Personal Statement
Member's Declaration

About this application

The life insurance policy being applied for with this application is a consumer insurance contract within the meaning of the *Insurance Contracts Act 1984* (Cth). When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, 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 your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

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

This duty applies to a new contract of insurance and 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. There are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth). These are intended to put us in the position we would have been in if the duty had been met.

Your cover could be avoided (treated as if it never existed), or its terms may be varied. 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.

Before we exercise any of these remedies, we will explain our reasons and what you can do if you disagree.

Guidance for answering our questions

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

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

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

If you need help

It's important that you understand this information and the questions we ask. Ask us or a person you trust, such as your adviser for help if you have difficulty understanding the process of buying insurance or answering our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help. If you want, you can have a support person you trust with you.

Notifying the insurer

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

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, Melbourne VIC 3004 Phone: 1800 333 613 Fax: 1800 832 266

A. Life Insured (Life insured to complete this section in full.)

1. Name — Title | Surname | Given Name

2. Date of Birth (dd/mm/yy)

3. Gender at Birth ☐ Male ☐ Female

4. Residential Address — No. | Street

Suburb | State | Postcode

5. Mailing Address (if different to above)

Suburb | State | Postcode

We may need to contact you to clarify information you have provided in the application. If so we will contact you during business hours.
Please nominate a preferred local contact time: ☐ 8am – 11am ☐ 11am – 2pm ☐ 2pm – 5pm

6. Contact Details — Phone (home) | Phone (work) | Mobile

E-mail

7. Are you an Australian citizen or permanent resident of Australia (as approved by the Department of Home Affairs) ~~or are you a New Zealand citizen living permanently in Australia?~~ ..... Yes ☐ No ☐

If 'No', are you applying for, or intending to apply for, Permanent Residency in Australia? ..... Yes ☐ No ☐

Please advise what type of visa you hold and expiry date.

B. Type of Insurance

(Please tick)

☐ New

☐ Increase

(Please tick)

☐ Death Only Amount $

☐ TPD Only Amount $

☐ Death & TPD Amount $

☐ Income Protection Amount $

Income Protection only:

Benefit Period ☐ 2 years (to age 65 if earlier) ☐ ~~To Age 65~~ ☐ Other – please specify ☐ years/other

Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other – please specify ☐ days

C. Personal History (Life insured to complete this section in full.)

1. (a) Do you have, or are you applying for life, disability (including Total & Permanent Disablement or Salary Continuance cover) or trauma insurance on your life (including any pending applications held with any other insurer)? ..... Yes ☐ No ☐
If 'Yes', please complete policy details below.

Policy Number	Commencing Date	Policy Owner	Insurer	Type of Cover	Amount of Cover	Existing Income Protection: Waiting Period/ Benefit Period	To Be Replaced 'Y' or 'N'

(b) Have you **ever** been declined, deferred or accepted on special terms for life, disability or trauma insurance? ..... Yes ☐ No ☐

(c) Have you **ever** claimed benefits from any source (excluding unemployment), e.g. Accident, Sickness, Workers Compensation, Social Security, Disability Income Insurance or Pension? If 'Yes' please give the name of the company, date, amount and reason for each claim below. ..... Yes ☐ No ☐

If you answered 'Yes' to 1(b) or 1(c) please provide details.

2. (a) In the last 12 months, have you smoked tobacco or any other substance such as cigarettes, cigars, pipes or used e-cigarettes or other nicotine products? ..... Yes ☐ No ☐
If 'Yes', please state substance and daily quantity below. (Please note 'packet' is not sufficient detail.)

(b) Do you drink alcohol? ..... Yes ☐ No ☐
If 'Yes', please state how many standard drinks you consume per week on average (one standard drink = 30 ml spirits (one nip), 100 ml wine, 10 oz/285 ml beer): .....

(c) Have you ever used illicit drugs or received advice, treatment or counselling for the use of alcohol or illicit drugs? ..... Yes ☐ No ☐
If 'Yes', please provide details.

3. (a) What is your height? ..... cm (b) What is your weight? ..... kg

4. Do you have definite plans to travel or reside overseas? If 'Yes', please state: ..... Yes ☐ No ☐

Cities/Countries	Duration of travel	Frequency of travel	Reason for travel	Date of departure
				/ /
				/ /

Note: If you are travelling, and you have been fully vaccinated by an Australian Approved COVID-19 vaccine, please 'tick' the box. ..... ☐
('Fully vaccinated' means you have received the recommended dosing regimen of a specific COVID-19 vaccine in accordance to the Australian Department of Health advice.)

5. Do you engage in or intend to engage in any of the following: abseiling, aviation (other than as a passenger on a recognised airline), football (all codes including touch football and oztag), long-distance sailing, hang gliding, scuba diving, motor racing, non-competitive off-road motorcycle sport (trail bike riding/dirt bike riding/motocross), parachuting, powerboat racing, mountaineering, martial arts or any other hazardous activity? ..... Yes ☐ No ☐
If 'Yes', please fill in **Section G** (Aviation or Activities/Pursuits Questionnaire).

C. Personal History (Life insured to complete this section in full.)

Family History

6. Have any of your immediate family (father, mother, brother, sister), prior to the age of 60 (living or dead), ever experienced heart disease, stroke, breast cancer, ovarian cancer, prostate cancer, colon (bowel) cancer, polycystic kidney disease, diabetes, Huntington's chorea, Alzheimer's disease, Dementia, Motor neurone disease, Multiple sclerosis, Muscular dystrophy, Parkinson's disease or any other hereditary disease? ..... Yes ☐ No ☐

If 'Yes', please provide details in the table below.

	Condition/Illness (for heart disease or cancer please specify the type)	Age at onset (approx.)	Age at death (if applicable)
Father			
Mother			
Brothers			
Sisters			

Sexual Health

7. (a) In the last 5 years, have you had sexual intercourse **without** a condom with the following persons?

(i) Someone who might have exposed you to the Human Immunodeficiency Virus (HIV) infection ..... Yes ☐ No ☐
(This may include unprotected sexual intercourse with someone other than your regular partner whose HIV status is unknown to you.)

(ii) Someone who injects non-prescribed drugs ..... Yes ☐ No ☐

(iii) Someone who is a sex worker ..... Yes ☐ No ☐

(iv) Someone who is infected with Human Immunodeficiency Virus (HIV) infection ..... Yes ☐ No ☐

(v) Someone who is infected with Hepatitis B ..... Yes ☐ No ☐
(You may answer 'No' if you are vaccinated and have immunity for Hepatitis B.)

(vi) Someone who is infected with Hepatitis C ..... Yes ☐ No ☐

(b) In the last 5 years, have you been diagnosed with or experienced symptoms of Sexually Transmitted Infection/s (STIs) (examples, chlamydia, gonorrhoea, syphilis)? ..... Yes ☐ No ☐

Remainder of this page has been left intentionally blank.

D. Medical and Health History (Life insured to complete this section in full and complete relevant questionnaire.)

1. Have you **ever** experienced symptoms of, or had, or been told you have, or received any advice, investigation or treatment for any of the following?

(a) High blood pressure, chest pains, high cholesterol, heart murmurs, rheumatic fever, any heart complaint or stroke. ..... Yes ☐ No ☐
If 'Yes', please complete Section H – **High Blood Pressure/High Cholesterol Questionnaire** OR Section J – **Multi-Purpose Questionnaire**.

(b) Asthma, chronic lung disease, sleep apnoea, COVID-19 (do not include a negative test result, or if never diagnosed) or other respiratory disorder..... Yes ☐ No ☐
If 'Yes', please complete Section I – **Asthma Questionnaire** OR Section J – **Multi-purpose Questionnaire**.

(c) Indigestion, gastric or duodenal ulcer or any bowel disorder..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(d) Depression, anxiety/stress state, fatigue (including chronic fatigue syndrome), panic attacks, psychiatric treatment/counselling, mental illness or nervous disorder..... Yes ☐ No ☐
If 'Yes', please complete Section K – **Mental Health Questionnaire**.

(e) Epilepsy, fits of any kind, paralysis, migraines, tinnitus, dizziness or recurrent headaches or any neurological disorder including multiple sclerosis. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(f) Arthritis, repetitive strain injury (RSI), fibromyalgia..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(g) Back or neck complaint, whiplash, sciatica or any other disorder of joints (excluding arthritis), bones or muscles. ..... Yes ☐ No ☐
If 'Yes', please complete Section L – **Spinal/Joints Disorder Questionnaire**.

(h) Psoriasis or eczema, skin disorder, defect in hearing or sight. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

(i) Diabetes, abnormal blood sugar, gout or thyroid disorder. ..... Yes ☐ No ☐
If 'Yes', please complete Section J – **Multi-Purpose Questionnaire**.

If you have answered 'Yes' to any of the above questions, please also complete a questionnaire for each condition (see Sections H to L).

(j) Cancer, cyst, lump, tumour or growth of any kind including skin cancer such as melanoma, BCC, SCC (basal cell or squamous cell carcinoma) or skin lesions/moles that have changed in shape, colour or size. ..... Yes ☐ No ☐

(k) Liver disorder (including fatty liver), pancreas, prostate, kidney or bladder disorder, renal colic or stone. ..... Yes ☐ No ☐

(l) Blood disorder, anaemia, haemochromatosis, haemophilia or leukaemia. ..... Yes ☐ No ☐

(m) Hepatitis B or C (including carrier), Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS)..... Yes ☐ No ☐

Females only

(n) Are you pregnant? If 'Yes', please provide estimated date child is due. ...../...../..... ..... Yes ☐ No ☐

Have you ever had or been advised to have treatment for:

(o) Any breast lump (even if you have not seen a doctor) or any abnormal mammogram or breast ultrasound? ..... Yes ☐ No ☐

(p) An abnormal cervical smear (pap smear) test including the detection of Human Papilloma Virus (HPV) or any abnormality of the ovaries?..... Yes ☐ No ☐

(q) Abnormal vaginal bleeding within the last 12 months or endometriosis? ..... Yes ☐ No ☐

2. Have you ever experienced symptoms of or had any other illness, disease or disorder? ..... Yes ☐ No ☐

3. In the last 5 years have you:

(a) Had any medical examinations, consultations, X-rays, pathology tests or procedures? ..... Yes ☐ No ☐

(b) Occasionally or regularly taken any stimulants, sedatives, medications or prescribed drugs? ..... Yes ☐ No ☐

4. Are you currently under ongoing monitoring, consultation or review for any condition, complaint or finding? ..... Yes ☐ No ☐

5. Are you currently considering or have you been advised/referred to undergo further treatment, investigation or procedure? .. Yes ☐ No ☐

For each 'Yes' answer in questions 1j–1q, 2, 3, 4 and 5 above, please provide full details in the table below.

Question Reference	Illness, Injury or Tests	Date of Illness/Injury	Time off Work	Degree of Recovery %*	Results of Tests	Reason and type of treatment including date of last symptoms	Full name and address of doctor or hospital (if any)

E. Doctor's Details (Life insured to complete this section in full.)

1. (a) Details of your personal doctor.
IF NO PERSONAL DOCTOR, PLEASE STATE NAME/ADDRESS OF LAST DOCTOR OR MEDICAL CENTRE YOU ATTENDED.

Name:		
Address:		Postcode
Phone ( )	Fax ( )	Email (if known)

(b) What was the date of your last consultation? (Give approximate date if exact date unknown.) / /

(c) How long have you been attending the surgery/practice?

(d) If less than 12 months, please provide the name and address of your previous personal doctor or medical centre.

Name:		
Address:		Postcode
Phone ( )	Fax ( )	Email (if known)

F. Present Occupation (Life insured to complete this section in full)

1. (a) What is your usual occupation?

(b) Do you perform any manual work? If 'Yes', please describe duties and percentage of time spent in each..... Yes ☐ No ☐

Type of work	% of time	Please describe your specific duties and where they are performed
Sendentary		
Light manual		
Heavy manual		

2. What is your annual income? $

3. Hours currently working per week

☐ Zero ☐ 1–14 hours ☐ 15–60 hours ☐ >60 hours – please provide number of hours if >60

If you have answered 'Yes' to Section D, question 1a–1m, please also complete a questionnaire for each condition (see Sections H to L).

Questionnaires (Life insured to complete – may be photocopied for additional activities/pursuits.)

G. Aviation Questionnaire

1. Please state the number of hours flown where applicable:

(a) **Private flying**

Type of Aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed Wing				
Rotary				
Other (eg. Ultralight, Microlight)				

(b) **Commercial flying** (excluding large mainstream carriers, eg. Qantas)

Type of Aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed Wing				
Rotary				
Other (eg. Ultralight, Microlight)				

(c) **Agricultural flying**

Type of Aircraft	Previous 12 months Pilot	Previous 12 months Passenger	Next 12 months Pilot	Next 12 months Passenger
Fixed Wing				
Rotary				
Other (eg. Ultralight, Microlight)				

2. Are your flying activities:
☐ Recreational, or ☐ Required for your occupation?
Please provide details.

3. (a) Name of aircrafts flown.

(b) Make and model of the aircrafts.

(c) **If pilot only.**
(i) Age of the aircrafts flown.
(ii) Is the aircraft serviced and maintained in Australia? If 'No', where is the aircraft serviced? ☐ Yes ☐ No

4. Do you fly or intend to fly outside Australia? If 'Yes', please provide details. ☐ Yes ☐ No

5. Do you participate in or intend to participate in any flying activities such as aerobatics, stunt flying or exhibitions? If 'Yes', please provide details. ☐ Yes ☐ No

6. Have you ever been involved in any aviation accidents? If 'Yes', please provide details. ☐ Yes ☐ No

G. Activities/Pursuits Questionnaire

1. Please describe the activity or pursuit.

2. Please advise the number of times you engage in the activity per year.

3. How many actual events/hours/trips/flights/dives/climbs/jumps/others, did you participate in over the last twelve months approximately?

4. What qualifications, certificates, licences, associations and club memberships do you hold?

5. How long have you been involved in this activity?

6. Where do you engage in this activity and in what locations?

7. Do you ever engage in this activity alone, or are you always with a group?

8. Do you compete in this activity? ☐ Yes ☐ No
If 'Yes', please advise the level of competition and names of events.

9. Do you receive any payments for your involvement in this activity? ☐ Yes ☐ No
If 'Yes', please advise details.

10. Please advise the maximum heights, speeds, depths the activity includes.

11. Are any of the above likely to change over the next 2 years? ☐ Yes ☐ No
If 'Yes', please provide full details.

12. Are you involved in any record attempts? ☐ Yes ☐ No
If 'Yes', please provide details.

13. Are all recognised/standard safety measures and precautions followed? Please provide any additional details.

14. Please provide details including engine size and model for any cars, boats, planes (state fixed wing or rotary) or other equipment used. For martial arts state whether contact or non-contact.

15. Have you ever been involved in any accident/ mishap whilst participating in this activity? ☐ Yes ☐ No
If 'Yes', please provide details.

Questionnaires (continued) (Life insured to complete – may be photocopied for additional conditions.)

H. High Blood Pressure/High Cholesterol Questionnaire

1. When was high blood pressure/ high cholesterol first diagnosed?

2. What were the blood pressure/cholesterol readings (including total cholesterol, HDL, LDL and Triglyceride) at time of diagnosis?

Readings	Results	Date diagnosed
Blood Pressure		
Total Cholesterol		
HDL		
LDL		
Triglycerides		

3. Please provide details of your past and current treatment. Include names of medication and dosage.

Date	Medication	Dosage

4. Are you still on treatment? ☐ Yes ☐ No
If 'No', when was treatment discontinued and why?

5. Please give date(s) and result(s) of any electrocardiography (ECG), echocardiogram, x-ray, urine test or other investigations which may have been carried out.

Date	Procedure	Results

6. Regarding the monitoring of your condition:
   (a) Name of medical attendant:
   (b) How often do you attend for follow-up?
   (c) When was your last consultation? Please provide details of your blood pressure reading and/or cholesterol (including total cholesterol, HDL, LDL and Triglyceride) reading at that time.
   (d) Have you experienced any of the following conditions:
      (i) Eye disorder (other than short/long sightedness) ☐ Yes ☐ No
      (ii) Symptoms or disorder relating to heart or circulatory system ☐ Yes ☐ No
      (iii) Kidney disorder or protein in urine ☐ Yes ☐ No
      (iv) Dizziness, fainting episodes or stroke ☐ Yes ☐ No

   If you answered 'Yes' to any of the above, please provide details:

Date	Symptoms	Investigations	Results

   (e) How long has your blood pressure/cholesterol been well controlled?
   ☐ < 6 months ☐ 6 months to 12 months ☐ > 12 months

7. Please provide any additional information on your condition which you feel will be helpful in processing your application.

8. Please attach copies of any reports or results (eg. xray, pathology, ultrasound, etc) you may have.

I. Asthma Questionnaire

1. Date asthma first diagnosed. / /

2. How often do you experience symptoms?
eg. wheezing, breathlessness, chest tightness.
☐ Daily ☐ Weekly ☐ Monthly ☐ Other

3. When was your most recent episode of asthma? / /

4. Are you aware of any causes that trigger your symptoms?
eg. allergy, exercise.

5. Have you ever been off work due to asthma? ☐ Yes ☐ No
If 'Yes', please advise when, and for how long.

6. Name of medications.
   (a) Dosage
   (b) Frequency
   (c) When was the last time you received medication?
   (d) What additional treatment do you use to control an attack?

7. Have you ever required steroid therapy (by tablet or syrup)? ☐ Yes ☐ No
If 'Yes', please provide details.

8. Have you ever been in hospital or received emergency treatment for asthma? ☐ Yes ☐ No
If 'Yes', please state when, for how long and where?

9. Have you ever undergone a lung function test? ☐ Yes ☐ No
If 'Yes', please advise dates and highest and lowest readings, if known.

10. Have you ever consulted a specialist for this condition? ☐ Yes ☐ No
If 'Yes', please advise name and address of doctor of last consultation.

11. Please provide details of your most recent visit to any other doctor for this condition. Include date, name and address of doctor consulted.

J. Multi-Purpose Questionnaire

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?
   (b) Please state which side. ☐ Left ☐ Right ☐ Not applicable
3. The cause.
4. (a) Date symptoms commenced. / /
   (b) How long have you been free of symptoms?
   (c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? ☐ Yes ☐ No
   If 'Yes', please state when, duration and reason/restriction.
6. Have you any residual, on-going effects or restriction in your daily activities? ☐ Yes ☐ No
   If 'Yes', please give details.
7. Have you taken regular or occasional medication for this condition? ☐ Yes ☐ No
   If 'Yes', advise names of medication(s), dosage(s) and frequency.
   Are you still taking this medication? ☐ Yes ☐ No
8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No
9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No
10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No
11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
    If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
    If 'Yes', please provide details.
13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
    If 'No', provide name and address of doctor who has full details.

J. Multi-Purpose Questionnaire

1. Name of condition (exact diagnosis).
2. (a) What part of the body was affected?
   (b) Please state which side. ☐ Left ☐ Right ☐ Not applicable
3. The cause.
4. (a) Date symptoms commenced. / /
   (b) How long have you been free of symptoms?
   (c) How often do/did you have symptoms?
5. Have you ever been off work or your normal daily activities restricted in any way related to this condition? ☐ Yes ☐ No
   If 'Yes', please state when, duration and reason/restriction.
6. Have you any residual, on-going effects or restriction in your daily activities? ☐ Yes ☐ No
   If 'Yes', please give details.
7. Have you taken regular or occasional medication for this condition? ☐ Yes ☐ No
   If 'Yes', advise names of medication(s), dosage(s) and frequency.
   Are you still taking this medication? ☐ Yes ☐ No
8. Have you had any other treatment for this condition (eg. physiotherapy, operation, alternative remedies)? ☐ Yes ☐ No
9. Have you had any diagnostic investigations (eg. scope, scan, x-rays, EEG, ECG etc)? ☐ Yes ☐ No
10. Have you ever been in hospital or received emergency treatment for anything related to this condition? ☐ Yes ☐ No
11. Have you seen a doctor or other therapist for anything related to this condition. ☐ Yes ☐ No
    If 'Yes' please provide details below. Include reason for consultation, investigation, findings and advice, and the name and specialty of the doctor/therapist.

If you answered 'Yes' to questions 8 –11 please advise details including date, type of treatment and tests.

12. Has further treatment been recommended for this condition? ☐ Yes ☐ No
    If 'Yes', please provide details.
13. Does your usual doctor have details of this condition? ☐ Yes ☐ No
    If 'No', provide name and address of doctor who has full details.

Questionnaires (continued) (Life insured to complete – may be photocopied for additional conditions.)

K. Mental Health Questionnaire

1. Please indicate the condition(s) you have had or received treatment for.

- ☐ Anxiety including generalised anxiety, panic or phobic disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression or mild depression
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenic or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic fatigue
- ☐ Other (please specify)

2. Describe your symptoms including the date they first started and how long they lasted.

Symptoms	Date from	Date to

3. Have you had any recurrences? ☐ Yes ☐ No
If 'Yes', please provide details.

Symptoms	Date from	Date to

4. (a) Has any reason for your condition been identified or are there any factors which trigger your condition?

(b) Have you ever had any suicidal thoughts, attempted suicide, threatened to self-harm or engaged in self-harm? ☐ Yes ☐ No
If 'Yes', please provide details.

5. (a) Please advise all treatments you have received and/or are receiving, including counselling, name(s) of medications, hospitalisation etc.

Type of treatment	Date commenced	Date ceased

(b) Are you currently receiving treatment? ☐ Yes ☐ No

(c) If 'Yes', please provide details.

6. Please provide details of doctors or health professionals, including psychiatrists and psychologists, consulted for your condition.

Name and address	Date first consulted	Date last consulted

7. Have you ever been off work or your normal daily activities restricted in any way due to your condition? ☐ Yes ☐ No
If 'Yes', when and how long?

8. Have you any ongoing effects or restriction to your activities of any kind due to your condition? ☐ Yes ☐ No
If 'Yes', please provide details.

L. Spinal/Joints Disorder Questionnaire

1. Area of spine (eg. neck, upper or lower back) and/or joints affected (eg. left knee, right hip, shoulders, elbows etc).

2. Please state the precise diagnosis.

3. When did symptoms first occur?

4. (a) What was the cause?

(b) Please describe your symptoms.

(c) Do you have or have you ever had pain, numbness or 'pins and needles' in your arms, shoulders, buttocks or legs? ☐ Yes ☐ No

(d) State frequency and severity of attacks/symptoms prior to treatment.

5. Are you still experiencing symptoms? ☐ Yes ☐ No

(a) If 'No', date of last experienced symptoms. / /

(b) If 'Yes', how frequently have symptoms occurred since commencing treatment?
☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

6. (a) What is the nature of the treatment (eg. medication, physiotherapy, exercise, etc)?

(b) Are you still receiving treatment? ☐ Yes ☐ No

(i) If 'No', when did you cease treatment? / /

(ii) If 'Yes', how often do you attend for follow-up and date of last consultation?

(c) Name and address of doctor or therapist consulted.

7. Have you had any x-rays or other investigations or have you ever consulted a specialist for this condition? ☐ Yes ☐ No
If 'Yes', please provide date(s) and full details including type of investigations, results and name of doctor.

8. Have you had an operation for this condition or is an operation being considered? ☐ Yes ☐ No
If 'Yes', please provide date(s) and full details including names of hospital and consultant/surgeon.

9. (a) Have you ever been off work due to your symptoms? If 'Yes', when and for how long? ☐ Yes ☐ No

(b) Are your occupation duties restricted in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

(c) Is it necessary to avoid lifting or to restrict your daily activities in any way? ☐ Yes ☐ No
If 'Yes', please provide details.

M. Declaration

- I declare that the information I provided in this Personal Statement (whether written in my hand or not) is true and correct and that no information material to the insurance has been withheld.
- I agree that any personal statements made (including this one) together with any relevant supporting documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.
- I also understand that my duty to take reasonable care continues after I have completed the insurance application until AIA Australia has accepted the risk. I understand AIA Australia may cancel the cover from inception or provide cover on amended terms if I do not comply with my duty to take reasonable care.
- I consent to AIA Australia collecting sensitive information, i.e. health information about me, for the purpose of the performance of this contract.
- I agree that cover will not commence until the premium is paid and AIA Australia has accepted the risk.
- I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy section of this form and the AIA Australia Privacy Policy available at www.aia.com.au as updated from time to time, including the exchange with third parties located in Australia and overseas. I agree that any personal and sensitive information AIA Australia holds will be governed by the most current Privacy Policy on AIA Australia's website.

By submitting this application for underwritten cover, I elect for the Trustee to take out and maintain insurance cover in relation to my Future Super account, even if:

- my account is inactive (i.e. no contributions received) for a continuous period of sixteen months or longer;
- my account balance is less than $6,000; and/or
- I am under the age of 25.

I acknowledge that, by submitting this application on the submission date indicated, I have elected for the benefits to continue in accordance with superannuation law regardless of the factors above (subject to meeting the policy terms including premium requirements), and that I can cease the insurance by submitting a request to info@myfuturesuper.com.au

I confirm the Declarations are true and accurate.

Signature ✗ Date

N. Privacy

Your privacy is important to us. The AIA Australia Privacy Policy sets out how your personal information (including sensitive information) is collected, used, handled and disclosed by us, and other important information. AIA Australia's current Privacy Policy is available at www.aia.com.au or by calling 1800 333 613. In summary, for the purposes set out in AIA Australia's Privacy Policy (including for the purposes of administering, assessing or processing your insurance or any claim) AIA Australia may:

- collect personal and sensitive information from you, including from application forms or other information submitted in respect of your insurance, or when interacting with you (including online);
- collect your personal and sensitive information from, and provide to, third parties in Australia and overseas, such as your financial adviser, employers, health professionals, reinsurers, government agencies, service providers and affiliates;
- be required or authorised to collect your personal and sensitive information under various laws including insurance, taxation, financial services and other laws set out in the AIA Australia Privacy Policy; and
- disclose personal and sensitive information to third parties which may be located in Australia, South Africa, the US, Europe, Asia and other countries including those set out in our Privacy Policy and you acknowledge that by providing your consent as set out in this form, Australian Privacy Principle 8.1 will not apply to the disclosure, we will not be accountable for those overseas parties under the Privacy Act and you may not be able to seek redress under the Privacy Act for breaches of the Privacy Act by those overseas parties.

If you do not provide the required personal and sensitive information, AIA Australia may not be able to provide insurance or other services to you. Information about how to access or correct your personal information held by AIA Australia or lodge a privacy-related complaint is set out in AIA Australia's privacy policy.

O. Authority to Release 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, (**AIA Australia**), 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

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 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 **AIA Australia**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **AIA Australia** 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.
- **AIA Australia** 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 **AIA Australia** 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:

✗

Date:

Authority 2

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.

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 **AIA Australia**, or to third parties they engage, only if **AIA Australia** 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:

- **AIA Australia** 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 **AIA Australia** 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:

✗

Date:

☐ I/We authorise and consent to any life insurance company disclosing to AIA Australia personal and sensitive information about me/us with regard to previous or current applications for insurance cover or claims made under other insurance cover which may include details of my/our health and medical history.