

Group Risk Insurance Application for Insurance



Suncorp Life & Superannuation Limited ABN 87 073 979 530 AFS Licence No 229880
Suncorp Portfolio Services Limited ABN 61 063 427 958
AFS Licence No 237905 RSE Licence No L0002059

Issued 1 January 2012

Details of Group Policy

Employer name

Policy No.

Death Only Death and Total & Permanent Disability Income Protection

Your duty of disclosure

To be read by the Policy Owner and Person to be Insured before completing this questionnaire.

Before you enter into a contract of life insurance with an insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer;
- that is of common knowledge;
- that your insurer knows, or in the ordinary course of their business, ought to know;
- as to which compliance with your duty is waived by the insurer.

Non-disclosure – If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

This duty continues to apply until the insurer notifies you that the risk has been accepted. It also applies when you extend, vary or reinstate a contract of life insurance.

A. Details of Person to be Insured (Must be fully completed)

Please use block letters

Title Male Female Smoker Non-smoker Single Married

Surname

Given name(s)

Date of birth / / Age next birthday

Home address

Street address

Suburb/Town

State Postcode

Phone (home) Mobile

Phone (work) Fax

Email

Postal address (if different from above)

Street address/
PO Box

Suburb/Town

State Postcode

B. Occupation details (Must be completed)

1. Please give details of your current occupation, industry and length of time in this occupation.

Occupation

Industry No. of years

2. What are the principal duties of your occupation (including % of time spent in each).

C. Insurance history (Must be completed)

If you have existing insurance providing benefits similar to that being applied for, we will take this existing insurance cover into account when considering whether or not to accept this application.

1. Excluding cover under this group policy, do you have with us or any other insurance company, or are you currently applying for, any type of life, superannuation, sickness, accident, trauma, lump sum disablement or disability insurance? Yes No

If 'yes', please provide:

| Name of insurer | Type of insurance | Insured benefit | Benefit period for Income Protection, sickness, accident or disability | Date commenced | Is policy to be discontinued/replaced? |
|-----------------|-------------------|-----------------|--|----------------|---|
| | | \$ | | / / | Yes* <input type="checkbox"/> No <input type="checkbox"/> |
| | | \$ | | / / | Yes* <input type="checkbox"/> No <input type="checkbox"/> |
| | | \$ | | / / | Yes* <input type="checkbox"/> No <input type="checkbox"/> |
| | | \$ | | / / | Yes* <input type="checkbox"/> No <input type="checkbox"/> |

***If you have indicated that it is your intention to replace insurance you currently have with the cover you are now applying for, the replacement cover under any policy we issue will only start when the insurance which is to be replaced is cancelled. However, we strongly recommend that you speak to your financial adviser before cancelling any insurance policies currently in force.**

2. Has any application for insurance ever been refused, postponed, accepted with an increased premium or on modified terms? Yes No

If 'yes', please provide details:

3. Have you been eligible to claim, are currently claiming or have previously claimed benefits from any source eg, an insurance policy, workers compensation, social security (including unemployment benefits), veterans affairs, sickness benefits, invalid pension, third party, etc? Yes No

If 'yes', please provide:

| Date | Source | Reason | Has the claim been settled/withdrawn/benefits ceased? | Date ceased |
|----------------------|--------|--------|--|-------------|
| <input type="text"/> | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | / / |
| <input type="text"/> | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | / / |
| <input type="text"/> | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | / / |

D. Residence and travel (Must be completed)

1. Were you born in Australia? Yes No

If 'yes', please go straight to question 3

2. Are you an Australian citizen or do you hold an Australian Permanent resident visa? Yes No

How long have you lived in Australia? Country of birth Visa type

3. Do you travel overseas in your job? Yes No

Countries Purpose

Duration Frequency

4. Do you have definite plans to live or travel overseas in the future? Yes No

If 'yes', please advise Date leaving Date returning

Countries to be visited Reason for trip

E. Medical history (Must be completed, except when a medical examination is required)

1. What is your height and weight? Height cm Weight kgs

2. Have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Heart attack, angina, chest pain, stroke, hypertension (high blood pressure) or high cholesterol readings? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Asthma, bronchitis, emphysema? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression, anxiety, panic attacks, stress (requiring advice from a doctor or counsellor), psychosis, schizophrenia or any other mental illness or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Epilepsy, fainting attacks or fits of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Recurrent indigestion, ulcer, hepatitis (A, B, C or D)? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer, tumour, sunspot, skin cancer, lump or growth of any kind or breast lumps (even if you have not seen a doctor)? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Any impairment of sight or hearing including symptoms such as tinnitus or blurred vision? (This does not include long or short sightedness corrected by glasses) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Back or neck pain or strain, sciatica or any other disorder of the spine or neck or any disorder of the joints, muscles, ligaments, cartilage or limbs? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Arthritis, gout, osteoporosis, fibromyalgia, tendonitis, tenosynovitis, RSI or any regional pain syndrome or chronic fatigue? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Diabetes or abnormal blood sugar? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Psoriasis, eczema or any other disorder or cancer of the skin, or any allergic or chemical sensitivity reaction? | <input type="checkbox"/> | <input type="checkbox"/> |

3. Other than those conditions stated in question 2, have you ever had any symptoms of, investigation or treatment for, or received a diagnosis for:
- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Heart murmur or any other heart or blood vessel disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tuberculosis or any other lung or respiratory system disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Paralysis, multiple sclerosis, recurrent headaches or any other disorder of the nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Passage of blood from the bowel, vomiting of blood or any other disorder of the liver, gall bladder, bowel, intestine, stomach or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Prostate disorder, sexually transmitted disease, renal colic or stone, blood in the urine or any other disorder of the kidneys, bladder or reproductive organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Sleep apnoea or any sleeping disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Thyroid disorder or any other glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Any sickness, injury or physical impairment not previously mentioned? | <input type="checkbox"/> | <input type="checkbox"/> |
4. Do you take any prescribed medication on a regular basis (other than the contraceptive pill)?
5. Have you ever had or are you considering having a genetic test?
6. Are you considering consulting a doctor, health professional, seeking a medical examination, advice, treatment, tests or an operation?
7. Other than already stated, during the last 3 years have you been examined or treated by or received advice from any doctor, psychologist, chiropractor, physiotherapist, natural therapist or any other health care professional, been in hospital, had any operation or had any tests or investigations (eg, x-ray, ECG etc)?
- | | | |
|--|------------------------------|-----------------------------|
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|
8. Has your mother or father, or any brother or sister had breast, ovarian, colon or other cancer, diabetes, high blood pressure, heart problems, stroke, mental disorder, haemochromatosis, Huntington's disease, muscular dystrophy, familial adenomatous polyposis, polycystic kidney, osteoporosis, Creutzfeldt-Jakob disease or any other hereditary disease?
- | | | |
|--|------------------------------|-----------------------------|
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|

If 'yes', please provide details in the following table.

| Family member (relationship to you) | Condition/Sickness (for cancer/heart disease, specify type) | Age at onset (approx) | Age at death (if applicable) |
|-------------------------------------|---|-----------------------|------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

9. Females only
- a. (i) Have you ever had an **abnormal** pap smear or breast ultrasound or mammogram?
- | | | |
|--|------------------------------|-----------------------------|
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|
- If 'yes', please provide details of test(s), result(s) and date(s).
- (ii) Have you had any follow up tests beyond the initial test mentioned in a(i)?
- | | | |
|--|------------------------------|-----------------------------|
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|
- If 'yes', please provide details of test(s), result(s) and date(s).
- b. Are you currently pregnant?
- | | | |
|--|------------------------------|-----------------------------|
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|
- (i) If 'yes', due date. / / / / /
- (ii) Have there been or are there expected to be any complications?
- | | | |
|--|------------------------------|-----------------------------|
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|
- If 'yes', please provide details.

If you answered 'yes' to any question in Section E.

Question no. Sickness, injury or tests

Test results

Date commenced |d|d| / |m|m| / |y|y|y|y| Time off work Degree of recovery (%)

Date of last symptoms |d|d| / |m|m| / |y|y|y|y| Treatment received

Date of Last Treatment |d|d| / |m|m| / |y|y|y|y|

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced |d|d| / |m|m| / |y|y|y|y| Time off work Degree of recovery (%)

Date of last symptoms |d|d| / |m|m| / |y|y|y|y| Treatment received

Date of Last Treatment |d|d| / |m|m| / |y|y|y|y|

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced |d|d| / |m|m| / |y|y|y|y| Time off work Degree of recovery (%)

Date of last symptoms |d|d| / |m|m| / |y|y|y|y| Treatment received

Date of Last Treatment |d|d| / |m|m| / |y|y|y|y|

Full name and address of doctor or hospital

State Postcode

Question no. Sickness, injury or tests

Test results

Date commenced |d|d| / |m|m| / |y|y|y|y| Time off work Degree of recovery (%)

Date of last symptoms |d|d| / |m|m| / |y|y|y|y| Treatment received

Date of Last Treatment |d|d| / |m|m| / |y|y|y|y|

Full name and address of doctor or hospital

State Postcode

Additional information from the Person to be Insured

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F. Habits (Must be completed, except when a medical examination is required)

1. Have you ever smoked tobacco or any other substance in the last 12 months?..... Yes No

If 'yes', type (eg, cigarettes, cigars)? Daily quantity?

How many years? Date ceased? if applicable / / | / / | / / | / / | / /

Other

2. Do you drink alcohol? Yes No

If 'yes', please advise number of standard drinks per week? Standard drink = 1 nip spirits, 1 wineglass, 1 sherry glass liqueur, port/sherry, 10oz/285ml beer.

3. Have you ever used or injected yourself with any illegal or illicit drugs? Yes No

4. Have you ever received advice, counselling or treatment for the use of drugs or alcohol?..... Yes No

If you answered 'yes' to question 3 or 4, please provide details in the following table

| Question no. | Date from | Date to | Type of usage (alcohol, heroin etc) | Name and address of doctor who has full details |
|----------------------|-----------|---------|-------------------------------------|---|
| <input type="text"/> | / / | / / | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | / / | / / | <input type="text"/> | <input type="text"/> |

G. Doctor's details (Must be completed)

If you do not have a regular doctor, answer these questions with reference to your most recent medical consultation.

1. Name of your regular doctor

Address Postcode

Phone Work () Fax ()

2. How long have you been a patient of this doctor? Date of last consultation / / | / / | / / | / /

Reason for last consultation

Outcome of last consultation

3. If you have been attending your current doctor for less than 2 years, please provide the following details:

Name of previous doctor/medical centre

Address Postcode

Please provide date and reason for last consultation.

Outcome of last consultation(s).

H. HIV (Must be completed)

1. Are you suffering from Acquired Immune Deficiency Syndrome (AIDS) or infected with the Human Immunodeficiency Virus (HIV) or are you carrying antibodies to HIV? Yes No

2. In the last 3 years have you or do you intend to:

a. Work as or engage in sexual intercourse with a prostitute?..... Yes No

b. Have sexual intercourse with an intravenous drug user?..... Yes No

c. Have sexual intercourse with someone you suspect or know to be HIV positive?..... Yes No

Males only

d. Engage in male to male anal sexual intercourse? Yes No

If you have answered 'yes' to any of the above, our underwriters will contact you for further information.

I. Activities (Must be completed)

1. In the last 12 months have you taken part or do you have definite intentions to take part in any organised sport or hazardous activity eg, football, parachuting, hang gliding, motor sport of any kind, underwater diving, rock climbing, paragliding, caving, mountaineering, ocean racing, martial arts, rodeo, aviation other than as a fare paying passenger on a licensed public service (eg, Qantas)? Yes No

If 'yes', please answer question 2 and complete the Activities questionnaire section J on page 6.

2. Type of activity

J. Activities questionnaire

(Must be completed if you answered 'yes' to question 1 in Section I)

Underwater diving

- a. Type (scuba, hookah etc) b. What are your qualifications for this activity?
- c. How long have you been doing this? d. How often do you do this?
- e. Are you professional or amateur?
- f. Maximum depth of dives Metres g. Average depth of dives Metres
- h. Geographical location
- i. Do you dive in wrecks, potholes or caves? Yes No
- j. Have you ever had a diving accident or diving sickness? (eg, blackout, needed decompression etc) Yes No
- k. Do you intend to change the scope of your license/participation? Yes No
- If 'yes' to i or k, please provide details.

Motor sports

- a. Type (car, bike etc) b. Events (speedway, off road etc)
- c. How long have you been doing this? d. How often do you do this?
- e. Are you professional or amateur?
- f.

| Category (eg, touring cars) | Class (eg, AA/D) | Vehicle & type of fuel | Engine capacity | No. of vehicles in event | Max speed km/hour |
|--------------------------------|----------------------|------------------------|----------------------|--------------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
- g. Do you intend to change the scope of your license/participation? Yes No
- If 'yes', please provide details.

Flying – power-driven aircraft or conventional glider

- a. What type of flying do you do (private, agricultural, ultralight etc)?
- b. Total number of hours flown as a pilot? Hrs Number of hours in the past 12 months? Fixed Wing Hrs Helicopter Hrs
- c. Number of hours expected in the next year? Fixed Wing Hrs Helicopter Hrs
- d. Geographical location
- e. What class license do you hold?
- f. Do you intend to change the scope of your license? Yes No
- If 'yes', please provide details.

Abseiling, caving, mountaineering, rock climbing

- a. Activity
- b. How long have you been doing this? c. How often do you do this?
- d. Geographical location
- e. Maximum altitude/depth f. Equipment used
- g. Maximum grade of climb h. Type (top roping etc)

Other activity

- a. Describe activity b. What are your qualifications for this?
- c. How long have you been doing this? d. How often do you do this?
- e. Geographical location f. Are you professional or amateur?

K. Authorisations by the Person to be Insured

1. Medical history authorisation (must be completed)

To Doctor

I authorise any doctor, hospital, clinic and other medical or related facility, or any other person who has attended me, to provide with any information with respect to any sickness, injury, consultation, tests (including genetic test(s)), prescriptions or treatment and copies of all hospital records.

I authorise the Health Insurance Commission to release to at their request, a copy of my medical history records.

I agree that a photocopy or facsimile of this authority should be considered as effective and valid as the original.

Name of Person(s) to be Insured Maiden name (if applicable)

or Children to be Insured

Signature Date / /

Signature of Person to be Insured or their guardian (if under 18).

2. Authority to PhoneCheck (optional)

If we need to get more information from you, may a Representative phone you? (this can save time and ensure that the underwriter fully understands your circumstances) Yes No

If 'yes', when is the most convenient time and place:

At home At work Days Convenient times From to

Signature Date / /

Signature of Person to be Insured or their guardian (if under 18).

L. Declaration by the Person to be Insured

I acknowledge that

- I have read this application form and confirm that the answers given are my true and accurate answers, even if the answers have been written by someone else.
- I have read and complied with my duty of disclosure and have not withheld any information material to my application for insurance and understand that this duty continues to apply and that the insurance applied for will not become effective until Suncorp Life and Superannuation Limited advises that the risk has been accepted in writing.
- I may request access to my personal information by contacting you, although I may in some circumstances not be granted access to it. Also, I acknowledge that if the personal information requested from me is not provided to you, then you may not be able to provide services covered in the Privacy Policy.
- My insurance cover will stop if I commence active duty with the armed forces of any country (excluding regular activities of the Navy, Army or Air Force Reserves).
- I have read, understood and signed the medical history authorisation which enables, at its discretion, to obtain full details of my medical records and I understand that may obtain, on a random basis, a report from my regular doctor or any doctor whom I have consulted.
- I will cancel each policy listed as a policy to be replaced or discontinued in the insurance history section of this application as soon as possible after a new policy is issued on the acceptance of this application.
- Any statements I have made on or with an application to another insurer and which I have presented to are intended by me as declarations and representations to and I acknowledge that will use them, and may request copies of them, in assessing this application for insurance.

I have read the Privacy Statement issued to me and consent to:

- The use of personal information about me by Suncorp Life and Superannuation Limited and the Trustee (if applicable) for the purposes of insurance through my membership of the plan, including to assess and decide whether to agree to an application and on what terms (if any) or any amendment or increase of any insurance provided; to provide and manage the insurance cover relating to an application that has been accepted; to investigate and, if covered, manage and pay any claims made in relation to any insurance I have with you or any other members of the Suncorp Group; and
- The disclosure of personal information about me by and/or the Trustee (if applicable) to, and obtaining personal information from, other parties for any of these purposes. These other parties include the policy owners, adviser, other members of the Suncorp Group, loss assessors and claim investigators, other insurance companies and reinsurers, mailing houses, claims reference providers, research and telephone service providers, hospitals, medical and other health professionals, government departments, other trustees, legal and other professional advisers and other service providers.

If I have disclosed personal information about any other person, I confirm that I am authorised to disclose personal information about that person and consent to its use and disclosure to other parties (and obtaining other personal information about that person from other parties) for the purposes above.

Signature of the Person to be Insured Date / /

Please return the completed form to:

Suncorp Life Group Risk
2SL073
GPO Box 1576
Sydney NSW 2001