting staff or Zurich authorised service provide the service of the service provide the service of the service</li></ul>	one number?
Days Time: From	То
Phone O Home O Work O Mobile	
<ul> <li>2. Residence and travel details</li> <li>1. Are you currently residing in Australia?</li> <li>Yes</li> <li>No</li> <li>If no, please advise where you are currently residing and how long you</li> </ul>	ou intend to reside there?
<ul> <li>2. Are you an Australian or New Zealand citizen or do you hold a v</li> <li>Yes</li> <li>No</li> <li>If yes, please proceed to question 3</li> <li>If no, please advise what type of visa you hold</li> </ul>	isa that entitles you to reside permanently in Australia?
<ul> <li>3. Do you have any intention of travelling outside Australia within</li> <li>Yes</li> <li>No</li> <li>If yes, please complete the following:</li> <li>Date of departure (dd/mm/yyyy) / /</li> </ul>	<b>the next two years?</b> Duration of stay
Destination(s) (country/cities)	
Purpose of stay O Holiday O Business O Residing	O Other
Please specify if <b>other</b>	

#### 3. Insurance details

1. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including Zurich (other than this application), including benefits under superannuation or insurance benefits by your employer?

O Yes

O No

If you have answered **yes**, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yyyy)		
		\$	/ /	🔿 Yes 🔿 No	/ /
		\$	/ /	○ Yes ○ No	/ /
		\$	/ /	○ Yes ○ No	/ /
		\$	/ /	○ Yes ○ No	/ /

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions?

O Yes

O No

If yes, please provide name of company, alteration, date and reason (if known)

## 3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans' Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation?

O Yes

O No

If yes, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc

#### 4. Occupation details

#### 1. What is your usual occupation?

2. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed
Sedentary/administration (e.g. filing, computer work, answering telephone, reception duties, etc)		
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5 kg, etc)		
Manual work – heavy (e.g. bricklaying, lifting over 5 kg, painting, carpentry, mechanic, etc)		

3. How many hours (on a	verage) do you work per weel	c in your principal occup	ation (include hours worked at home) <sup>,</sup>	?
	nual income earned through pe nuation contributions, but after o			
b. What is the percentage	of your superannuation contrib	oution? %		
5. Are you familiar with a	ll applicable safe-work proced	lures relating to your occ	upation?	
O Yes				
() No				
If <b>no</b> , please indicate the re	eason you gave this response			
If <b>yes</b> , do you practice the	se at all times when performing	your work? 🔿 Yes	O No	
lf <b>no</b> , please provide detai	ls of when safe-work procedure	es are not practiced in you	r occupation	
<ul><li>6. Do you have more than</li><li>Yes</li></ul>				
O No				
	occupation, your normal duties	and the average hours you	u work per week in each of your other oc	cupation(s)
5. Pastimes				
Have you any intention o				
	ng other than as a means of tra	insportation to and from	work?	
○ Yes ○ No				
2. any hazardous activiti	es or sports, e.g. motor or wate ving, body contact sports, glid		ng), football, parachuting, recreations	involving heights,
O Yes	ring, body contact sports, gild	ing, hang gilang etc.		
O No				
3. aviation/flying, other t	han as a fare-paying passenge	er?		
⊖ Yes				
O No				
If you answered <b>yes</b> to any	y of questions 1, 2 or 3 above, pl	ease continue completing	this section below for the relevant activ	/ity
Motorcycle/motor racing	I			
Do you have a Motorcyclir	ng Australia (MA), FIM internatio	onal or similar licence	◯ Yes ◯ No	
Vehicle type			Races p.a.	
Engine size	Max. speed (km/h)	Class	O Recreational O Amateur	Professional
Scuba/skin diving				
Average depth (m)	Maximum	depth (m)	Dives per annum	
Do you use explosives?	O Yes O No	Do you dive in cav	ves or potholes? O Yes O No	
If <b>yes</b> , give details				

#### Football/Soccer/Aussie Rules, etc

Code played and grade	
Games p.a. O Recreational O Amateur O Professional	
Do you receive any income participating in Football/Soccer/Aussie Rules etc?	○ Yes ○ No
If <b>yes</b> , provide amount and details	
Aviation/flying	
Do you hold a Civil Aviation Safety Authority (CASA) licence?	◯ Yes ◯ No
If <b>yes</b> , state type and period held	
Do you intend to change the scope of your present licence?	◯ Yes ◯ No
Have you ever had an accident or been charged with violating CASA regulations?	○ Yes ○ No
Do you always use authorised landing areas?	○ Yes ○ No
Please complete the table below	

No. of hours flown	Past 12 months		Future annual average	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories		
(e.g. ballooning, aerobatics, parachuting, paragliding)?	○ Yes	🔿 No

If **yes**, please provide frequency and details.

#### Other sports or pastimes

Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc)

a. Activity			
On what basis do you partake in this activity	O Recreational	O Amateur	O Professional
b. Activity			
On what basis do you partake in this activity	O Recreational	O Amateur	O Professional
c. Activity			
On what basis do you partake in this activity	O Recreational	O Amateur	O Professional

#### 6. Personal statement

1. What is your current height and weight?	Height (cm)	Weight (kg)		
2. Has your weight varied by more than 10 kg during the la	ist 12 months (excluding pregna	ancy)?	⊖ Yes	O No
If <b>yes</b> , please provide details				
3. During the last 12 months have you smoked tobacco or or used any form of electronic cigarette?	any other substance		⊖ Yes	O No
If <b>yes</b> , please state <b>type</b> and <b>quantity</b> per day				
4. During the last three months, have you used nicotine re or anti-smoking medication (e.g. Zyban, Chantix, etc)?	placement therapy (e.g. nicotin	ne gum, patches, etc)	⊖ Yes	O No
If yes, please state type(s) and length of time you have been	n using this			
5. Non-smokers – have you ever smoked regularly in the p	past?		⊖ Yes	O No
If <b>yes</b> , please state <b>type, quantity</b> per day and date ceased				
6. Do you consume alcohol?			⊖ Yes	O No
If <b>yes</b> , please state how many standard drinks you consume <b>p</b>	<b>per</b> day (a standard drink is 125 ml	wine, 250 ml beer or 30 m	nl spirits)	
7. Have you ever been advised to stop or reduce your alco	hol intake due to a medical con	dition?	⊖ Yes	() No
If <b>yes</b> , please provide full details				

If you are required to a have a full medical examination, go to Section 9 on page 12

#### 7. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so)

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, diabetes mellitus, breast cancer, bowel cancer, ovarian cancer, multiple sclerosis, motor neurone disease, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder?

O Yes

O No

2. Have any of your parents, brothers or sisters (alive or deceased) been diagnosed before the age of 60 with any of the following conditions: heart disease, stroke, mental illness, haemochromatosis, cervical cancer, prostate cancer, melanoma or any other cancer (please specify type)?

O Yes

O No

If you answered yes to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed	

Note: You are only required to disclose family history information pertaining to first degree blood-related family members – living or deceased (mother, father, brothers, sisters).

### 8. Medical history

To the best of your knowledge, have you ever had any of the following:

Please select the appropriate box and circle the specific conditions that are applicable.

Pleas	e select the appropriate box and circle the specific conditions that are applicable.				
		No	Yes		
1	Asthma?	0	0		
2	High blood pressure?	0	0		
3	High cholesterol?	0	0		
4	Diabetes?	0	0		
5	Stress, anxiety, depression or any other mental health condition?	0	0		
6	Back or neck pain, sciatica or any disorder of the spine or neck?	0	0		
7	Arthritis, shoulder or knee pain or any other disorder of the joints?	0	0		
8	Cyst, mole or skin lesion?	0	0		

#### If you answered yes to any of the conditions in bold above, please complete the relevant questionnaire on pages 15 to 25

9	Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition?	0	0
10	Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder?	0	0
11	Thyroid or glandular trouble?	0	0
12	Ulcers or recurring indigestion?	0	0
13	Epilepsy, fits or dizziness, fainting of any kind or persistent headaches?	0	0
14	Alzheimer's disease or dementia?	0	0
15	Kidney, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis?	0	0
16	Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs?	0	0
17	Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)?	0	0
18	Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)?	0	0
19	Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders?	0	0
20	Any abnormality affecting eyesight, hearing or speech?	0	0
21	Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis or any diagnosed intellectual disability or cognitive impairment)?	0	0
22	Anaemia, haemophilia or any other disease of the blood?	0	0
23	Bowel, liver or gall bladder disease or hepatitis?	0	0
24	Coughing of blood or passing of blood from the bowel or in the urine?	0	0
25	Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason?	0	0
26	Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)?	0	0
27	Do you now have any symptoms of ill health or disability?	0	0
28	Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future (e.g. X-ray, ECG, blood test, etc)?	0	0
29	Do you take, or have you <b>ever</b> taken drugs or any medications on a regular or ongoing basis?	0	0
30	Have you <b>ever</b> used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence?	0	0
31	Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands?	0	0
32	Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS-related condition?	0	0
33	Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis?	0	0

		No	Yes
34	<ul> <li>a. Is the combined total of your existing insurance(s) detailed in Section 3 question 1, and any new insurance you are applying for with Zurich, more than any one of the following; \$500,000 Death; \$500,000 TPD; \$200,000 Trauma; \$4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover?</li> </ul>	0	0
	If you answered Yes to question 34(a) please proceed to 34(B), otherwise continue to question 35		
	b. Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (Please do not include any test conducted solely for the purpose of medical research study and where the result of the test has not been or will not be, provided to you).	0	0

#### FEMALES ONLY

35	a. Have you ever had any complications with pregnancy or childbirth?				
	b. Are you now pregnant? If <b>yes</b> , please advise due date (dd/mm/yyyy) / /	0	0		
	c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram?				
	d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium?	0	0		

If you answered **yes** to any questions from 9–35, please complete the following table. If there is not enough space here, please provide details on page 25.

Question no:	Question no:		
/ /	/ /		
First / / Last / /	First / / Last / /		
⊖ Yes	⊖ Yes		
O No	O No		
⊖ Yes	⊖ Yes		
O No	O No		
/ /	/ /		
	/ / / / First / / Last / / O Yes O No O Yes O No		

	Question no:	Question no:		
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)	/ /	/ /		
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First / / Last / /	First / / Last / /		
Has further treatment, referral or	⊖ Yes	⊖ Yes		
investigation(s) been recommended?	O No	O No		
Time off work				
Have you completely recovered?	⊖ Yes	⊖ Yes		
	O No	O No		
Date of last symptoms (dd/mm/yyyy)	/ /	/ /		
Name and address of medical facility and attending doctor				
and attending doctor				

	Question no:	Question no:		
Disability, illness, injury or condition				
Investigation type(s) and result(s)				
Date of first symptoms (dd/mm/yyyy)	/ /	/ /		
Frequency of symptoms				
Type of treatment				
Date treatment provided and ceased (dd/mm/yyyy)	First / / Last / /	First / / Last / /		
Has further treatment, referral or	⊖ Yes	⊖ Yes		
investigation(s) been recommended?	O No	O No		
Time off work				
Have you completely recovered?	⊖ Yes	⊖ Yes		
	O No	O No		
Date of last symptoms (dd/mm/yyyy)	/ /	/ /		
Name and address of medical facility				
and attending doctor				

#### 9. Usual doctor or medical centre details

#### 1. Full name and address of usual doctor/medical centre

Doctor/Medical centre

Phone						
No. and street						
Suburb	State	Postcode				
2. How many years have you been attending this doctor/medical centre?	Years	Months				
a. When was your last visit to this doctor/medical centre?						
b. Reason for check-up or consultation?						
c. Outcome including medication, treatment etc						
d. Degree of recovery? %						

- 3. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned?
- O Yes
- O No

If **yes**, please provide details

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yyyy)	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc
	/ /		
	/ /		
	/ /		
	/ /		

#### 10. Declaration by the life insured or applicant

- I have read and understood the questions in this Personal Statement.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and declare that the statements and answers provided in this application are true, accurate and complete.
- I have read the Privacy Statement at Section 12 of this form (below). (Zurich's Privacy Policy details how we manage personal information. It is available at zurich.com.au/important-information/privacy)
- I acknowledge and consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in the Privacy Statement on this form (see Section 12).
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I have read and understood my duty to take reasonable care not to make a misrepresentation and the consequences of not meeting the legal duty and answering all questions truthfully and completely.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to Zurich in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is
  made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an
  application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the Product
  Disclosure Statement(s) (PDS) for the type(s) of cover for which I am applying.
- I acknowledge that if I do not complete this form correctly or I do not sign and date this Declaration, my application will not be considered by Zurich.

#### Life insured/applicant - signature

Date / /

#### 11. Consent for accessing Health Information

#### 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, Zurich, 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.

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.

Surname					
Given name(s)					
Date of birth (dd/mm/yyyy)	/	/			

Super Fund/Employer details

# **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 Zurich, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Zurich 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.
- Zurich 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 Zurich 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.

**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 Zurich, or to third parties they engage, only if Zurich 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:

- Zurich 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 Zurich 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.

Name			
Signature			
X			
Date (dd/mr	m/yyyy)		
/	/		

- Name Signature
- X

Date (dd/mm/yyyy)

1 /

#### 12. Privacy Statement

In this section 'we', 'us' and 'our' refers to Zurich Australia Limited. 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information (including health and other sensitive information) from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information (including health and other sensitive information). Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from zurich.com.au/important-information/privacy

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose your personal information (including health and other sensitive information) to certain third parties as outlined below.

Unless you consent to such disclosure we will not be able to consider the information you have provided.

#### **PROVIDING YOUR INFORMATION TO OTHERS**

The parties to whom we may routinely disclose your personal information (including health and other sensitive information) include:

- an organisation that assists us to detect and protect against consumer fraud;
- any related company of Zurich which will use the information for the same purposes as Zurich and will act under Zurich's Privacy Policy;
- organisations performing administration and/or compliance functions in relation to the products and services we provide;
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers);
- our solicitors or legal representatives;
- organisations maintaining our information technology systems;
- organisations providing mailing and printing services;
- persons who act on your behalf (such as your agent or financial adviser);
- the policy owner (or parties acting on behalf of the policy owner);
- regulatory bodies, government agencies, law enforcement bodies and courts;
- our related companies (members of the Zurich Insurance Group Ltd group), including for carrying out any group business functions;
- organisations, including those in alliance with us or our related companies, to distribute, manage and administer our products and services, carry out business functions and analytics activities.

We will also disclose your personal information (including health and other sensitive information) in circumstances where we are required by law to do so. Examples of such laws are:

- the Family Law Act 1975 (Cth) enables certain persons to request information about your interest in a superannuation fund;
- there are disclosure obligations to third parties under the Anti-Money Laundering and Counter-Terrorism Financing Act 2006.

#### INFORMATION REQUIRED BY LAW

Zurich may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at zurich.com.au/important-information/privacy

#### PRIVACY CONSENT

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions please notify us in writing.

If you give us personal information about someone else, you must show them a copy of this document or our Privacy Policy available at zurich.com.au/important-information/privacy so that they may understand the manner in which their personal information may be used or disclosed by us in connection with your dealings with us.

#### **PRIVACY POLICY**

Our Privacy Policy contains information about:

- when we may collect information from a third party;
- how you may access and seek correction of the personal information (including health and other sensitive information) we hold about you; and
- how you can raise concerns that we have breached the Privacy Act or an applicable code and how we will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing: GPO Box 75 Sydney NSW 2001

Email: privacy.officer@zurich.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 133 667.

More information can be found in our Privacy Policy at zurich.com.au/important-information/privacy

#### **OVERSEAS RECIPIENTS**

We may disclose your personal information (including health and other sensitive information) to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in our Privacy Policy at zurich.com.au/important-information/privacy

## 13. Supplementary questionnaires

## **ASTHMA QUESTIONNAIRE**

Only complete this questionnaire if you answered <b>yes</b> to question	1 in Section 8		
1. When did you have your first episode of asthma?	Date (dd/mm/yyyy)	/	/
2. When was your most recent episode of asthma?	Date (dd/mm/yyyy)	/	/
3. Approximately how many episodes have occurred in the las	t 12 months?		
4. Have you ever suffered from nocturnal asthma attacks?			
⊖ Yes			
) No			
If <b>yes</b> , please provide the frequency of these attacks and approxin	nate date of last attack		
5. Have you had any time off work due to this condition?			
) Yes			
○ No			
If <b>yes</b> , please provide the dates and duration			
6. Are the symptoms/attacks typically precipitated by anything	g in particular (e.g. seasonal, exer	cise indu	ced, a cold or bronchitis)?
) Yes			
⊃ No			
If <b>yes</b> , please provide details			
7. Have you sought medical treatment or advice for asthma?			
⊖ Yes			
⊃ No			
If <b>yes</b> , please provide details			
Name of doctor/health professional			
Address			
Suburb	State	)	Postcode
Date of last consultation (dd/mm/yyyy) / /			
8. How has your doctor described your asthma? O Mild	O Moderate O Severe		
9. Have you ever used any medication, including steroids?			
⊖ Yes			
○ No			
lf <b>yes</b> , please provide details			

Туре	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

#### 10. Have you ever been hospitalised due to asthma?

$\bigcirc$	Yes
$\smile$	163

O No

If **yes**, please provide details

Date from (dd/mm/yyyy)	/	/	Date to (dd/mm/yyyy)	/	/

Name of hospital

Address

Suburb

#### 11. Have you ever had lung function tests performed?

O Yes

O No

If **yes**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	
/ /	

Postcode

State

#### **BLOOD PRESSURE QUESTIONNAIRE**

Only complete this questionnaire if you answered **yes** to question 2 in Section 8

1. When was your high blood pressure first diagnosed?	Date (dd/mm/yyyy) /	/
2. What was your blood pressure reading at that time?	Systolic	Diastolic

#### 3. Have you ever been treated by medication?

- O Yes
- O No

#### If **yes**, please provide details

Туре	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

#### 4. Did you undergo any tests or investigations?

O Yes

O No

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

#### 5. Is the treating doctor different to your usual doctor?

O Yes

O No

If **yes**, please provide details

Name			
Address			
Suburb		State	Postcode
Date of last consultation (dd/mm/yyyy) / /			
6. What was the date of your last blood pressure check?	Date (dd/mm/yyy	y)	/ /
7. What was your blood pressure reading at that time?	Systolic		Diastolic
8. How has your doctor described your blood pressure control?	O Excellent	O Good	O Poor O Other
If <b>other</b> , please provide details			
9. What is the date of your next blood pressure check-up?	Date (dd/mm/yyy	y)	1 1
CHOLESTEROL QUESTIONNAIRE			
Only complete this questionnaire if you answered <b>yes</b> to question 3 in Section	on 8		
1. When was your high cholesterol first diagnosed?	Date (dd/mm/yyy	y)	/ /
2. What were your cholesterol readings at that time?	Cholesterol		Triglycerides
	HDL Cholesterol		LDL Cholesterol
3. Did you undergo any tests or investigations?			
() Yes			

O No

If **yes**, please provide details

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

#### 4a. Have you ever used any medication?

O Yes

O No

Туре	Date commenced (dd/mm/yyyy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yyyy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

#### 4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)?

O Yes

O No

If  $\ensuremath{\textit{yes}}$  , please provide date of when treatment changed and the reason(s) for change

5. Is the treating doctor different to your usual doctor?	
○ Yes	
O No	
If <b>yes</b> , please provide details	
Name	
Address	
Suburb	State Postcode
Date of last consultation (dd/mm/yyyy) / /	
6. What was the date of your last cholesterol check?	Date (dd/mm/yyyy) / /
7. What were your cholesterol readings at that time?	Cholesterol Triglycerides
	HDL Cholesterol LDL Cholesterol
8. How has your doctor described your cholesterol control?	O Excellent O Good O Poor O Other
If <b>other</b> , please provide details	
9. What is the date of your next cholesterol check-up?	Date (dd/mm/yyyy) / /
DIABETES QUESTIONNAIRE	
Only complete this questionnaire if you answered <b>yes</b> to question 4 in Sec	ction 8
1. What type of diabetes were you diagnosed with?	
2. When was your diabetes first diagnosed?	Date (dd/mm/yyyy) / /
3. How is your diabetes controlled?	
O Insulin – go to question 3	
O Diet only – go to question 4	
Oral – list medications below and then go to question 4	
4. How many times a day do you administer insulin?	
O l'mon an insulin pump	
One or two times daily	
O Three or more times daily	
5. How often do you monitor your sugar levels?	
One or two times daily	
○ Three or more times daily	

O Other

## 6. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine?

- O Yes
- O No

If yes, please provide details

Condition	Date (dd/mm/yyyy)	Treatment
	/ /	
	/ /	

#### 7. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months?

○ Yes

O No

If **yes**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

Is this result consistent with others taken over the last 12 months?

⊖ Yes

O No

If **no**, please provide details

Date (dd/mm/yyyy)	Test results
/ /	
/ /	

#### 8. Is the treating doctor different to your usual doctor?

O Yes		
O No		
If <b>yes</b> , please provide details		
Name		
Address		
Suburb	State	Postcode
Date of last consultation (dd/mm/yyyy) / /		

#### MENTAL HEALTH QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 5 in Section 8.

#### 1. Please select the conditions you have had (or currently have), or received treatment for:

- O Anxiety including generalised anxiety, panic or phobia disorder
- O Eating disorder including anorexia nervosa or bulimia
- O Depression including major depression or dysthymia
- O Manic depressive illness or bipolar disorder
- O Alcohol or other substance abuse or addiction

If other, please describe

- O Post traumatic stress
- O Schizophrenia or any other psychotic disorder
- Stress, sleeplessness or chronic tiredness
- O Other

#### 2. Please complete the table below for all described conditions

Condition	Describe your symptoms	Date diagnosed (dd/mm/yyyy)	Date condition ceased (if applicable) (dd/mm/yyyy)		
		/ /	/ /		
		/ /	/ /		
		/ /	/ /		
		/ /	/ /		

#### 3. Have you ever had any recurrence of the symptoms?

O Yes

O No

If yes, please provide details including dates

4. Are you currently symptom free?	○ Yes ○ No		
5. Date of last symptoms	Date (dd/mm/yyyy)	/	/

O Yes

O No

If yes, please provide details including when, name and address of treating doctor, clinic or hospital

#### 7. Are you aware of the cause or reason for your condition(s)?

O Yes

O No

If yes, please provide details

#### 8. Have you ever had any time off work due to your condition(s)?

O Yes

O No

If yes, please provide the dates and duration

#### 9. Are you currently or have you ever been on treatment, including medication?

O Yes

O No

If yes, please provide details

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc)	Date commenced (dd/mm/yyyy)	Date ceased (if applicable) (dd/mm/yyyy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

10. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life?

O Yes

O No

11. Have you been referred for consultation with a psychiatrist or psychologist?		
O Yes		
O No		
If <b>yes</b> , please provide details		
Name of consultant		
Address		
Suburb/Town	State	Postcode
Date of last consultation (dd/mm/yyyy) / /		
12. Have you been admitted to hospital or any other care facility?		
O Yes		
O No		
If <b>yes</b> , please provide details		
Name of institution		
Address		
Suburb/Town	State	Postcode
Date of last consultation (dd/mm/yyyy) / /		
Doctor(s) consulted		
BACK/NECK QUESTIONNAIRE		
Only complete this questionnaire if you answered <b>yes</b> to question 6 in Section 8		
1. When did your back/neck condition first occur?	Date (dd/mm/yyyy)	/ /
2. Which area(s) of your back/neck was affected (e.g. middle back)?		
3. What was the cause or reason for the condition?		
<ol> <li>Please describe the exact nature of the condition, including the symptoms and (e.g. sciatica, prolapsed disc, whiplash etc)</li> </ol>	doctor's diagnosis if kn	own

#### 5. Was an X-ray, CT scan or any other type of investigation performed?

O Yes

O No

If **yes**, please provide details

Tests	Date of tests (dd/mm/yyyy)	Results
	/ /	
	/ /	

#### 6. Have you had recurrent or multiple episodes of the back/neck condition?

O Yes

O No

If yes, please provide details including the number of episodes and the date of the most recent episode including duration

#### 7. Please provide details of all people you have consulted for this condition in the table below

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	
		/ /	

#### 8. Have you had any time off work due to this condition?

O Yes

O No

If yes, please provide the dates and duration

#### 9. Are your work duties or activities limited/affected by the condition?

O Yes

O No

If yes, please provide details

#### 10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind?

- O Yes
- O No

11. Overall do you feel that your back/neck condition is?	O Resolved	O Impro	ving	○ Stable	O Deteriorating
12. What was the date of your last symptoms?	Date (dd/mm/y	/yy)	/	/	

#### **ARTHRITIS/JOINT QUESTIONNAIRE**

Only complete this questionnaire if you answered yes to question 7 in Section 8

1. Which joint is/was affected (please select relevant box/es)? If more than one box is selected, please copy this questionnaire and complete for each condition

	Left	Right			Left	Right	
Ankle	$\bigcirc$	$\bigcirc$	Wrist		$\bigcirc$	$\bigcirc$	
Elbow	$\bigcirc$	$\bigcirc$	Hip		$\bigcirc$	$\bigcirc$	
Shoulder	$\bigcirc$	$\bigcirc$	Other		$\bigcirc$	0	
Knee	$\bigcirc$	$\bigcirc$					
lf <b>other</b> , state v	which joint						
2. When did t	his condition fi	rst occur?	Date (dd/mm/yyyy)	/	/		
3. What was t	he cause or rea	son for the c	ondition?				

#### \_\_\_\_\_

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known

#### 5. Have you had recurrent or multiple episodes of the condition?

O Yes

O No

If yes, please provide details including the number of episodes and the date of the most recent episode including duration

#### 6. Please provide details of all people you have consulted for this condition in the table below

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yyyy)	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		/ /	
		/ /	
		/ /	

#### 7. Have you had any time off work due to this condition?

O Yes

O No

If yes, please provide the dates and duration

#### 8. Do you have any residual pain, limitation of movement or restriction of any kind?

O Yes

O No

If yes, please provide details

#### 9. Are your work duties or activities limited/affected by the condition?

O Yes

O No

#### 10. Are you still undergoing treatment?

O Yes

O No

If **yes**, please provide details

11. Overall do you feel that your condition is	O Resolved	O Improv	ing	○ Stable	O Deteriorating
12. What was the date of your last symptoms?	Date (dd/mm/yy	уу)	/	/	

#### CYST/MOLE/SKIN LESION QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 8 in Section 8

#### 1. Please provide details in the table below

Date diagnosed (dd/mm/yyyy)	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
/ /		
/ /		
/ /		
	Date diagnosed (dd/mm/yyyy) / / / / / /	Date diagnosed (dd/mm/yyyy)     Type (e.g. basal cell carcinoma, melanoma, cyst, mole)       /     /       /     /       /     /       /     /

#### 2. Was the cyst/mole/skin lesion(s) removed?

O Yes ○ No Date (dd/mm/yyyy)

/

/

If **yes**, please provide details for each

By what method (e.g. surgically, frozen or burnt off)?

If <b>no</b> plagge provide	dataile including	data sat for ramoval	if annlicable
If <b>no</b> , please provide	uctails including	uale set for removal,	

#### 3. Have you been or are you required to attend any further treatment or regular follow-up since the original removal?

⊖ Yes

O No

If yes, please provide details and advise how often follow-up is required

#### 4. Have you had any other tests, investigations or treatments not mentioned above?

O Yes

O No

Tests/Treatments/ Investigations	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor?				
O Yes				
○ No				
If <b>yes</b> , please provide details				
Name				
Address				
Suburb	State	Postcode		
Date of last consultation (dd/mm/yyyy) / /				
Additional information/comments				

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