



To be completed by the Member (Life to be insured)

Please read the notices relating to 'Duty of Disclosure' and 'Privacy - Use and disclosure of personal information' on page 21 before completing this form.

Warning: You have a duty to disclose all information relevant to our decision to accept your application. We rely on this information to assess your application. Any incorrect information may affect your entitlement to benefits.

Please follow the instructions carefully when completing this form.

Step A Member details (mandatory)

Mr
 Mrs
 Miss
 Ms
 Other please specify
 Gender Male Female

Surname (please print)
 Given name(s)
 / / Date of birth

Street number and name
 Town/Suburb
 State
 Postcode

Employer
 Plan reference
 Member reference

() Home Telephone
 () Work telephone
 Mobile number

Email address

If you are applying for:

- Between 1 or 2 units of Death or Death and Total and Permanent Disablement (TPD) cover (Super Directions for Business), or
 - \$1 or \$2 per week of Death or Death and TPD cover (Simple Super and Tailored Super)
- and automatic acceptance does not apply, please complete Step B on page 2.

For any other type of cover, please complete Step C commencing on page 3, the 'Medical and financial authorities' on page 19 and the 'Declaration and consent' on page 21.

Please return the completed form to:

AXA Customer Service Centre
PO Box 14669
MELBOURNE VIC 8001.

Personal statement

Step B Health questionnaire

- 1** Were you absent from work due to sickness or injury on the day of joining the plan? ▶ No Yes
- 2** At any time in your life have you ever suffered from, received advice for, experienced symptoms of, or been diagnosed with any of the following (even if you have not seen a doctor):
- (a) Heart complaint, rheumatic fever, chest pain, high blood pressure, raised cholesterol, vein or circulation disorder? ▶ No Yes
 - (b) Disease or disorder related to kidney, bladder, prostate, bowel, stomach or liver (including Hepatitis B&C)? ▶ No Yes
 - (c) Disease or disorder of the brain, nervous system, stroke or epilepsy? ▶ No Yes
 - (d) Diabetes or thyroid disorder? ▶ No Yes
 - (e) Asthma, bronchitis, lung condition, breathing or respiratory disorder, sleep apnoea? ▶ No Yes
 - (f) Mental illness, depression, anxiety, chronic fatigue, nervous condition, stress or post traumatic stress disorder? ▶ No Yes
 - (g) Cancer, leukaemia, tumour of any kind, blood disorder, cyst, growth or breast lump? ▶ No Yes
 - (h) Back/neck disorder, arthritis, joint, bone or muscle disorder? ▶ No Yes
 - (i) Disorder of the eyes, ears or skin? ▶ No Yes
 - (j) Any other illness, injury, operation or disability (other than colds and influenza)? ▶ No Yes
- 3** (a) Do you or any of your current or previous sexual partners have HIV/AIDS, or any sign of HIV infection?
For example, some signs are unexplained weight loss, swollen glands or persistent diarrhoea ▶ No Yes
- (b) In the last 3 years: Are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?
HIV risks include but are not limited to: sex with or as a prostitute; sex with an intravenous drug user; contact with someone else's blood (for example through injection or scratch with a used needle); and anal intercourse (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least 3 years) ▶ No Yes
- 4** Have you lost the sight of an eye or total and permanent loss of the use of a limb ('limb' means the whole hand or foot)? ▶ No Yes
- 5** Have you ever had any medical advice, investigation or treatment for any disease or disorder of the joints, bones or muscles, including the neck and back, which has required more than two weeks off work? ▶ No Yes
- 6** Have you ever made a claim or received benefits under disablement insurance, worker's compensation, motor vehicle accident insurance, Social Security sickness or invalid benefits or Veterans Affairs sickness or invalid benefits? ▶ No Yes
- 7** Including annual holidays, are you likely to live, travel or work overseas? ▶ No Yes
- 8** Are you a **non-permanent** resident of Australia or New Zealand? ▶ No Yes

If you have answered:

- 'Yes' to any of the questions above, please complete **Step C** commencing on page 3, the 'Medical and financial authorities' on page 19 and the 'Declaration and consent' on page 21.
- 'No' to all of the questions above, please complete the 'Declaration and consent' on page 21.

Personal statement

Step C Personal statement

Your personal details

		years	
Marital status	Maiden name, where applicable	Age	Place of birth

What is your occupation title and in which industry do you work?

What was your gross income less business expenses from personal exertion in the last 12 months? \$

Residential address (if different from address in Step A)

Street number and name	Town/Suburb
State	Postcode

We may need to contact you regarding the details of your Application. Please provide contact number(s) and suitable contact times (8am to 8pm):

Contact phone numbers

()		()	
Daytime	Times	After hours	Times

Residence and travel details

Q1 Are you an Australian citizen or a permanent resident of Australia? No Yes

If no, please provide details including the type of visa you hold:

Q2 In the next 12 months, do you intend to leave Australia to go and live in another country? No Yes If yes, please provide details:

Where	Duration

Q3 Do you intend to travel outside Australia or New Zealand for holiday or business purposes? No Yes If yes, please provide details:

Where	When	Duration

Personal statement

Insurance details

Q4 Other than this application, are you covered by, or are you applying for, life, disability, trauma, income insurance or business expenses insurance with **any company**? Note: this includes benefits under superannuation, business or credit insurance or benefits provided by an employer.

No Yes If yes, please provide details:

Name of company	Type of cover	Sum insured	Date commenced	To be replaced?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes

Important note: if this application for insurance is intended to replace the existing plan(s) listed in the table above, when the insurer notifies you that it has accepted your application for insurance, you must cancel such plan(s). If you do not cancel the existing plan(s) listed in the table above, any claim made by you to AXA for the insurance applied for and accepted may not be considered.

Q5 Has **any company** ever indicated they would not issue you insurance, or would apply a loading, modify, restrict or exclude your insurance in any way? No Yes If yes, please provide full details including reason, date, company name and type of cover:

Q6 In the last five years have you, or do you intend in the next 12 months, to claim unemployment benefits? No Yes

If yes, please provide details:

/ /

Benefit type Date

Q7 Have you ever, or do you intend to claim benefits under any insurance plan, government scheme, armed forces, pension or allowance, or court proceedings?

No Yes If yes, please provide details:

Company/benefit type	Reason	Benefit amount	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Personal habits

Q8 (a) Have you ever been a smoker or used any sort of tobacco products?

No ► Go to Q9

Yes ► What do you or did you use?

Cigarettes Tobacco pipes Cigars

Nicotine replacement products Other If other, please specify

On average, how many do you or did you smoke daily?

If you have stopped, when? month year

Q9 (a) How many standard drinks containing alcohol do you consume per week on average? standard glasses per week
[standard drink = 1 nip (30ml) spirits, 100ml wine, 10oz/285ml beer]

(b) Have you ever been advised by a health care professional to reduce your alcohol intake or seek alcohol treatment?

If yes, please advise your alcohol intake amount at the time, reason you were advised and details of any treatment:

Q10 Have you ever used recreational drugs or drugs not prescribed by a doctor? No Yes

If yes, please give details, including the type of drug and the date(s) used:

Personal statement

Your health details

'You' refers to the Person to be insured.

Doctor details

Q11 Please provide the details of the General Practitioner/medical centre you would normally consult for medical conditions or advice, including the details of your last consultation.

Name of General Practitioner/medical centre

Street number and name

Town/Suburb

State

Postcode

Phone number

Facsimile

How long have you been his/her patient?

years

**Date of last
consultation**

Reason

Result

Personal health history

Q12 (a) What is your: Height Weight

(b) Has your weight varied in the last 12 months? No Yes

If yes, please tick one of the following and provide the amount and the reason: Gain Loss

kg	
Amount	Reason

Q13 At any time in your life have you ever had, received advice for, or experienced symptoms of the following (even if you have not seen a doctor)?

- (a) No Yes **Back or neck disorder** including slipped disc, sciatica or whiplash
- (b) No Yes **Disorder or injury of the joints** including arthritis or gout (eg a disorder or injury of the ankle, elbow, hip, knee, wrist or shoulder)
- (c) No Yes Disorder or injury of the muscles, bones or limbs (eg fracture, tendonitis or tenosynovitis)
- (d) No Yes **Nervous disorder or mental illness** (eg depression, anxiety, stress, insomnia, post-natal depression or post traumatic stress disorder)
- (e) No Yes **Chronic fatigue or chronic pain syndrome**
- (f) No Yes Fibromyalgia, fibrositis or myalgia
- (g) No Yes Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury
- (h) No Yes Multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, paralysis or cerebral palsy
- (i) No Yes Epilepsy, fit or blackout, migraine or recurrent headaches
- (j) No Yes Any neurological complaint or disorder of the nervous system including dizziness, involuntary shaking, memory loss, weakness, loss of feeling, or tingling of limbs or face
- (k) No Yes **High blood pressure or raised cholesterol** (including being advised to take medication or have your levels monitored)
- (l) No Yes Heart condition including irregular heartbeat, heart murmur, heart disease or chest pain
- (m) No Yes Disorder of the blood including anaemia or haemophilia
- (n) No Yes **Asthma**
- (o) No Yes Bronchitis, sleep apnoea, pneumonia or any other lung, respiratory or breathing disorder
- (p) No Yes Disorder of the thyroid
- (q) No Yes Diabetes, sugar in the urine or raised blood sugar levels
- (r) No Yes Disorder of the kidney or bladder including blood or protein in the urine, urinary infections or kidney stones
- (s) No Yes Disorder of the digestive system, gall bladder, stomach, bowel or liver including hepatitis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, hernia or irritable bowel syndrome
- (t) No Yes Disorder of the eyes not corrected by glasses or contact lenses (eg iritis, glaucoma, optic neuritis, blurred or double vision)
- (u) No Yes Disorder of the ears or speech including hearing loss or tinnitus
- (v) No Yes Disorder of the skin including psoriasis, eczema or dermatitis
- (w) No Yes Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, melanoma or skin cancer or any malignant condition
- (x) No Yes **Cyst, skin lesion, growth, lump** (including breast lump), **mole or freckle** that has bled, become painful, changed colour or increased in size
- (y) No Yes Any sexually transmitted infection or disease

If you answered 'YES' to any of the items in Q13, please provide details in the table below, EXCEPT for any condition in bold text above for which you should complete the relevant section of Q21 instead. If you answered 'NO' to all items, go to Q14.

Item no. eg (f)	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery %
<input type="text"/>	/ /	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	%
<input type="text"/>	/ /	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	%
<input type="text"/>	/ /	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	%
<input type="text"/>	/ /	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	%
<input type="text"/>	/ /	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	%

Personal statement

To be completed by the person to be insured.

Q14 At any time in your life have you ever had, received advice for, or experienced symptoms of the following (even if you have not seen a doctor)?

Males only

(a) No Yes Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine or undescended testicle?

Females only

(b) No Yes Are you currently pregnant? If yes, please advise expected delivery date

(c) No Yes Have you ever had any complications with pregnancy or childbirth? If yes, please provide details below, including whether resolved after delivery.

(d) No Yes Have you ever had an abnormal breast ultrasound, mammogram or investigation?

(e) No Yes Have you ever had an abnormal cervical pap smear or biopsy of the cervix or uterus?

If you answered 'YES' to any of the items in Q14, please provide details in the table below.

Item no. eg (b)	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery %
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> %
		<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> %
		<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> %
		<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>		

Q15 Other than what you have already told us in this application, have you in the last **five years** (not including colds or flu):

(a) No Yes Attended any other medical appointment (eg counselling), or had any other test (eg xray, blood, genetic) with any other doctors, medical centres or health care professionals, including chiropractors, physiotherapists, naturopaths, osteopaths, podiatrists or herbalists?

(b) No Yes Used or currently using any medication, prescribed or unprescribed (taken by mouth, injections, inhaled spray, cream, ointment) or had any treatment for any symptoms, sickness, injury or medical condition?

(c) No Yes Had any sickness, symptom or injury that prevented you from performing any of the duties of your usual occupation for more than three consecutive days?

If you answered 'Yes' to any of the items above, please provide details in the table below.

Item no. eg (b)	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Date treatment or medication ceased (if applicable)	Time off work	Degree of recovery %
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> %
		<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>			
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> %
		<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>			
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> %
		<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>			

Q16 Other than what you have already told us in this application:

(a) Have you ever been admitted to hospital for any reason? No Yes

(b) Are you experiencing any symptoms or complaints for which you have not consulted a doctor? No Yes

(c) Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery? No Yes

If you answered 'Yes' to Q16 (a), (b) or (c) above please provide details:

Personal statement

To be completed by the person to be insured.

- Q17** (a) Have you or any of your current or previous sexual partners tested positive for HIV/AIDS, or have any sign of HIV infection (eg some signs of HIV/AIDS are: unexplained weight loss, swollen glands or persistent diarrhoea)? No Yes
- (b) In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? No Yes

Note – HIV risk situations include but are not limited to:

- sex with or as a prostitute
- sex with an intravenous drug user
- contact with someone else’s blood (eg through injection or scratch with a used needle)
- anal intercourse (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years).

(If you answered ‘Yes’ to any part of Q17 we will send you a confidential questionnaire to complete).

Family history

- Q18** Have any of your parents, brothers or sisters suffered from heart disease, stroke, high blood pressure, diabetes, breast cancer, bowel cancer, other cancer, polycystic kidney disease, Huntington’s Chorea, inherited blood disease, inherited brain disease, kidney failure, muscular dystrophy, or any other inherited disease? No Yes

If yes, please provide details in the table below:

Direct family member (please state their relationship to you but not their name)	Condition/illness (for cancer or heart disease, please specify the type)	Age at onset (approx.)	Age at death (if applicable)

Sports and pastimes details

- Q19** Have you in the last 12 months, do you currently, or do you intend to take part in any of the following activities?

- (a) No Yes **Aviation (other than a fare paying passenger on a licensed public service)**
- (b) No Yes **Motor racing (including car, bike and boat)**
- (c) No Yes **Underwater diving**
- (d) No Yes Football
- (e) No Yes Motor bike riding, including trail bike riding and commuting (please specify below)
- (f) No Yes Any other hazardous activity, pursuit or sport not previously disclosed (including, but not limited to: rock climbing, hang-gliding, ocean racing, martial arts, horse riding, or any other motor sports)

If you answered ‘YES’ to items (d), (e) or (f), please provide details of each activity in the table below. For any activity in bold text above please complete the relevant section of Q20. If you answered ‘NO’ to all items above, go to Q21.

Item no. eg (f)	Activity, sport and location	Other details (including remuneration received)	No. events/ hours per year	Amateur/ Professional?	Competitive/ Non-competitive?
				<input type="checkbox"/> Amateur	<input type="checkbox"/> Competitive
				<input type="checkbox"/> Professional	<input type="checkbox"/> Non-competitive
				<input type="checkbox"/> Amateur	<input type="checkbox"/> Competitive
				<input type="checkbox"/> Professional	<input type="checkbox"/> Non-competitive
				<input type="checkbox"/> Amateur	<input type="checkbox"/> Competitive
				<input type="checkbox"/> Professional	<input type="checkbox"/> Non-competitive
				<input type="checkbox"/> Amateur	<input type="checkbox"/> Competitive
				<input type="checkbox"/> Professional	<input type="checkbox"/> Non-competitive

Q20 Detailed sports and pastimes questionnaires

► Only complete the relevant sections of this question if you answered 'Yes' to Q19 (a), (b) or (c) above.

(a) Aviation questionnaire

- 1 Do you hold a Department of Transport licence to fly aircraft? No Yes If yes, please state type of licence and period held:
- 2 Do you intend to change the scope of your present licence? No Yes If yes, please provide details:
- 3 Have you ever had an accident or been charged with violating civil aviation regulations? No Yes If yes, please provide details:
- 4 Do you always use recognised Department of Transport airfields? No If no, please provide details below: Yes
- 5 Please provide details of the type(s) of aviation you are involved in (eg commercial, private, agricultural, aero club, helicopter, ultralight aircraft, aerobatics):
- 6 Please provide details of the number of hours flown:
 (i) in total as a pilot
 (ii) in the last 12 months
 (iii) expected each year in the future
- 7 Do you intend to engage in any form of aviation other than the above? (eg ballooning, paragliding) No Yes
 If yes, please provide details:

(b) Motor racing questionnaire

- 1 What type(s) of motor sports activities do you participate in (eg circuit racing, drag racing, formula racing, karting, rallies, speedway, stock car racing, time trials)?
- 2 What type(s) of motor vehicles do you drive or crew? Please state the make, model, year of manufacture, engine size, category, group and class details:
- 3 Please state the nature of your participation:
 Recreational Competitive Sponsored Amateur Professional
- 4 Number of events you participate in: Last 12 months Next 12 months (expected)
- 5 Where have you, or do you intend to compete or race? Please provide the name of all organised events:
- 6 What maximum speeds do you reach?
- 7 Please provide details of your licences/certifications and memberships attained:

Licence/certification or membership details	When attained/joined
<input style="width: 100%;" type="text"/>	
<input style="width: 100%;" type="text"/>	
- 8 Have you ever had your licence restricted or suspended for any reason? No Yes If yes, please provide details:

Q20 Detailed sports and pastimes questionnaires continued

(c) Underwater diving questionnaire

- 1 What type of diving activities do you participate in (eg snorkelling, scuba diving, free diving)?
- 2 What diving certification do you hold?
- 3 Average depth you dive to metres
- 4 Maximum depth you dive to metres
- 5 Number of times you dive per year
- 6 Professional Amateur
- 7 Do your diving activities include pothole, cave or sink hole diving, wreck exploration or any other hazardous diving?
 No Yes If yes, please provide details, including how often:
- 8 Do you ever dive alone? No Yes If yes, please provide details, including where and how often:
- 9 Have you ever had a diving accident or sickness? No Yes If yes, please provide details:
- 10 Do you dive at night? No Yes If yes, please provide details:

Q21 Detailed health questionnaires

► Only complete the relevant health questionnaires, if you answered 'Yes' to any items in bold text in Q13.

(a) Back or neck disorder

- 1 Neck disorder Back disorder - please clarify which part of the back is/was painful (eg upper, lower, middle, neck):
- 2 What was the cause of the disorder (eg accident, arthritis, osteoporosis)?
- 3 (a) When did you **first** experience symptoms?
- (b) When did you **last** have any symptoms?
Please describe symptoms fully, including details of any radiation of pain down either the legs or arms:
- (c) On average, how long does each episode last?
- 4 Have you had any recurrence of this disorder? No Yes
If yes, when and how often? (please include the number of recurrences, the causes and how long they lasted):
- 5 How long, if at all, have you been symptom free?
- 6 How many times have you been absent from work or unable to perform your normal daily activities?

(a) Back or neck disorder continued on next page ►

Q21 Detailed health questionnaires continued

(a) Back or neck disorder continued

7 Are you currently able to do your work or perform your normal activities without any restriction, stress or discomfort?

No Yes If yes, please provide details:

Two empty text boxes for providing details.

8 (a) Are you currently receiving treatment? No Yes

(b) What is or was the nature of the treatment? Please include details of any medication, physical therapy or surgery:

Two empty text boxes for providing details of treatment.

9 Have you had any investigations such as an X-Ray, CT Scan or MRI? No Yes If yes, what were the results?

One empty text box for providing results of investigations.

10 Please provide names and addresses of all doctors and health care professionals consulted in relation to your back or neck disorder and approximate dates of consultations:

Two empty text boxes for providing names and addresses of professionals.

(b) Disorder or injury of the joints questionnaire

1 What is the name of your disorder or injury?

One empty text box for the name of the disorder or injury.

2 Please state which joints are or were affected, including whether left or right:

One empty text box for stating affected joints.

3 Please describe symptoms fully:

Two empty text boxes for describing symptoms.

4 When did you **first** experience symptoms of this disorder or injury?

Small date input box with slashes for first experience.

5 When did you **last** experience symptoms of this disorder or injury?

Small date input box with slashes for last experience.

6 What was the cause of the disorder or injury?

One empty text box for stating the cause.

7 Have you had any treatment for your disorder or injury? No Yes

If yes, please provide details (eg medication, surgery, plates or screws inserted/removed, arthroscopy, physiotherapy, injection):

Two empty text boxes for providing treatment details.

8 Are you currently receiving treatment or is any treatment expected in the future? No Yes If yes, please provide details:

One empty text box for providing current or future treatment details.

9 Have you had any recurrence of this disorder? No Yes If yes, when and under what circumstances?

One empty text box for providing recurrence details.

10 Please provide names and addresses of all doctors and health care professionals consulted in relation to your joint disorder or injury and the approximate dates of consultations:

Three empty text boxes for providing names and addresses of professionals.

11 Have you ever taken time off work or been unable to perform your normal daily activities because of this disorder or injury?

No Yes If yes, please provide details:

One empty text box for providing details of time off work.

Q21 Detailed health questionnaires continued

(c) Nervous disorder, mental illness, depression, anxiety, chronic fatigue, chronic pain questionnaire

1 Have you ever suffered from, or had treatment for, or been diagnosed with any of the following? Please tick.

- Stress Anxiety Obsessive compulsive disorder
- Depression Fears or phobias Chronic pain
- Inability to sleep Chronic fatigue Other – please specify:

[Empty text box for specifying other symptoms]

2 What was the cause of your symptoms?

[Empty text box for cause of symptoms]

3 Please describe your symptoms fully:

[Empty text box for describing symptoms]

[Empty text box for describing symptoms]

4 (a) What was the date of the first symptom?

[Date input box: / /]

(b) What was the date of the last symptom?

[Date input box: / /]

5 Did you have more than one episode of symptoms? No Yes If yes, please provide full details, including number of recurrences:

[Empty text box for details of recurrences]

[Empty text box for details of recurrences]

6 Please provide details of the treatment you have received for this condition (eg treatment with tranquillisers or other drugs, counselling, psychotherapy or surgery):

[Empty text box for treatment details]

[Empty text box for treatment details]

7 Have you ceased treatment? No Yes

If no, and treatment is ongoing, please provide details (eg dosage and type of medication, counselling):

[Empty text box for ongoing treatment details]

[Empty text box for ongoing treatment details]

If yes, please provide a date and whether or not this was at the direction of your doctor:

[Empty text box for date and doctor direction]

[Empty text box for date and doctor direction]

8 Have you ever been an inpatient at a hospital or clinic?

No Yes If yes, please provide details including number of times, dates and hospital/clinic name:

[Empty text box for inpatient details]

[Empty text box for inpatient details]

9 Have you ever thought about, or tried to deliberately harm yourself or take your own life?

No Yes I would like to provide my answer confidentially (we will contact you to discuss)

If yes, please provide details:

[Empty text box for self-harm details]

[Empty text box for self-harm details]

10 Have you ever taken time off work or been unable to perform your normal daily activities because of your symptoms?

No Yes If yes, please provide details, including dates:

[Empty text box for work/activities details]

[Empty text box for work/activities details]

(c) Nervous disorder, mental illness, depression, anxiety, chronic fatigue, chronic pain questionnaire continued on next page ►

Q21 Detailed health questionnaires continued

(c) Nervous disorder, mental illness, depression, anxiety, chronic fatigue, chronic pain questionnaire continued

11 Are you currently able to do your work or perform your normal daily activities without any restriction, stress or discomfort?

No If no, please provide details: Yes

12 (a) Name of doctor or health professional **last** consulted for this disorder and the date of the **last** consultation:

(b) Please provide names and addresses of any other doctors or health care professionals consulted for this condition, including approximate dates of consultations:

(d) High blood pressure or raised cholesterol questionnaire

1 Please indicate which of the following have been raised/high: Blood Pressure Cholesterol Both

2 (a) When did you first find that your readings/levels were raised or were you advised to have your reading/levels monitored or noted?

(b) What was your reading/level at the time noted in 2(a)?

Blood pressure / Cholesterol /

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

Blood pressure / Date / /

Cholesterol reading / Date / /

(b) Is the reading above consistent with others when checked? No Yes

If no, what is a typical reading?

4 How often are you required to see your doctor for reviews/check-ups?

Monthly Quarterly Twice yearly Annually Other - details:

5 When is your next check-up due?

 / /

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

No - go to question 8 Yes, please provide the name of any medication you take and the daily dosage

Condition	Medication	Daily dosage
Blood pressure		
Cholesterol		

7 Has your treatment type or dosage changed within the last 12 months?

No - go to question 9 Yes, please provide the details below and continue to question 9:

When was it changed?	What was changed?	Why was it changed?

8 Have you ever been prescribed medication for blood pressure/cholesterol? No Yes

If no, how has the condition been managed?

If yes, when and why have you ceased taking this medication?

(d) High blood pressure or raised cholesterol questionnaire continued on next page ►

Q21 Detailed health questionnaires continued

(d) High blood pressure or raised cholesterol questionnaire continued

9 Have you undergone or been referred for any other investigations (eg resting or exercise ECG, 24hr holter monitor, urinalysis, echocardiogram)?

No Yes If yes, please provide details:

[Text input box]

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

No Yes If yes, please provide details:

[Text input box]

(e) Asthma questionnaire

1 When was your asthma diagnosed?

[Date input box: / /]

2 When did you first have symptoms?

[Date input box: / /]

3 When did you last have symptoms?

[Date input box: / /]

4 Approximately how many times per year do you or did you get symptoms?

[Number input box]

5 Does the environment in which you work or perform your normal daily duties, exacerbate or cause your symptoms of asthma (eg dust, sawdust, pollen, grass)?

No Yes If yes, please provide details:

[Text input box]

6 In the last 12 months have you taken time off work or been unable to perform your normal daily activities because of your asthma?

No Yes If yes, please provide details including the number of times and days:

[Text input box]

[Text input box]

7 Please provide details of the treatment for your asthma, including dosage of drugs taken and frequency (eg aerosol spray, tablets or injections, amounts and number of times per day):

[Text input box]

[Text input box]

[Text input box]

8 Have you ever been treated for your asthma with steroids (eg Prednisone)?

No Yes If yes, please provide details, including dates:

[Text input box]

[Text input box]

9 Have you ever attended a hospital emergency room or been admitted to hospital because of your asthma?

No Yes If yes, please provide details:

[Text input box]

[Text input box]

10 In the last three years, have you had or been advised to have a chest X-Ray or respiratory function test?

No Yes If yes, please provide dates and results:

[Text input box]

(e) Asthma questionnaire continued on next page ►

Q21 Detailed health questionnaires continued

(e) Asthma questionnaire continued

11. Have you ever had any complications or other conditions related to your asthma (eg cardiac or respiratory arrest, heart disease, chest deformities)?

No Yes If yes, please provide details:

12 (a) Please provide details of the doctor who you consult for your asthma:

(b) When did you **last** consult this doctor for asthma?

(f) Cyst, skin lesion, growth, lump, mole or freckle questionnaire

1 Please indicate the condition(s) you have had, or received treatment for, the number, the site and the date diagnosed:

Condition	Number	Site	Date diagnosed
Basal cell carcinoma (BCC)	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Hyperkeratosis or solar keratosis	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Melanoma	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Mole or naevi	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Sebaceous (fatty) cyst	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Squamous cell carcinoma (SCC)	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Other, please specify:	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

2 For each cyst, mole, growth, lump or skin lesion disclosed above, please advise if removed.

If removed, please provide date and method (ie by surgery, freezing or otherwise):

If not removed, please provide reason why it was not removed:

3 Were any special tests, investigations or treatment required? No Yes If yes, please provide details:

4 Please advise the results of any laboratory testing: Malignant Benign Do not know

5 Do you have, or are able to obtain a copy of the laboratory testing results?

No Yes If yes, please attach a copy of these results.

6 Have you been or are you required to attend any further treatment or follow-up since the original cyst, mole or skin lesion was removed?

No Yes If yes, please provide details of date(s) and what was advised:

7 Did you consult a doctor other than your usual doctor as disclosed in Q11?

No Yes If yes, please provide full details:

Occupation details

ONLY to be completed by the Person to be insured if applying for: Total and Permanent Disablement, Total but Temporary Disablement or Salary Continuance insurance.

If you are applying for Death only cover ► Go to page 19

'You' refers to the Person to be insured (unless otherwise indicated).

Q22 Please give details of your current and previous occupation or jobs over the last five years. If you have a second occupation, please give details in Q31 below.

	From	To	Occupation	Employer	Tick which is applicable				
					Employed by own company	Self-employed	Partnership	Employee	Contractor
Current principal occupation	/ /	Present			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous occupation	/ /	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous occupation	/ /	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous occupation	/ /	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q23 In the last five years have you, or do you intend to, cease working for reasons other than holidays (eg unemployment or end of contract)?

No Yes If yes, please provide details:

Q24 How many hours per week do you spend working at your main occupation? hours

Q25 How many weeks per year do you spend working at your main occupation? weeks per year

Q26 In your **main** occupation, what percentage of time do you spend performing the following types of duties:

	Describe details of specific duties performed	
Sedentary/Administrative	<input type="text"/>	<input type="text" value=""/> %
Supervising manual work	<input type="text"/>	<input type="text" value=""/> %
Light manual	<input type="text"/>	<input type="text" value=""/> %
Heavy manual	<input type="text"/>	<input type="text" value=""/> %
Home duties (include details of dependants including ages and any other relevant information)	<input type="text"/>	<input type="text" value=""/> %
Other (including hazardous duties, eg handling dangerous substances, working at heights)	<input type="text"/>	<input type="text" value=""/> %
Total duties		100%

Q27 (a) What qualifications do you hold in relation to your main occupation (eg trade certificate, degree)?

(b) When did you qualify/graduate / /

(c) Please give details of any other qualifications you hold:

Q28 Do you ever work from home? No Yes

If yes, provide details of actual work you perform at home, your work set-up (eg separate office) and frequency and type of contact with clients:

Q29 Do you intend to change your occupation or employment status? No Yes If yes, please provide details below:

Q30 Have you or any business with which you have been associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration?

No Yes If yes, (a) when / / (b) date of discharge / /

Q31 Do you have any other occupations or jobs? No Yes If yes, please provide details below including specific duties:

Q32 Number of hours per week worked and annual income derived from your other occupation or jobs: hours \$

Personal statement

Income details

Q33 Insurable income

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, we may call for evidence of your income and business expenses.

- ▶ **If you are self-employed, in a partnership or an employee of your own company (or contractor), please complete the 'For self-employed' section on page 18**
- ▶ **If you are an employee, please complete the 'For employees' section below**

For employees

- ▶ **Only complete this section if you are an employee and do not have any ownership in your employer's business.**

(j) Please indicate your current employment status:

- Permanent full time
- Permanent part time
- Casual or non-permanent
- Not currently employed

Other, please specify:

(k) Please give details of your total remuneration package from all sources currently and for the last two financial years.

Please include any additional benefits (eg pre-tax superannuation guarantee contributions, regular bonuses and commissions, fringe benefits):

Current remuneration	Last financial year	Previous financial year	
\$ <input style="width: 100%;" type="text"/>	30 / 6 / <input style="width: 100%;" type="text"/>	\$ <input style="width: 100%;" type="text"/>	30 / 6 / <input style="width: 100%;" type="text"/>

(l) If you have applied for Income Insurance, did you include superannuation guarantee contributions in the calculation of the Monthly Benefit?

- No Yes If yes, how much? \$ (Maximum is 9 per cent of gross income. This amount will be allocated to a complying Superannuation Fund in the event of a claim.)

(m) Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)?

- No Yes If yes, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax
<input style="width: 95%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>
<input style="width: 95%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>
<input style="width: 95%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>
<input style="width: 95%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>

(n) If you were to become disabled, would any of your income (including investment income) continue? No Yes If yes, please answer (i) and (ii):

(i) What is the income amount that would continue, for how long, and the source (eg salary, sick pay, company profits, investments, rental)?

(ii) Is there an agreement in place (written or otherwise) that determines when this entitlement will cease? No Yes, please provide details:

(o) Will you be providing supporting financial evidence with this application? No Yes

ONLY to be completed by the Person to be insured if applying for: Total and Permanent Disablement, Total but Temporary Disablement or Salary Continuance insurance.

What is Insurable income?
 This is income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will stop if you are unable to work. It does not include investment or interest income.

Personal statement

Q33 Insurable income continued

For self-employed

► Only complete this section if you are self-employed. This includes sole traders, partners, contractors or if you are an employee in your own company.

(a) Please provide your company's business income details in the table below for the last two financial years for which tax returns, assessment notices and accounts are available. Do not include any amounts paid to you which are paid from past profits, capital or loans.

Year ending	Gross income for entire business	Less all expenses incurred in earning that income	Equals net business income before tax	Your share of net business income	Wages/salary/super drawings/director's fees paid to you	Your total income
30 / 6 /	\$	\$	\$	\$	\$	\$
30 / 6 /	\$	\$	\$	\$	\$	\$

(b) If you have applied for income insurance, did you include superannuation guarantee contributions in the calculation of the Monthly Benefit?
 No Yes If yes, how much? \$ (Maximum is 9 per cent of insurable income. This amount will be allocated to a complying Superannuation Fund in the event of a claim.)

(c) What percentage of the business do you own? %
 If not 100 per cent owner, please provide percentage ownership and roles/duties of the other owners. Please include details of any income splitting arrangements.

(d) How many people do you employ?
 (e) What proportion of total business income is from your personal exertion? %

(f) Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)?
 No Yes If yes, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax
	\$
	\$
	\$
	\$

(g) If you were to become disabled, would any of your income (eg investment income and trail/renewal commission) continue?
 No Yes If yes, please provide the following details:

(i) What type and amount of income would continue if you were not working?

(ii) Is there an agreement in place (written or otherwise) in relation to this entitlement and when it may cease?
 No Yes If yes, please provide further details:

(h) Has your business had a net operating loss over either of the last two financial years? No Yes
 If yes, please provide copies of your full company accounts for the last two financial years, including any associated entities.

(i) So far this financial year, is your business trading profitably? No - please provide details in the space below: Yes

(j) What percentage of your work is on a contract basis? %
 Please provide contract details, including duration of contract and hourly rates of pay:

(k) Will you be providing financial evidence? No Yes

Medical and financial authorities

Medical authorities

Please complete ALL medical authorities below because some health professionals prefer an original signature.

Authority to release medical information to AXA

I, [Family name] [Given name(s)] [Date of birth] authorise any medical practitioner, doctor, health professional, hospital, clinic or any other insurer to disclose to the insurer (NMLA trading as AXA and its group of companies), or representatives appointed to collect, the full details of my health and medical history. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

[X] [Signature of Person to be insured] [Date]

Authority for AXA to release medical information to usual doctor

Only complete this section if you authorise AXA to release medical information to your doctor upon an adverse assessment of your application.

I, [Family name] [Given name(s)] [Date of birth] authorise NMLA trading as AXA to advise Doctor [Doctor] of the reason(s) behind any adverse assessment of my application if it was based on health evidence obtained during the assessment of this Application. I also authorise AXA to provide copies of the relevant health evidence to the doctor noted above.

[X] [Signature of Person to be insured] [Date]

Financial authority

Only complete this section if you want your accountant or financial adviser to release information to AXA.

Authority to release financial information to AXA

I, [Family name] [Given name(s)] [Date of birth] authorise my accountant/financial adviser to release to the insurer (NMLA trading as AXA and its group of companies), all information which the insurer requests for the purpose of assessing my Application for insurance. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

[X] [Signature of Person to be insured] [Date]

[Accountant/financial adviser name] ([) Accountant/financial adviser contact number(s)

[Accountant/financial adviser address]

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Personal statement

Duty of Disclosure

Insurance Contracts Act 1984

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 which is relevant to the insurer’s decision whether to accept the risk of insurance and if so, on what terms.

You have the same duty to disclose those matters to the insurer before you renew or extend, vary or reinstate a contract of life insurance. 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 its business, ought to know, or
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure (or make a misrepresentation to us) and the insurer would not have entered into the contract on any terms if you had complied with your duty of disclosure (or made no misrepresentation), the insurer may avoid the contract within three years of the commencement date. If your non-disclosure (or misrepresentation) 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 three years of the commencement date, 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.

Privacy – Use and disclosure of personal information

The privacy of your personal information is important to you and also to AXA. The purpose of collecting your information is to assess your application and manage your membership with the Fund.

If you are also applying for insurance cover, we will collect additional information about you and your immediate family background that is necessary for assessing your application for insurance, or any claim you may make, and for managing your cover. This includes information about health, financial situation, occupation and lifestyle. If the information you give us is not complete or accurate we may not be able to provide you with the products and services you have applied for.

In assessing your application, or any subsequent claim, and managing your super, AXA may disclose your personal information to government bodies as required by law (eg. the ATO), to individuals as required by law (eg under family law superannuation splitting arrangements) and to other parties, such as providers of retirement and savings products, a financial adviser, your employer, a policy committee (where applicable), an online web service provider, re-insurers, medical and financial professionals and judicial or dispute resolution bodies.

We will only use information about your nominated preferred dependant(s) or legal personal representative in the event of your death.

In the future, we may contact you about new products or special offers. If, at any time, you do not want to receive this information you can opt out by telephoning 133 056 and quoting your plan and member number.

We may provide a financial adviser of your current or former employer plan with information about your membership such as your contact details, account balance and insurance cover so that they can contact you to discuss other financial products and services. If you do not want us to provide your information to a financial adviser for this purpose, please contact us. We do not give your personal details to any other external parties for marketing purposes.

You are entitled to request reasonable access to information we have about you. We reserve the right to charge an administration fee for collating the information you request.

For a copy of our policy on privacy refer to axa.com.au or contact our Customer Service Centre on 133 056.

Declaration and consent

I understand that my employer or I have applied to the Trustee for the provision of insurance cover in respect of me through the Fund.

I have read the ‘Your Duty of Disclosure’ above and acknowledge that I have an obligation to reveal every matter that is relevant to AXA’s decision whether to accept the risk and if so on what terms.

I have checked the truth, accuracy and completeness of the answers in this form, and all statements in writing given in support of this application which shall, subject to the law, form the basis of the contract of insurance.

I understand that if any of my answers in this form are untrue, incomplete or inaccurate, the insurer may be entitled to avoid its liability under the insurance contract and this may result in a reduction in the benefits payable to me or my beneficiaries under the Fund.

I acknowledge that any change of material circumstances between the time the Trustee provides this statement to the insurer (AXA) and acceptance of the application for insurance by the insurer may entitle the insurer to cancel the arrangement under which insurance was to be provided.

I give AXA permission to seek any medical information needed in connection with this application or any policy issued as a result.

I have read and understood the Privacy Disclosure Statement contained above. I consent to my personal information being collected and used in accordance with the Privacy Disclosure Statement. I acknowledge that I can opt out from the use of that information for the purpose of direct marketing by telephoning 133 056.

Signature of member and life insured

Date