Application to increase insurance cover:
- Colonial Select Personal Superannuation
- Colonial (C-life & Pru) products
- Personal Superannuation Umbrella Investment Plans

Colonial Mutual Superannuation Pty Ltd ABN 56 006 831 983 AFSL 235025 (the 'Trustee')
The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFSL 235035 (the Insurer)

How to apply

1. Read the Duty of disclosure section carefully on page 2 of this application form.
2. Complete, sign and date all relevant sections of this Application Form.
3. Mail this Application Form to:
   For Colonial Select Personal Superannuation – Locked Bag 5075 Parramatta NSW 2124
   For Colonial (C-Life and Pru) products – GPO BOX 3306 Sydney NSW 2001
   For Personal Superannuation Umbrella Investment Plans – PO BOX 320 silverwater NSW 2128

Note: To enable your insurance premiums to continue to be paid from your account you must ensure at the time each insurance premium is to be deducted that there are sufficient funds in your account for this purpose.

Checklist for applicants

Personal Statement	Death, Total and Permanent Disablement (TPD) and Income Protection cover
Section A – Occupation and income details	☐
Section B – Habits	☐
Section C – Height and weight	☐
Section D – Doctor's details	☐
Section E – Insurance history details	☐
Section F – Family history details	☐
Section G – Medical history details	☐
Section H – Additional medical details	☐
Section I – Lifestyle	☐
Section J – Residence and travel details	☐
Section K – Pastimes and activities	☐
Section L – General health questionnaire	☐
Section M – Specific questionnaires	☐
Section N – Pastimes and activities questionnaires	☐

Declaration	Death, Total and Permanent Disablement (TPD) and Income Protection cover
Section O – General declaration	☐

Other requirements

- ☐ Read the Duty of disclosure (page 2)
- ☐ Read the Privacy Collection Statement (page 2)
- ☐ Sign the Medical authority (page 25)
- ☐ Sign the Customer contact authority (page 25)

Your duty of disclosure

When you apply for insurance cover within your superannuation plan, you are the life insured and the trustee of the superannuation plan is the owner of the life insurance contract.

Before a superannuation plan enters into, or increases cover under, a life insurance contract in respect of the life of a person (you), it has a duty to tell the insurer anything that it knows, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms.

The superannuation plan entering into the contract has this duty of disclosure until the insurance is provided.

The superannuation plan has the same duty before it extends, varies or reinstates the contract.

The superannuation plan does not need to tell the insurer anything that:

- reduces the risk of the insurance; or
- is common knowledge; or
- the insurer knows or should know as an insurer; or
- the insurer waives the duty to tell the insurer about.

If you as the person whose life is to be insured under the superannuation plan do not tell the insurer something that you know, or could reasonably be expected to know, may affect the insurer's decision to provide the insurance and on what terms, this may be treated as a failure by the superannuation plan to comply with its duty of disclosure.

If you or the superannuation plan do not tell the insurer something

In exercising the following rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If the insurer does, it may apply the following rights separately to each type of cover.

If you or the superannuation plan do not tell the insurer anything they are required to, and the insurer would not have provided the insurance if it had been told, the insurer may avoid the contract within 3 years of entering into it.

If the insurer chooses not to avoid the contract, it may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if the you and the superannuation plan had told the insurer everything they should have. However, if the contract has a surrender value or provides cover on death, the insurer may only exercise this right within 3 years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount of insurance provided, it may, at any time, vary the contract in a way that places the insurer in the same position it would have been in if you and the superannuation plan had told the insurer everything they should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If the failure to comply with the duty of disclosure is fraudulent, the insurer may refuse to pay a claim and treat the contract as if it never existed.

Privacy Collection Statement

The personal information we collect about you can include information such as your identity and contact detail, your gender, marital status and medical, lifestyle and financial information. We collect this information directly from you and from other sources such as service providers, agents, advisers, employers or family members and anyone that holds information relevant to the assessment of your claim and the administration of your policy.

We identify and verify the information you provide. We do this by collecting and verifying the information about you and persons who act on your behalf. The collection and verification of information helps to protect against identity theft, money-laundering and other illegal activities and enables us to verify the accuracy of information we are provided eg to verify with an employer the employment and remuneration information provided. We may disclose your personal information in carrying out verification.

Accuracy

It's important you provide us with accurate and complete information. If you don't, we may not be able to provide you with the service you are seeking.

How do we use your personal information

We collect, use and exchange your personal information so that we can:

- establish and verify your identity and assess applications for products and services
- price and design our products and services, conduct and improve our business and improve the customer experience
- administer our products and services and manage our relationship with you
- manage our risks and help identify and investigate illegal activity, such as fraud
- contact you, for example if we need to tell you something important
- conduct and improve our businesses and improve the customer experience
- comply with our legal obligations and assist government and law enforcement agencies or regulators
- identify and tell you about other products or services that we think may be of interest to you.

We may also collect, use and exchange you information in other ways as permitted by law. If you have given us your electronic contact details, we may use these details to provide information to you electronically, including for example, sending reminders via SMS or email.

Who do we exchange your information with

We may exchange your personal information with other members of the Commonwealth Bank group, so that the group may adopt an integrated approach to its customers. Group members may use this customer information in the same way we use your information (see **How do we use your personal information** above).

We may exchange your information with third parties where this is permitted by law or for any of the purposes we use your information.

Third parties include:

- your employer or former employers
- brokers, agents and advisers and persons acting on your behalf, for example guardians and persons holding power of attorney
- medical practitioners (to verify or clarify, health information you may provide or part of an independent assessment of your claim)
- claims-related providers such as assessors and investigators, insurance reference agencies, reinsurers, auditors and other insurers (to verify or clarify other claims made and assess and manage your claim)
- organisations to whom we may outsource certain functions (eg IT support)
- any one that we reasonably believe may hold information relevant to your claim or the policy
- government and law enforcement agencies or regulators
- entities established to help identify illegal activities and prevent fraud.

In all circumstances where our contractors, agents and outsourced providers become aware of customer information, confidentiality arrangements apply. Personal information may only be used by our agents, contractors and outsourced service providers for our purposes.

We may be required to disclose customer information by law, eg under Court Orders or Statutory Notices pursuant to taxation or social security laws or under laws relating to sanctions, anti-money laundering or counter terrorism financing.

Sending information overseas

From time to time we may send your information overseas, including to overseas Commonwealth Bank group members and to service providers or other third parties who operate or hold data outside Australia. Where we do this, we make sure that appropriate data handling and security arrangements are in place.

We may send information overseas to complete assessment of your claim or to manage your claim or where this is required by law and regulation of Australia or another country. Overseas parties can include reinsurers, medical or rehabilitation practitioners or other parties. Please note that Australian law may not apply to some of these entities. For more information on what countries your information may be sent to overseas, please refer to the Commonwealth Bank Group Privacy Policy which is available at commbank.com.au or upon request at any Commonwealth Bank Branch.

Access

You may (subject to permitted exceptions) access your information. Requests for access should firstly be directed to us. If necessary, we will send you the form you need to complete to access the information. We may charge you for providing access. For further information, please refer to the Commonwealth Banks Group Privacy Policy, which is available at commbank.com.au or upon request at any Commonwealth Bank Branch.

Making a privacy complaint

For more information on how to make a complaint and how we deal with your complaint, please refer to the Commonwealth Banks Group Privacy Policy, which is available at commbank.com.au or upon request at any Commonwealth Bank Branch.

Personal Details

Life insured

Policy / Account number

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname

Given name(s)

Postal address

State Postcode

Home address (PO Box is not acceptable)

State Postcode

Daytime phone number ( )

Evening phone number ( )

Mobile phone

Email address

Date of birth

Gender ☐ Male ☐ Female

Increased insurance cover application details

Please complete sums insured for the appropriate cover desired.

Type of cover	Sum insured	
Death	$	Minimum amount – $50,000 Maximum amount – No maximum
Total and Permanent Disablement (TPD)	$	Minimum amount – $50,000 Maximum amount – $1,000,000
Income Protection	$	Maximum amount – $10,000 per month

Please note: TPD cover can only be taken with Death cover and the amount of TPD cover cannot exceed the level of Death cover. You can apply for an increase to Death cover up to age 64, TPD cover up to age 54 and Income Protection cover up to age 54.

Personal Statement

You need to complete all sections of this Personal Statement as indicated.

Customer contact

Our underwriters are committed to assessing insurance applications as quickly as possible.
To do this, our underwriters or representatives may need to contact you directly to speed up the process.

Are you happy if we call/email you to clarify or gain further information?

Yes ☐ **Please complete below**

No ☐

Most convenient day to contact you:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any

Preferred method of contact		Preferred contact time (Monday to Friday 8am to 6pm)			
Home phone number	☐	from	am/pm	to	am/pm
Business phone number	☐	from	am/pm	to	am/pm
Mobile phone number	☐	from	am/pm	to	am/pm
Email address	☐				

Section A - Occupation and income details

1. What is the main occupation you are working in?

What industry do you work in?

2. What is your employer's name (or business name if self-employed)?

3. What is your actual business address (not a PO box)?

State Postcode

4. Does your main occupation involve performing in any of the following hazardous duties or environments?

Working at heights above 15 metres (for more than 10% of the time)	☐ Yes	☐ No
Working in armed forces or with fire arms	☐ Yes	☐ No
Working on oil or gas rigs/platforms	☐ Yes	☐ No
Working underground or handling explosives	☐ Yes	☐ No
Underwater diving	☐ Yes	☐ No

Please provide full details of the hazardous duty including but not limited to the percentage of time on the duty.

5. What is your employment status? (please tick (✔) the appropriate box)

☐ Self-employed (or employee of own company)*/Contractor ☐ Employed ☐ Unemployed

☐ Home duties ☐ Student ☐ Retired

***If 'Self-employed', please complete questions below, otherwise go to Q6.**

a. How long have you operated in this capacity?

Years Months

b. What are the number of hours you consistently work per week?

6. What is the nature of the work in your main occupation?

Note: the list below represents the physical nature of duties only.

Nature of duty	Percentage (%) time spent on each duty
Administration/clerical (e.g. filing, computer work, office duties)	%
Light manual work (e.g. deliveries, lifting under 5kg)	%
Supervision of manual work	%
Care of dependants/homemaker (only if TPD and occupation is home duties)	%
Manual work (e.g. cleaning, lifting over 5kg, carpentry, plumbing)	%
Total	**= 100%**

7. Do you work from home?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q8**

a. What percentage of your time is spent working from home?

%

b. What weekly percentage of time are you in face-to-face contact (i.e. other than by phone, fax or email) with your clients/employer?

%

c. Do you have the following in your business set-up?

Separate office	☐ Yes	☐ No
Separate entrance to place of residence	☐ Yes	☐ No
Separate business phone/fax	☐ Yes	☐ No

8. What is your current annual income* earned through personal exertion (excluding superannuation) from your main occupation (less all business expenses), but before tax?

$ p.a.

***Note:** current annual income excludes superannuation, but includes reportable fringe benefits you earned. If you are self-employed, current annual income also excludes all business expenses, but includes eligible payments to your spouse, share of depreciation, director's fees or share of profit from a trust or supporting service company.

Additional income details – Only complete if you are applying for an increase to your Income Protection insurance cover.

9. What is the percentage (%) of superannuation contribution (e.g. up to 15%)?

	%

10. What was your annual income earned through personal exertion, from your main occupation, less all business expenses, but before tax, over the last two financial years?

	Period		Annual income earned
Last financial year	**01/07/**	**– 30/06/**	$
Previous financial year	**01/07/**	**– 30/06/**	$

11. Do you receive other income from investments (e.g. interest, dividends, net rental income), which **exceeds 25%** of your current annual income?

Yes ☐ **Please complete below**

No ☐ **Go to Q12**

Please provide details of other income from investments	**Amount p.a.**
Dividends and interest	$
Net rental income	$
Other source of income (please specify):	$
Total	**$**

12. If you became disabled, would any part of your income continue beyond 30 days?

Yes ☐ **Please complete below**

No ☐ **Go to Q13**

Source of income (e.g. sick pay, pension, company profit, salary continuance insurance)	**Amount of income per month**	**How long would this continue?**	
	$	Years	Months
	$	Years	Months

13. Do you intend to change your occupation or duties, employment situation or take extended leave (e.g. sabbatical, maternity leave, paternity leave) in the next 12 months?

Yes ☐ **Please complete below**

No ☐ **Go to Q14**

Please provide details of change

14. In the last five years, have you been made bankrupt or placed in receivership or liquidation, or are you currently in the process of being assessed for bankruptcy or insolvency?

Yes ☐ **Please complete below**

No ☐ **Go to Section B - Habits**

a. Have you been discharged?

Yes ☐ **Please complete below**

No ☐ **Go to Section B - Habits**

b. How long ago were you discharged?

Years	Months

Section B – Habits

1. Have you smoked tobacco at any time during the last 12 months?

Yes ☐ **Please indicate type and amount smoked below**

No ☐ **Go to Q2**

Type smoked	Per day	Per week	Per month	Per year
Cigarettes ☐				
Cigars/Pipes ☐				

2. Do you drink alcohol?

Yes ☐ **Please indicate the average number of standard drinks* in only ONE of the below**

No ☐ **Go to Section C – Height and weight**

Per day	Per week	Per month	Per year

* A standard drink is equivalent to: one nip of spirits, one glass of wine, 250ml of beer.

Section C – Height and weight

What is your current height and weight?

Height	cm	**OR**	feet	inches
Weight	cm	**OR**	feet	inches

Section D – Doctor's details

1. Please provide the name and address of the last doctor or medical centre that you consulted.

Doctor's name or medical centre

Address

State Postcode

Phone number ( )

Fax number ( )

2. Have you been a patient of this doctor or medical centre for less than 12 months?

Yes ☐ **Please provide the name and address of your previous doctor or medical centre below**

No ☐ **Go to Section E – Insurance history details**

Doctor's name or medical centre

Address

State Postcode

Phone number ( )

Fax number ( )

Section E – Insurance history details

1. Other than this application, have you ever applied for, or are you currently applying for, any life, disability, trauma, accident or sickness insurance cover with CMLA or any other insurance company or under any superannuation scheme

Yes ☐ **Please complete below**

No ☐ **Go to Q2**

Insurer	Type of cover	Insured amount	Policy number (if known)	Date policy commenced	To be replaced by this cover*?
		$		/ /	☐ Yes ☐ No
		$		/ /	☐ Yes ☐ No
		$		/ /	☐ Yes ☐ No
		$		/ /	☐ Yes ☐ No

*** Important Note for Applicants/Policyowners: If it has been indicated above (i.e. by ticking 'Yes') that certain cover is to be replaced by the increased cover now being applied for, any increased cover CMLA issues is conditional on the other cover being cancelled before an insured event occurs under that cover. This means any increased cover CMLA issues does not apply until the other cover has been cancelled as required.**

2. Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?

Yes ☐ **Please complete below**

No ☐ **Go to Q3**

Insurer	Type of cover	Terms offered	Reason for terms	Date policy commenced
				/ /
				/ /

3. Are you **claiming** or have you **ever claimed** under legislation (e.g. Worker's Compensation, Disability Pension, Veterans' Affairs) or any other insurance policy **providing accident or sickness benefits** (including but not limited to disability, trauma insurance, insurance provided by a superannuation scheme, credit card insurance or travel insurance)?

Yes ☐ **Please complete below**

No ☐ **Go to Section F – Family history details**

Benefit type/Source	Reason for claim	Date claim made	Total claim amount	Date claim finalised
		/ /	$	/ / **OR** ongoing ☐
		/ /	$	/ / **OR** ongoing ☐

Section F – Family history details

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

To the best of your knowledge, have any of your natural parents, brothers or sisters suffered from or been diagnosed with any of the following:

Heart problems, cardiomyopathy, stroke, high blood pressure, diabetes Depression or any other mental illness or dementia/Alzheimer's Cancer of any type (specify type of cancer in table below e.g. breast or colon cancer) Huntington's disease, muscular dystrophy, multiple sclerosis, polycystic kidney disease or any other hereditary disease	☐ Yes ☐ No

If you answered 'Yes' please complete table below, otherwise go to Section G – Medical history details.

Family member	Condition	Approximate age diagnosed

Section G – Medical history details

1. Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following?

a.	**Asthma (except childhood), chronic bronchitis, emphysema, recurrent pneumonia** or any **other lung complaint**	☐ Yes	☐ No
b.	**Diabetes, gestational diabetes, insulin resistance** or **abnormal blood sugar**	☐ Yes	☐ No
c.	**Cysts, moles, sunspots, skin lesion** or **skin cancer**	☐ Yes	☐ No
d.	**Back, neck, shoulder, knee, elbow** complaints, sciatica, disc or spine complaints, injury or disorder of the joints, bones or muscles	☐ Yes	☐ No
e.	**Depression** or **mental illness** (including but not limited to stress, anxiety, panic attacks, behavioural disorders [attention deficit disorder, Asperger's syndrome], nervous disorders or schizophrenia/bipolar disorder]	☐ Yes	☐ No
f.	High blood pressure, raised cholesterol	☐ Yes	☐ No

If you have answered **'Yes' to any part of Q1 a to f above**, please complete the **Specific questionnaire** on the related condition in **Section M – Specific questionnaires on page 16-21**.

2. Have you ever had or sought advice or treatment for, experienced symptoms of or suffered from any of the following?

a.	Chest pains, heart complaint, cardiomyopathy, heart murmur, palpitations or rheumatic fever	☐ Yes	☐ No
b.	Stroke, paralysis, neurological disorder, multiple sclerosis, muscular dystrophy or blood vessel disorder	☐ Yes	☐ No
c.	Alzheimer's, Parkinson's, dementia or any other disorder of the brain	☐ Yes	☐ No
d.	Cancer, tumour or melanoma	☐ Yes	☐ No
e.	Thyroid, glandular, pituitary or pancreatic disorder	☐ Yes	☐ No
f.	Gastric or duodenal ulcer, persistent indigestion, gastro-oesophageal reflux disorder or Barrett's oesophagus	☐ Yes	☐ No
g.	Ulcerative colitis, Crohn's disease, colonic polyps, irritable bowel or any other bowel disorder	☐ Yes	☐ No
h.	Any disorder of the gall bladder or liver (including fatty liver/raised liver function tests)	☐ Yes	☐ No
i.	Varicose veins, haemorrhoids or hernia	☐ Yes	☐ No
j.	Disorder of the kidney, bladder, blood in urine, kidney stones or prostate (including raised prostate specific antigen (PSA)	☐ Yes	☐ No
k.	Epilepsy, fits of any kind, fainting episodes, dizziness, vertigo, recurring headaches or migraines	☐ Yes	☐ No
l.	Lethargy, sleep apnoea or any sleeping disorder including insomnia	☐ Yes	☐ No
m.	Arthritis (including osteo, rheumatoid or psoriatic), gout or osteoporosis/osteopenia	☐ Yes	☐ No
n.	Chronic fatigue syndrome, ongoing tiredness, fibromyalgia, repetitive strain injury or any other chronic pain syndrome	☐ Yes	☐ No
o.	Psoriasis, eczema, dermatitis or any other skin disorder	☐ Yes	☐ No
p.	Anaemia, leukaemia, haemophilia, deep vein thrombosis, pulmonary embolus, haemochromatosis or any other blood disorder (e.g. Factor V Leiden)	☐ Yes	☐ No
q.	Any impairment of sight including blurred vision (other than short or long sightedness), hearing including tinnitus, deafness and high frequency hearing loss or speech	☐ Yes	☐ No
r.	Any sexually transmitted diseases	☐ Yes	☐ No

If you have answered **'Yes' to any part of Q2 a to r above**, please complete the **General health questionnaire(s)** in **Section L on page 14 for each of these conditions**.

Section H – Additional medical details

1. In the last two years have you consulted a doctor or health professional for any other reason not already mentioned in Section G Q1 and 2 in this application (excluding minor ailments such as colds and flu and contraceptive medication)?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q2**

a. When was this consultation? (please tick (✔) the appropriate box)

☐ In the last 3 months ☐ 3–6 months ago ☐ 6–12 months ago ☐ 12–24 months ago

b. What was the condition/reason for the consultation?

c. What was the result/outcome of the consultation? (please tick (✔) **ONLY ONE** of the below)

- ☐ All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication
- ☐ Tests conducted – results pending
- ☐ Routine tests conducted – results all clear and normal
- ☐ Not fully recovered yet
- ☐ Referred to specialist/health professional
- ☐ Ongoing treatment/surveillance/on-going monitoring

2. In the next two years are you considering or been advised to seek medical advice, treatment or tests (other than for routine general health check-ups) or surgery in the future?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q3**

What is the reason for seeking advice, treatment, tests or surgery in the future?

3. Are you currently being tested for or have any signs or symptoms of ill health or disability not already mentioned in this application?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q4**

Please provide details of tests being conducted or symptoms

4. In the last 5 years, due to injury or illness, have you been off work for more than 5 consecutive days for any condition not already mentioned in this application?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q5**

Please provide details of the condition and the total time off work

5. Do you take or have you ever taken or been prescribed any medications on a regular or ongoing basis for any conditions not already mentioned in this application?

Yes ☐ ▶ **Please complete below**

No ☐ ▶ **Go to Q6**

Please provide details of the treatment or medication and the condition

6. Do you take or have you ever taken or been prescribed any medications on a regular or ongoing basis for any conditions not already mentioned in this application?

Yes ☐ ▶ **Please complete 'a' below**

No ☐ ▶ **Go to Q7**

Have you ever undergone screening for diseases or conditions such as, but not limited to, bowel cancer?

a. Were you advised to seek further medical follow-up or specific ongoing monitoring?

Yes ☐ ▶ **Please complete 'a' below**

No ☐ ▶ **Go to Q7**

Please provide details of the condition and follow up investigations

Section H – Additional medical details (continued)

7. Have you had a genetic test where you received (or are currently awaiting) an individual result, or are you considering having such a test?

Yes ☐ **Please complete below**

No ☐ **Go to Q8 – females only. Otherwise proceed to Section I – Lifestyle**

Note: where a genetic test has specifically been performed to assess your response to medication then the test does not need to be disclosed.

a. What is the reason for the genetic test? (please tick (✔) the appropriate box)

☐ Family member or relative have had a positive genetic test result

☐ Family member or relative have a condition linked to this genetic test

☐ My doctor recommended a referral for a genetic test

☐ Other (please specify reason)

b. What condition/disorder does this test relate to?

c. What was the result of the genetic test? (please tick (✔) the appropriate box)

☐ Have not been tested yet ☐ Positive (I have the gene) ☐ Negative (I do not have the gene) ☐ Unsure

Additonal questions (for female life to be insured only).

8. Have you had an abnormal pap smear?

Yes ☐ **Please complete below**

No ☐ **Go to Q9**

a. What type of abnormal pap smear did you have? (e.g. HPV CIN 1, CIN 2, CIN 3) (please tick (✔) the appropriate box)

☐ Atypia cells ☐ CIN 1 (low grade abnormality) ☐ CIN 2 (high grade abnormality)

☐ CIN 3 (high grade abnormality) ☐ Human Papilloma Virus (HPV) ☐ Not known

b. How long ago was this? (please tick (✔) the appropriate box)

☐ In the last 6 months ☐ 6-12 months ago ☐ 12-36 months ago ☐ 3-5 years ago ☐ More than 5 years ago

c. Have you successfully been treated for this condition? (e.g. colposcopy, cone biopsy, hysterectomy, laser or Lletz)

☐ Yes ☐ No

d. Were your last three pap smears normal and at least six months apart?

Yes ☐ **Go to Q9**

No ☐ **Please provide details below**

9. Have you ever had a breast lump, cyst or any other type of breast abnormality (even if you have not consulted a doctor) or an abnormal breast ultrasound or mammogram test result?

Yes ☐ **Please complete below**

No ☐ **Go to Q10**

a. How long ago was this? (please tick (✔) the appropriate box)

☐ In the last 6 months ☐ 6-12 months ago ☐ 12-36 months ago ☐ 3-5 years ago ☐ More than 5 years ago

b. What type of abnormal pap smear did you have? (e.g. HPV CIN 1, CIN 2, CIN 3) (please tick (✔) the appropriate box)

☐ Ultrasound ☐ Fine needle aspiration ☐ Mammogram ☐ Not investigated

☐ Other (please specify):

c. What was the result/outcome of your test? (please tick (✔) the appropriate box)

☐ Test conducted – results pending ☐ Test conducted – results all clear and normal

☐ Ongoing treatment/investigations ☐ Ongoing monitoring

d. Have you been advised by your doctor that this condition was due to cancer, tumour or abnormal cells?

☐ Yes ☐ No

10. Have you ever had or sought treatment for any condition of the ovaries, uterus, endometrium or perineum?

Yes ☐ **Please complete below**

No ☐ **Go to Q11**

Section H – Additional medical details (continued)

11. Are you currently pregnant?

Yes ☐ **Please complete below**

No ☐ **Go to Section I – Lifestyle**

a. How many weeks pregnant are you?

b. Do you or have you ever had any complications with pregnancy or childbirth (e.g. diabetes, pre-eclampsia, post natal depression) excluding elective caesarean or miscarriage within the first 15 weeks of pregnancy?

Yes ☐ **Please complete below**

No ☐ **Go to C**

Please tick (✔) the appropriate box

☐ Gestational diabetes ☐ Pre-eclampsia (high blood pressure) ☐ Post-natal depression

☐ Other (please specify):

c. Will you be returning to work in the same capacity as your current occupation (e.g. back to the same or greater hours) within or at the end of 12 months from the date you commence maternity leave?

Yes ☐ **Go to Section I – Lifestyle**

No ☐ **Please complete below**

Please provide details of any intended change in working status, occupation, hours, etc.

Section I – Lifestyle

1. In the last 10 years have you taken any illegal drugs?

Yes ☐ **Please complete below**

No ☐ **Go to Q2**

a. What type of drugs were they? (e.g. marijuana, ecstasy, speed, MDMA, GBH)

b. When did you start taking drugs?

/ /

c. When did you last take drugs?

/ /

2. In the last 10 years have you been advised to cease drinking alcohol or received counselling or treatment for alcohol or substance abuse?

Yes ☐ **Please complete below**

No ☐ **Go to Q3**

a.	I received counselling and/or treatment for the use of alcohol	☐ Yes	☐ No
b.	I received counselling and/or treatment for the use of drugs	☐ Yes	☐ No
c.	When did you start receiving counselling/treatment for the use of drugs or alcohol?	/ /	
d.	When did you last use drugs or drink alcohol?	/ /	

3. Have you ever been tested positive for HIV, Hepatitis B or Hepatitis C or are you awaiting the results of such a test?

Yes ☐ **Please complete below**

No ☐ **Go to Q4**

Please specify which condition you were tested positive for

4. **In the last 5 years have you had:**

a.	Anal intercourse without a condom (except in a relationship between you and one other person only where neither of you had sex with anyone else for at least 5 years)?	☐ Yes	☐ No
b.	Sex without a condom with someone you know or suspect to be HIV positive?	☐ Yes	☐ No
c.	Sex without a condom with anyone who injects non-prescribed drugs?	☐ Yes	☐ No
d.	Sex without a condom with a sex worker or as a sex worker?	☐ Yes	☐ No

If you have answered Yes to questions 4 a to d please provide details below. If you answered No to questions 4 a to d go to Section J.

Note: you may be asked to complete a confidential questionnaire.

Section J – Residence and travel details

1. Are you a permanent resident of Australia or New Zealand?

Yes ☐ **Go to Q2**

No ☐ **Please complete below**

a. What country did you migrate from?

b. What type of visa do you hold? (please tick (✔) the appropriate box)

☐ 457 (Temporary work (skilled) visa) ☐ Spouse's visa ☐ 418 (Education or Student visa)

☐ 419 (Visiting academic visa) ☐ Tourist visa ☐ 426 or 427 (Domestic staff visa)

☐ Other (please specify)

c. What type of visa do you hold? (please tick (✔) the appropriate box)

☐ Within 12 months ☐ 12-24 months ☐ More than 2 years

2. Have you lived in Australia for more than 2 years?

Yes ☐ **Go to Q3**

No ☐ **Please complete below**

Please provide details of the type of visa or status held previously (e.g. bridging visa, spouse visa, refugee status) and the country you migrated from

3. In the next 12 months, do you plan to travel, live or work in another country?

Yes ☐ **Please complete below**

No ☐ **Go to Section K – Pastimes and activities**

a. What country/ies do you plan to travel to?

b. What is the reason for travelling? (please tick (✔) the appropriate box)

☐ Holiday ☐ Business ☐ Residing

☐ Visiting family/relatives ☐ Studying ☐ Emigrating

c. How often do you intend to travel to this country/ies in the next 12 months? (Please enter the number of times below)

d. What is the total duration of your trip/s? (Please advise the number of weeks)

weeks

Section K – Pastimes and activities

1. Do you currently engage or intend to engage, through your occupation(s) or pastimes, in any of the following sports or hazardous activities?

a.	Flying (other than as a fare-paying passenger on a commercial airline) e.g. fixed wing, helicopter or ballooning	☐ Yes	☐ No
b.	Underwater diving	☐ Yes	☐ No
c.	Football of any code (excluding touch football and Oztag)	☐ Yes	☐ No
d.	Motorised sports of any kind e.g. motorcross, rally driving or motorbike racing, etc.	☐ Yes	☐ No
e.	Ocean racing, yachting, powerboat racing etc.	☐ Yes	☐ No
f.	Trail bike, quad bike or three-wheeler bike riding (including off road and dirt bike)	☐ Yes	☐ No
g.	Any other sport or hazardous activities e.g. body contact sports, parachuting, hang-gliding, competitive horse riding or cycling, abseiling, mountaineering or caving etc.	☐ Yes	☐ No
h.	Any sport played in a professional or semi-professional capacity	☐ Yes	☐ No

Note: if you have answered '**Yes**' to any part of Q1 a to h above, please complete the **Pastimes and activities Specific questionnaire(s)** on the related activity in **Section N on pages 22-24.**

Section L – General health questionnaires

General health questionnaire 1 (indicate the question you answered 'Yes' in Section G, Q2 a to r)

a. Illness/Injury/tests

b. Main symptoms or cause

c. Date commenced (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years
☐ 6-12 months ☐ 3-6 months ☐ 5-10 years
☐ 2-5 years

d. Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates

e. How long ago did the symptoms cease? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years
☐ 6-12 months ☐ 3-6 months ☐ 5-10 years
☐ 2-5 years

f. Did you require time off work for this condition?

☐ Yes ☐ No

g. If **Yes** how long have you had off work?

Days Weeks Months

h. What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i. Have you made a full recovery?

Yes ☐
No ☐ **Please provide details below**

j. Do you have any residual ongoing limitations?

Yes ☐ **Please provide details below**
No ☐

k. Does your usual GP have details of this condition?

Yes ☐
No ☐ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

General health questionnaire 2 (indicate the question you answered 'Yes' in Section G, Q2 a to r)

a. Illness/Injury/tests

b. Main symptoms or cause

c. Date commenced (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years
☐ 6-12 months ☐ 3-6 months ☐ 5-10 years
☐ 2-5 years

d. Was this episode (please tick (✔) the appropriate box)

☐ Single ☐ Recurrent ☐ Ongoing

If recurrent provide dates

e. How long ago did the symptoms cease? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ More than 10 years ☐ 1-2 years
☐ 6-12 months ☐ 3-6 months ☐ 5-10 years
☐ 2-5 years

f. Did you require time off work for this condition?

☐ Yes ☐ No

g. If **Yes** how long have you had off work?

Days Weeks Months

h. What treatment did you receive? (include medication, further tests, surgery, physio or referral to specialist)

i. Have you made a full recovery?

Yes ☐
No ☐ **Please provide details below**

j. Do you have any residual ongoing limitations?

Yes ☐ **Please provide details below**
No ☐

k. Does your usual GP have details of this condition?

Yes ☐
No ☐ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

Section M – Specific questionnaires

If you answered 'Yes' to:
Section G Q1a on page 9, then please complete **Asthma, bronchitis or any other lung complaint** questionnaire below
Section G Q1b on page 9, then please complete **Diabetes and abnormal blood sugar** questionnaire below
Section G Q1c on page 9, then please complete **Cysts/Moles/Sunspots/Skin lesions** questionnaire **on page 17**
Section G Q1d on page 9, then please complete **Joint/Musculoskeletal** questionnaire **on page 18**
Section G Q1e on page 9, then please complete **Mental health** questionnaire **on page 19**
Section G Q1f on page 9, then please complete **High blood pressure and raised cholesterol** questionnaire **on page 21**

1. Asthma, bronchitis or any other lung complaint questionnaire

a. Please tick (✔) the appropriate box

☐ Asthma ☐ Chronic bronchitis ☐ Recurrent pneumonia
☐ Emphysema ☐ Other (please specify)

b. Frequency of symptoms in the last 2 years? (please tick (✔) the appropriate box)

☐ Daily ☐ None – childhood only ☐ One-off episode
☐ Occasionally ☐ Weekly

c. Severity of symptoms? (please tick (✔) the appropriate box)

☐ Mild – Infrequent attacks, exercise induced or seasonal
☐ Moderate – Frequent symptoms, no specific triggers, occasional steroid therapy
☐ Severe – Very frequent attacks with almost constant wheezing, restriction of work duties and frequent use of oral steroids

d. In the last two years have you required hospitalisation or emergency treatment?

☐ Yes ☐ No

e. In the last two years have you required more than three prescriptions for oral steroids?

☐ Yes ☐ No

f. In the last 12 months has this caused you to have time off work?

Yes ☐ ▶ **Please complete below**
No ☐

Total number of days you had off work in the last 12 months?

g. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**
No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

2. Diabetes and abnormal blood sugar questionnaire

a Please tick (✔) the appropriate box

Gestational diabetes	☐ ▶ **Go to b**
Diabetes Type 1 – insulin dependent	☐ ▶ **Go to c**
Diabetes Type 2 – diet controlled, oral medication	☐ ▶ **Go to c**
Abnormal blood sugar	☐ ▶ **Go to c**
Insulin resistance	☐ ▶ **Go to c**

b. Have your blood sugar levels returned to normal after the delivery of your baby?

☐ Yes ☐ No

c. At what age were you diagnosed with this condition?

d. In the last 6 months, have you had an HbA1c (Glycosylated Haemoglobin) or Fasting Blood Sugar/glucose level test?

Yes ☐ **Please complete below**

No ☐

HbA1c (Glycosylated Haemoglobin) (please tick (✔) the appropriate box)

☐ Up to 6.0% ☐ 6.1% to 8.0%

☐ 8.1% or more ☐ Don't know

Fasting blood sugar (please tick (✔) the appropriate box)

☐ Up to 6.0% ☐ 6.1% to 8.0%

☐ 8.1% or more ☐ Don't know

e. As a result of your condition, have you ever experienced complications such as eye problems, numbness or tingling in your legs or feet, a diabetic or insulin coma?

Yes ☐ **Please complete below**

No ☐

Please specify the complication and the date this occurred

f. Is your treating doctor different from the last doctor you consulted?

Yes ☐ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

3. Cysts/Moles/Sunspots/Skin lesions questionnaire

a. Please tick (✔) the appropriate box

☐ Cyst/Mole ☐ BCC (Basal Cell Carcinoma) ☐ Dysplastic naevi

☐ Sunspot ☐ SCC (Squamous Cell Carcinoma) ☐ Melanoma

☐ Other

b. Location of growth(s) e.g. face, back, right arm

c. Date of treatment(s)

/ / / /

d. Have you been advised that your growth(s) or skin lesion(s) were cancerous or malignant?

☐ Yes ☐ No

e. How many growth(s) or skin lesion(s) did you have?

f. Have all your growth(s) or skin lesion(s) been removed or treated?

Yes ☐

No ☐ **Please complete below**

(i) How many were treated?

(ii) Why were they not all removed or treated?

g. Were any of your growth(s) or skin lesion(s) removed surgically, cut out or scraped off?

Yes ☐

No ☐ **Please complete below**

(i) How many?

h. Were any further tests, investigations, treatments, wider excisions or follow-ups recommended?

Yes ☐ **Please provide details below**

No ☐

i. What was the date of your last skin check?

/ /

j. What was the result of your last skin check?

k. Does your usual doctor have knowledge of this condition?

Yes ☐

No ☐ **Please complete below**

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

4. Joint/Musculoskeletal questionnaire

a. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone, dislocated shoulder

b. What part of the body was affected e.g. lower back, neck, left or right limb

c. Is the nature of the condition arthritic, degenerative or a disc problem?

☐ Yes ☐ No

d. Has this condition occured more than once?

Yes ☐ **Please complete below**

No ☐

How often has condition occured?

e. When did your symptoms first occur? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ 2-5 years ago ☐ 12-24 months ago

☐ 6-12 months ago ☐ 3-6 months ago ☐ more than 5 years ago

f. Has this condition caused you to lose time off work?

Yes ☐ **Please complete below**

No ☐

Total number of days you have had off work

g. Are you experiencing symptoms or have any residual restrictions or limitations to your work duties?

Yes ☐ **Please complete (i) below**

No ☐ **Please complete (ii) below**

(i) Please provide details of any symptoms, residual restrictions or limitations to your work duties

(ii) When did your symptoms cease? (please tick (✔) the appropriate box)

☐ Within the last 3 months ☐ 2-5 years ago ☐ 12-24 months ago

☐ 6-12 months ago ☐ 3-6 months ago ☐ more than 5 years ago

h. Is your treating doctor different from the last doctor you consulted?

Yes ☐ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

5. Mental health questionnaire

a. Are you currently suffering from, or have you previously experienced symptoms of or sought advice or treatment for any of the following:

Single episode of depression (including adjustment disorder, postnatal depression or grief reactions)	☐ Yes	☐ No
Chronic or recurrent depression	☐ Yes	☐ No
Stress (including acute stress reaction, work-related stress or adjustment disorder	☐ Yes	☐ No
Anxiety disorder(s) (including generalised anxiety, obsessive compulsive, phobic/panic anxiety, or Post Traumatic Stress)	☐ Yes	☐ No
Bipolar I or II disorder, or Cyclothymia	☐ Yes	☐ No
Schizophrenia or other psychotic disorder(s) (including drug-induced delusional disorder)	☐ Yes	☐ No
Eating disorder(s) (including anorexia nervosa or bulimia)	☐ Yes	☐ No
Attention Deficit Disorder (including ADD/ADHD)	☐ Yes	☐ No

Other (please specify diagnosis)

b. Have any reasons or causes for the condition been identified?

Yes ☐ **Please complete below**

No ☐

If **yes** advise details including cause, and if the cause is still persisting

c. When were you first diagnosed with the condition?

/ /

d. Are there any physical/other medical conditions contributing to or associated with your condition? (such as chronic pain)

Yes ☐ **Please provide details below**

No ☐

e. Please describe your symptoms, including the date they started

/ /

f. When did you last experience these symptoms? (Or specify if ongoing)

/ / ☐ Ongoing

g. Did your symptoms include suicidal thoughts or ideation?

Yes ☐ **Go to Question h**

No ☐ **Go to Question i**

h. If yes, have you ever attempted suicide?

Yes ☐ **Please complete below**

No ☐

Provide details including dates

/ /

/ /

i. Have you had any recurrences of these symptoms?

Yes ☐ **Please complete below**

No ☐

Provide details including dates

	/ /
	/ /

j. Please complete the table below with details of all treatments prescribed, recommended or received for your condition (including medications, counselling and alternative/ complementary therapies)

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received

/ /

Date treatment ceased (or specify if ongoing)

/ / ☐ Ongoing

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received

/ /

Date treatment ceased (or specify if ongoing)

/ / ☐ Ongoing

Name of treatment

Treating/Prescribing doctor or health care professional

Date treatment prescribed, recommended or first received

/ /

Date treatment ceased (or specify if ongoing)

/ / ☐ Ongoing

k. Are you limited in your ability to work or perform your activities of daily living as a result of this condition?

Yes ☐ **Please provide details below**

No ☐

l. Does your usual doctor have knowledge of this condition?

Yes ☐ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

6. High blood pressure and raised cholesterol questionnaire

a. Please tick (✔) the appropriate box(es)

☐ High blood pressure*

☐ Raised cholesterol#

b. When were you first diagnosed with this condition? (please tick (✔) the appropriate box)

☐ Within the last 12 months

☐ More than 12 months ago

c. Do you have any problems or complications resulting from this condition? (e.g. heart disease, kidney disorder)

☐ Yes ☐ No

d. Are you taking regular medication for this condition?

☐ Yes ☐ No

***Additional questions for high blood pressure**

e. Is your blood pressure being monitored by your doctor and considered to be well controlled? (e.g. less than 140/90)

☐ Yes ☐ No

f. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

#Additional questions for raised cholesterol

g. When was your last cholesterol reading? Please tick (✔) the appropriate box(es)

☐ Within the last 12 months

☐ More than 12 months ago

h. When was your last cholesterol reading? Please tick (✔) the appropriate box(es)

☐ 2.0 to 6.5 mmol ☐ 6.6 to 7.5 mmol

☐ 7.6 mmol or above ☐ Don't know

i. Is your treating doctor different from the last doctor you consulted?

Yes ☐ ▶ **Please complete below**

No ☐

Name of doctor

Doctor/medical centre/hospital address

State Postcode

Phone number ( )

Fax number ( )

Section N – Pastimes and activities questionnaires

If you answered 'Yes' to:
Section K a on page 13, then please complete **Flying** questionnaire below
Section K b on page 13, then please complete **Underwater diving** questionnaire **on page 23**
Section K c on page 13, then please complete **Football of any code** questionnaire **on page 23**
Section K d on page 13, then please complete **Motor sports of any kind** questionnaire **on page 23**
Section K e to h on page 13, then please complete **Other sports or hazardous activities** questionnaire **on page 24**

1. Flying questionnaire

a. What type of aerial device/aircraft do you fly? (please tick (✔) the appropriate aircraft(s))

		Number of hours flown in the last 12 months	Number of hours in the next 12 months
Fixed wing (Private/recreational/commuter travel)	☐		
Helicopter (Private/recreational/commuter travel)	☐		
Fixed wing (Charter flying)	☐		
Helicopter (Charter flying)	☐		
Fixed wing and Helicopter (Agriculture/crop/mustering)	☐		
Helicopter, fixed wing – occupation i.e aerial surveyor, photographer etc.	☐		
Ballooning	☐		
Gliding	☐		
Ultra-light/gyroplane	☐		
Aerobatics/stunts	☐		

b. Do you hold an Air Service licence?

☐ Yes ☐ No

c. Do you intend to change the scope of your present licence?

Yes ☐ ▶ **Please complete below**

No ☐

Please state the change in scope of your present licence

d. Have you ever had an accident or been charged with violating civil aviation regulations?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

e. Do you intend to engage in any form of aviation other than already mentioned?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details on the other form of aviation

f. Do you ever use unauthorised landing areas?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

g. Please advise the make and model of the aircraft that you fly/pilot

Make Model

2. Underwater diving questionnaire

a. At what level do you participate? (please tick (✔) the appropriate box)

- ☐ Recreational only (non-competiton)
- ☐ Recreational only (with competition)
- ☐ Semi-professional/professional

b. How many times per year do you participate in this activity?

c. Do you ever dive:

alone? e.g. without a buddy	☐ Yes	☐ No
over 40 meters in depth?	☐ Yes	☐ No
in wrecks, caves or potholes?	☐ Yes	☐ No

If Yes to any above, please provide details

d. What type of qualification do you hold? (please tick (✔) the appropriate box)

- ☐ No qualification
- ☐ PADI
- ☐ BSAC
- ☐ NAUI
- ☐ Other (please specify)

3. Football of any code questionnaire

a. What type of football code do you participate in? (please tick (✔) the appropriate box)

- ☐ Rugby League
- ☐ Australian Rules
- ☐ American football
- ☐ Rugby Union
- ☐ Touch football/Oztag
- ☐ Soccer

b. At what level do you participate? (please tick (✔) the appropriate box)

- ☐ Recreational only (non-competiton)
- ☐ Recreational only (with competition)
- ☐ Semi-professional/professional

c. In the last two years have you had a sporting injury to your shoulder, leg, knee or ankle that required any time off work?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

d. Do you receive an income from participating in this activity?

Yes ☐ ▶ **Please complete below**

No ☐

How much do you earn from this activity per year?

$

4. Motor sports of any kind questionnaire

a. What type of vehicle or motor activity do you engage in?

b. At what level do you participate? (please tick (✔) the appropriate box)

- ☐ Recreational only (non-competiton)
- ☐ Semi-professional/professional
- ☐ Recreational only (with competition)
- ☐ Record attempts or prototype testing

c. Have you ever been involved in any accidents whilst practising, testing or racing?

Yes ☐ ▶ **Please complete below**

No ☐

Provide details of when this occurred and whether you have any restrictions of your work duties or activities as a result

d. Do you hold a CAMS license and/or are you a member of a motor racing club or organisation?

Yes ☐ ▶ **Please complete below**

No ☐

Please provide details

Section N – Pastimes and activities questionnaires (continued)

e. Which events do you race in? (e.g. circuit racing, drag racing) Please provide details including class of racing event

f. Please advise the following details

Number of times per year that you participate in this activity

Vehicle type including make

Engine size

What maximum speed is reached?

5. Other sport or hazardous activity questionnaire

a. What type of activity do you engage in?

b. At what level do you participate? (please tick (✔) the appropriate box)

☐ Recreational only (non-competiton) ☐ Recreational only (with competition) ☐ Semi-professional/professional

c. How many times per month do you play, jump / launch or participate in this activity?

d. Do you receive an income from participating in this activity?

Yes ☐ **Please complete below**

No ☐

How much do you earn from this activity per year?

$

Section O – General declaration

The following declarations apply to all policy owner(s):

1. I understand that the insurance applied for will not become effective unless and until the Application is accepted by CMLA and CMLA is under no liability until acceptance is effected.
2. I acknowledge Commonwealth Bank of Australia does not guarantee the obligations or performance of its subsidiaries or the products they offer.
3. I confirm that the declarations and answers to all questions in this application are true and correct including those not in my own handwriting (for a life insured, this confirmation relates to answers and declarations about them).
4. I have read and understood my Duty of disclosure as set out in this application and I am aware of the consequences of non-disclosure. I understand my duty to disclose any changes to any circumstances continues after this application has been submitted until the application has been accepted in writing.
5. I have read and understood the Privacy Collection Statement on page 2 of this application form.
6. I hereby authorise Colonial Mutual Superannuation Pty Limited and The Colonial Mutual Life Assurance Society Limited to deduct premiums for this cover from my account and acknowledge that any benefits or other moneys payable by CMLA with respect to this cover will be credited to that account.

Name of life insured

Signature of life insured

X

Date

/ /

Medical authority

The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFSL 235035 (CMLA).

I hereby authorise any medical practitioner, hospital, clinic or an authorised person (including any life insurer or underwriter) to give all information with respect to any illness, injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photocopy of this authorisation is as effective and valid as the original.

Name of life insured

Previous surname (if applicable)

Signature of life insured

✗

Date

/ /

Customer contact authority

The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFSL 235035 (CMLA).

Only complete this section if you are happy to be contacted by a representative of Colonial Mutual Life Assurance Society Limited for more information in order to speed up the assessment process.

Name of life insured

I,

agree that CommInsure or an authorised representative may contact me in respect of my insurance application or policy.

Signature of life insured

✗

Date

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