insurance

group insurance personal statement

this application form is effective 15 August 2011

redefining / insurance

Important information for applicants

Please read these instructions carefully before starting this Application

Your duty of disclosure

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 us every matter that you know, or could reasonably be expected to know, is relevant to our decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to us before you renew, 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 his 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 (or make a misrepresentation to us) and we would not have entered into the contract on any terms if you had complied with your duty of disclosure (or made no misrepresentation to us), we 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 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.

For members of superannuation funds

If the insurance you are applying for is offered under your superannuation fund, before you complete and sign this application form you should refer to the current Product Disclosure Statement (PDS) issued by the trustee of your superannuation fund.

The PDS contains important information to help you understand the product and to decide whether it is appropriate for your needs.

Privacy - Use and disclosure of personal information:

The privacy of your personal information is important to you and also to AXA Australia. We will collect only information about you and your immediate family background, that is necessary for the purposes of assessing your application for insurance, any claim you may make under the policy, and for managing the policy (including Group Insurance plans). Necessary information includes details 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 insurances you have applied for. In assessing your cover or any claim you may make, (including under Group Insurance plans), AXA Australia may need to disclose your personal information to other parties, such as re-insurers, claims assessors, medical professionals, policy intermediaries/advisers, the Policy Owner, judicial or dispute resolution bodies, and AXA Australia Group companies.

You are entitled to request reasonable access to information we have about you. AXA Australia reserves the right to charge an administration fee for collating the information you request. For AXA's policy on Privacy refer to **www.axa.com.au**.

Definitions in this Application

'**Person to be insured**' is the person whose life, health or income is to be insured under this Application. Most of the questions in this Application are about the Person to be insured.

'You' refers to the Person to be insured.

'We' refers to the underwriter, The National Mutual Life Association of Australasia Limited, trading as AXA and AC&L.

Intermediary and Adviser use only

The Application will only display the sections relevant to your answers.

What cover is the person applying for?

- ☐ Death only
- ☐ Death and Total and Permanent Disability (TPD)
- ☐ Group Salary Continuance (GSC)/Total but Temporary Disability (TTD)/ Income protection (IP)

Intermediary or adviser contact details

Name of company (ie the company you work for)

Contact name

Business phone number

Fax number

Email address

Member details

Plan/ Fund name (eg Larger Super Trust)

Sub plan/Employer plan name (if applicable)

Sub plan/ Employer plan number (if applicable)

Group Life/GSC plan number/s

GL

Member name

Member number

Sex ☐ Male ☐ Female

Benefit category/class

Reason for underwriting request (eg cover is over the automatic acceptance limit of $x per month for GSC)

Date of birth

Date joined company

Date joined fund

Annual Salary

$

Effective date of salary

Please complete cover details

Current death cover

Additional death cover requested

Total death cover

Current TPD cover

Additional TPD cover requested

Total TPD cover

Current salary continuance cover (per month)

Additional salary continuance cover requested (per month)

Total salary continuance cover (per month)

Additional information (eg any medical evidence included)

Personal details

Person to be insured

Title | Given name(s) | Family name | Previous name(s) (if applicable)

Gender ☐ Male ☐ Female | Marital status | Date of birth | Country of birth

Occupation title and the industry that the Person to be insured works in

Insurable income in last 12 months $ (Personal exertion income after expenses but before income tax)

Residential address of Person to be insured

Street number and name | Town/Suburb | State | Postcode | Country

Australia

Answer(s) to be provided by the Person to be insured.

Personal details

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.

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

Contact details for Person to be insured

IMPORTANT: Please refer to 'Important information for applicants' section for details of your Duty of Disclosure.

We may need to contact you between 8.00 am to 7.00 pm regarding the details of your application.

Daytime phone number ☐ Hours you can be contacted ☐

After hours phone number ☐ Hours you can be contacted ☐

Mobile phone number ☐ Hours you can be contacted ☐

Email address ☐

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

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?
				☐ No ☐ Yes
				☐ No ☐ 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.

Answer(s) to be provided by the Person to be insured.

Personal details

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.

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

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

Your health details

Answer(s) to be provided by the Person to be insured.

'You' refers to the Person to be insured.

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 or use daily? ______

If you have stopped, when? ______ month ______ year

(b) Have you ever been advised by a health care professional to reduce your smoking because of a medical condition? ☐ No ☐ Yes

If yes, please advise the name of the condition and any treatment received:

Condition	Treatment

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

______ standard glasses per week

(b) Have you ever been advised by a health care professional to reduce your alcohol intake or seek alcohol treatment? ☐ No ☐ Yes

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:

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

Your health details

Answer(s) to be provided by the Person to be insured.

'You' refers to the Person to be insured.

Personal health history

Q12 (a) What is your: Height ☐ (cm) Weight ☐ (kg)

(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 reason: ☐ Gain ☐ Loss

Amount ☐ (kgs)

Reason:

Your health details

Answer(s) to be provided by the Person to be insured.

'You' refers to the Person to be insured.

Personal health history

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 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

Note: 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 Q22 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 %	
					%	
					%	
					%	
					%	

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?

Your health details

Answer(s) to be provided by the Person to be insured.

'You' refers to the Person to be insured.

Note: 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 %
					%
					%
					%
					%

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 (e.g. counselling), or had any other test (eg xray, blood) 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 %
						%
						%
						%

Q16 Have you ever had, are you currently waiting for a result of, or are you considering having a genetic test? ☐ No ☐ Yes

Note: You do not have to provide a result if you were or are taking part in a medical research project or trial and haven't been or will not be provided with your individual result.

If yes, please provide full details:

Q17 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 from 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 Q17 (a), (b) or (c), please provide details:

Your health details

Answer(s) to be provided by the Person to be insured.

'You' refers to the Person to be insured.

Q18 (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 (for example, 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 the Q18 we will send you a confidential questionnaire to complete).

Family history/sports and pastimes details

Answer(s) to be provided by the Person to be insured.

Q19 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?

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

☐ 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)

Q20 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 Q21. If you answered 'NO' to all items above, go to Q22.

Item No. eg (f)	Activity/sport and location	Other details (including remuneration received)	No. events/ hours per year	Amateur/ Professional?	Competitive/ Non-competitive		
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive		
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive		
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive		

Sports and pastimes details

Answer(s) to be provided by the Person to be insured.

Q21 Detailed sports and pastimes questionnaires

▶ **Only complete the relevant sections of this question if you answered 'yes' to Question 20 (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

Sports and pastimes details

Answer(s) to be provided by the Person to be insured.

4 Number of events you participate in:

Last 12 months	Next 12 months (expected)

5 Where do 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

8 Have you ever had your licence restricted or suspended for any reason? ☐ No ☐ Yes If yes, please provide details:

(c) Underwater diving questionnaire

1 What type of diving activities do you participate in? (eg. snorkeling, scuba diving, free diving)

2 What diving certification do you hold?

3 Average depth you dive to metres

4 Maxmium 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 other hazardous diving? ☐ No ☐ Yes

If yes, please provide details, including how often:

8 Do you 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:

Answer(s) to be provided by the Person to be insured.

Q22 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 questionnaire

1 ☐ Neck disorder ☐ Back disorder - please clarify which area 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 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?

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

☐ No ☐ Yes If no, please provide 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:

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

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

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

Answer(s) to be provided by the Person to be insured.

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

(b) Disorder or injury of the joints questionnaire

1 What is the name of your disorder or injury?

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

3 Please describe symptoms fully:

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

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

6 What was the cause of the disorder or injury?

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):

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

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

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:

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

Answer(s) to be provided by the Person to be insured.

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

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

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

☐ Stress ☐ Anxiety ☐ Chronic fatigue ☐ Inability to sleep

☐ Depression ☐ Fears or phobias ☐ Chronic pain ☐ Obsessive compulsive disorder

☐ Other - please specify:

2 What was the cause of your symptoms?

3 Please describe your symptoms fully:

4 (a) What was the date of the **first** symptoms? / /

(b) What was the date of the **last** symptoms? / /

5 Did you have more than one episode of symptoms? ☐ No ☐ Yes

If yes, please provide full details, including the number of recurrences:

6 Please provide details and nature of treatment for this condition, (eg treatment with tranquillisers or other drugs, counselling, psychotherapy or surgery):

7 Have you ceased treatment? ☐ No ☐ Yes

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

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

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:

Answer(s) to be provided by the Person to be insured.

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

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:

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:

11 Are you currently able to do your work or perform your normal daily activities without any restriction, stress or discomfort? ☐ No ☐ Yes

If no, please provide details:

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

Answer(s) to be provided by the Person to be insured.

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

(d) High blood pressure/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 readings/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?

Answer(s) to be provided by the Person to be insured.

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

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

☐ No ☐ Yes - please provide details:

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

☐ No ☐ Yes If yes, please provide details:

Answer(s) to be provided by the Person to be insured.

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

(e) Asthma questionnaire

1 When was your asthma diagnosed? / /

2 When did you **first** have symptoms? / /

3 When did you **last** have symptoms? / /

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

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:

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:

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):

8 Have you ever been treated for your asthma with steroids (eg Prednisone)? ☐ No ☐ Yes If yes, provide details, including dates:

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:

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:

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? / /

Answer(s) to be provided by the Person to be insured.

Q22 Detailed health questionnaires

▶ **Only complete the relevant health questionnaires, if you answered 'yes' to any items in bold text in Q13.**

(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)			
Hyperkeratosis or solar keratosis			
Melanoma			
Mole or naevi			
Sebaceous (fatty) cyst			
Squamous cell carcinoma (SCC)			
Other, please specify:			

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 you 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 for 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

Do not complete the Occupation and Income Details sections if you are only applying for death cover.

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

Q23 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 Q32 below.

	From	To	Occupation	Employer	Tick which is applicable				
					Employed by own company	Self-employed	Partnership	Employee	Contractor
Current principal occupation		Present			☐	☐	☐	☐	☐
Previous occupation					☐	☐	☐	☐	☐
Previous occupation					☐	☐	☐	☐	☐

Q24 In the last five years have you ceased, 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

Q25 How many hours per week do you spend working in your main occupation? ______ hours

Q26 How many weeks per year do you spend working in your main occupation? ______ weeks per year

Q27 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		%
Supervising manual work		%
Light manual		%
Heavy manual		%
Home duties (include details of dependants including ages and any other relevant information)		%
Other (including hazardous duties, eg handling dangerous substances, working at heights)		%
Total duties		**100** %

Q28 (a) What qualifications do you hold in relation to your main occupation (eg trade certification, degree)?

(b) When did you qualify/graduate?

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

Q29 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:

Q30 Do you intend to change your occupation or employment status? ☐ No ☐ Yes If yes, please provide details below:

Occupation details

Do not complete the Occupation and Income Details sections if you are only applying for death cover.

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

Q31 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 / /

Q32 Do you have any other occupations or jobs? ☐ No ☐ Yes If yes, please provide details below including specific duties:

Q33 Number of hours per week worked and annual income derived from your other occupations or jobs hours $

Income details

Do not complete the Occupation and Income Details sections if you are only applying for death cover.

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.

Q34 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, please complete the 'For self-employed' section**
- ▶ **If you are an employee, please complete the 'For employees' section**

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 that 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
30/06/	$	$	$	$	$	$
30/06/	$	$	$	$	$	$

(b) 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.

(c) How many people do you employ?

(d) What proportion of total business income is from your personal exertion? ______ %

(e) 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
	$
	$

(f) 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:

Income details

Do not complete the Occupation and Income Details sections if you are only applying for death cover.

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.

Q34 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, please complete the 'For self-employed' section**
- ▶ **If you are an employee, please complete the 'For employees' section**

(g) 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.

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

Income details

Do not complete the Occupation and Income Details sections if you are only applying for death cover.

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.

Q34 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, please complete the 'For self-employed' section**
- ▶ **If you are an employee, please complete the 'For employees' section**

For employees

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

(i) Please indicate your current employment status

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

☐ Other, please specify:

(j) 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 superannuaton contributions, regular bonuses and commisions, fringe benefits):

Current remuneration	Last financial year		Previous financial year	
$	30 / 06 /	$	30 / 06 /	$

(k) 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
	$
	$

(l) If you become disabled, would any of your income (including investment income) continue? ☐ No ☐ 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

If yes, please provide details:

Medical authority

To be completed by the Person to be insured. **This application is effective from 15 August 2011.**

Authority to release medical information to AXA

I authorise my medical practitioner, doctor, health professional, hospital, clinic or other professional (such as a financial adviser or an accountant) to disclose any information that they may possess about me, whether held electronically, in hard copy or other format, that is related to:

- my application for insurance, or
- any claim made under a policy of insurance

to the insurer The National Mutual Life Association of Australiasia Ltd (also trading as NMLA, AXA and/or the AXA group of companies), or to its representatives who are appointed to collect the details of my health, medical history and any other information on its behalf. I agree that a photocopy (or similar copy) of this authorisation should be considered as if it was an original.

Signature of Person to be insured	Date signed
X	

Name

Declaration, consent and signatures

This application is effective from 15 August 2011

- **Duty of disclosure** - I acknowledge that I have read Your duty of disclosure notice set out in the 'Important information for applicants section' (Warning: you have a duty to disclose all information relevant to the insurer's decision to accept your Application.)
- **Truth and accuracy** - I declare that I have read and checked the truth, accuracy and completeness of the information either contained in the attached statements (whether written in my hand or provided by me for input into this electronic application), and that no information material to the insurance application has been withheld. I acknowledge and agree that any personal statements made or completed electronically together with any relevant documents shall form the basis of my membership in a group insurance policy. I have not given any further information relevant to the underwriting risks related to my insurance application to a financial adviser or to the insurer, which have not been included in the insurance application.
- **Electronic application** - I acknowledge and agree that my financial adviser or superannuation fund may submit my insurance application to AXA electronically.
- **Changes make contract void** - I agree that any change of material circumstances between the time of this Application and its acceptance which is not disclosed to the insurer may allow the insurer to avoid the contract of insurance.
- **Medical and financial information** - I give the insurer permission to seek any medical or financial information needed in connection with the Application or any plan issued as a result. I understand that if I withhold consent, AXA may not be able to provide the products and services requested.
- **Privacy** - I have read and understood the Privacy Disclosure Statement set out in the 'Important information for applicants' section. 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 1800 788 667.
- **Acceptance** - is subject to the insurer searching its records for any other business with the Person to be insured and the insurer may vary the terms of the plan to be issued on the basis of any information contained in its records.

Signature of Person to be insured

Family name	Given name(s)	Date of birth

Street number and name	Town/Suburb	State	Postcode

Signature	Date signed
X	

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The National Mutual Life Assocation of Australasia Limited
ABN 72 004 020 437 AFS Licence No. 234649
Registered Office: 750 Collins Street Docklands Victoria 3008

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