Full personal statement

This form can be used to obtain or change your insurance cover

Information about genetic tests

If you've had a genetic test, you only need to disclose this to us if your total insurance cover will be more than the amounts listed below. When considering your total insurance cover amounts you need to include the cover you're applying for, your cover held in superannuation and your cover held with other life insurers. The total insurance cover you can have and not disclose if you've had a genetic test are:

- **$500,000 life cover, or**
- **$500,000 total and permanent disability cover (TPD), or**
- **$200,000 critical illness (trauma) cover, or**
- **$4,000 a month income protection cover, salary continuance cover or business expenses cover.**

You also need to consider all cover that may have been arranged through a financial adviser, or directly with a life insurance company, or cover held under a group insurance arrangement.
If you've had a favourable (negative) genetic test result you can provide this information regardless of the amount of cover applied for.

Your duty to take reasonable care not to make a misrepresentation

About this application and your duty

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

The duty to take reasonable care

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

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

The duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If you do not meet your duty

If you do not meet your legal duty, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

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

- think carefully about each question before you answer. If you are unsure about any question, we are here to help and you can contact us.
- answer every question.
- answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted, and
- you must not assume that we will contact your doctor for any medical information. If you are unsure about whether you should include information or not, please include it.

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts. The duty applies when you answer questions in your application and whenever we obtain more information from you.

If you need help

It's important that you understand this information and the questions we ask. Ask us or your adviser for help if you need help understanding the process of buying insurance or answering our questions.

If you're having difficulty due to a disability, understanding English or for any other reason, we're here to help and can provide additional support for anyone who might need it. If you want, you can have a support person you trust with you.

What can we do if the duty is not met?

If the person who answers our questions does not take reasonable care not to make a misrepresentation, there are different remedies that may be available to us. These are set out in the Insurance Contracts Act 1984 (Cth). These are intended to put us in the position we would have been in if the duty had been met.

For example we may:

- avoid the cover (treat it as if it never existed);
- vary the amount of the cover; or
- vary the terms of the cover.

Whether we can exercise one of these remedies depends on a number of factors, including:

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances;
- what we would have done if the duty had been met - for example, whether we would have offered cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will explain our reasons, how to respond and provide further information, including what you can do if you disagree.

For completion by the Life Insured

Section 1 Insurance details

Fund/Policy name

Hostplus

Member number

Please specify the type of insurance cover being applied for:

☐ New ☐ Increase

☐ Death only ☐ Death and TPD ☐ Income Protection

Please enter the TOTAL amount of insurance cover being applied for under this policy (including any existing cover).

Type of Insurance	Number of Units (Existing Cover)	Number of Units (New Cover)	Total Cover
Death only			
Death & TPD			

Income Protection Waiting Period

☐ 30 days ☐ 90 days

☐ 75% of Income ☐ 50% of Income

Section 2 Adviser details (only if applicable)

Adviser name

Adviser phone number

( )

Adviser email

I agree to the Insurer or any one of their authorised representatives contacting the client directly if required to collect further information to assist with the completion of this application. I am lawfully authorised to advise on, and deal in, MLC Group Insurance policies under an Australian Financial Services Licence. I do not provide these services on behalf of MLC Limited ABN 90 000 000 402 AFSL 230694.

Signature of the financial adviser listed above

X

Date (DD/MM/YYYY)

Section 3 Life Insured's details

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr Other: ☐

First name

Middle name

Family name

Previous name(s) (if applicable)

Gender

☐ Male ☐ Female

Date of birth (DD/MM/YYYY)

Contact details

Phone number

Email (Please provide your email address so notices about your application can be sent to you)

Address (Your residential address cannot be a PO Box)

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Section 4 Options in underwriting your case

Fast tracking medical requirements

Unified Healthcare Group (UHG) is our preferred provider for insurance related tests. UHG provides a customer health evaluation service for us (and other insurers) that helps with fast and efficient processing of your application. This means that if you consent, UHG may contact you to arrange blood tests or other medical checks required for your insurance application. UHG is subject to our privacy requirements to protect your confidentiality. Do you permit us to arrange this service?

Yes ☐ No ☐

Section 5 Disclosure

We have explained to you earlier in this application the duty to take reasonable care not to make a misrepresentation that you are under when applying for cover with us, and want to take a moment to explain why it is so important.

You and your family's future and your ability to earn an income or maintain your business are worth protecting. To help ensure you and your loved ones are covered, we need to ask the following questions on your health and individual circumstances.

Please ensure that all your answers are accurate and correct. Failure to provide the correct information on any question may result in the company altering or voiding your policy, which may mean a claim will not be payable when you and your family need it most.

Declaration

Do you declare that:

- you will provide honest answers throughout this application, and
- you are aware that MLC can check your answers at any time after the policy is issued, and
- providing false or incorrect information may result in MLC altering or voiding your policy.

I, ☐ have understood and agree to the above declaration

Section 6 Other insurance(s)

1 **Are you covered by, or are you applying for, any other life, disability, critical illness, income protection or salary continuance insurance with any company, including us (other than this application), including benefits under superannuation or insurance benefits provided by your employer?**

Yes ☐ Please provide details below

Company	Benefit type	Date started	Benefit amount	Waiting/ Benefit periods	Policy number	To be replaced*
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐

*If you answered 'Yes' that cover is to be replaced, please ensure you cancel your insurance with the Insurer or other provider once this application has been accepted.

No ☐

2 **Have you ever had or applied for any life, disability, accident, sickness or trauma cover that was declined, cancelled or accepted with an exclusion or higher than standard premium or modified in any way?**

Yes ☐ Please provide details below

No ☐

Section 7 Occupation and Financial

These questions help us to understand what you do in your job and your financial circumstances.

3 **Please provide details of your main job and any professional or trade qualifications you have.**

a) Main job

b) Industry

c) Name of employer or trading name

d) Professional or trade qualifications

e) If less than 12 months with the employer above, please provide details of last employer, job and time with that employer

4 Please provide the percentage of time you spend doing the following types of work in your job. Your answer must add up to 100%.

Type of work	Percentage of time
Sedentary/Administration: includes all general clerical, office, administration and desk duties. The emphasis is on mental rather than physical work although there may be a small element of standing/walking, and driving to and from appointments.	
Supervision of manual workers, field work or site visits	
Light manual work: includes light lifting of up to 10kg, using hand tools, operation of light machinery	
Heavy manual work: includes carrying, lifting, pushing, pulling more than 10kg, the operation of heavy machinery, driving a commercial vehicle	
Other	
Total	**100%**

5 Does your job include any hazardous types of work? Hazardous types of work may result in serious injury or death. Some common hazardous types of work are listed in the table below.

Yes ☐ Please provide details in the table below

Type of work	Percentage of time	Specific duties you perform
Heights over 10 metres		
Flying		
Underground work		
Offshore work – within Australian waters		
Offshore work – outside Australian waters		
Diving		
Using or handling explosives		
Using or handling chemicals, dangerous substances, or asbestos		
Other (please specify)		

No ☐

6 Date you started with your employer

7 On what basis are you employed?

a) Full-time ☐
b) Part-time ☐
c) Casual ☐
d) Contract ☐
e) Fixed-term employment ☐
f) Self-employed ☐
g) Not working ☐

8 In your main job, on average:

How many hours per week do you work?	
How many weeks per year do you work?	

If you are not currently working and have provided this information in question 7 above, please add zero here.

9 What are your current annual earnings from your main job?
(earnings are your base salary before tax and not including super contributions)

$

Section 8 Claims History

10 Have you ever made a claim or received benefits (including Income Protection, Total and Permanent Disablement (TPD), Salary Continuance, workers' compensation or third party insurance benefit) in regard to any illness, injury or condition, or have you applied for unemployment, sickness or accident benefits or other Centrelink or Veteran's Affairs benefits?

Yes ☐ Please provide details in the table below

Benefit type	Benefit amount	Reason for claim	Time off work	Date benefit ceased

No ☐

Section 9 Sports and Pastimes

We all enjoy our leisure time and do different things to stay active. These questions are to understand what you do in your leisure time.

11 Which of the following do you currently participate in, or intend to participate in, over the next 2 years?

Yes ☐ Please tick all that apply

- ☐ Diving
- ☐ Motor car, motor cycle or motor boat racing
- ☐ Flying as a pilot or crew in an aircraft
- ☐ Football (all codes)
- ☐ Hang-gliding, paragliding, skydiving, pursuits involving heights
- ☐ Mountaineering and rock climbing
- ☐ Other hazardous pursuits, activities or sports? (eg polo, competitive judo, mountain biking, downhill biking)

If you ticked any of these boxes, please complete the **Pastimes questionnaire** located at the back of this application form

No ☐

Section 10 Doctor's Details

12 Do you have a usual doctor?

Yes ☐ Please provide full name and address of your usual doctor or medical centre.

No ☐ Please provide the name and address of the last doctor you visited.

Name of doctor or medical centre

Address

Suburb | State | Postcode | Country

Telephone | Email

Section 10 Doctor's Details continued

13 How long have you been attending this doctor / medical centre?

years months

When did you last attend?

What was the reason for your last visit to this practitioner?

What was the outcome?

Was there any medication prescribed, referral given or tests ordered?

14 If you have been attending this doctor or medical centre for less than 12 months, please also provide name and address of your previous doctor

When did you last attend?

What was the reason and outcome for your last visit to this practitioner?

Section 11 Height and weight details

15 What is your height?

cm **or** feet/inches

What is your weight? Please do not guess. Weigh yourself if you have not done so in the last week.

kg **or** stone/pounds

16 Has your weight changed by more than 10kg (or 22lbs) in the last 12 months?

Yes ☐ Please provide details

No ☐

17 Have you undergone surgery to reduce your weight in the last five years?

Yes ☐ Please provide details, including date of surgery and how much weight has been lost

No ☐

Section 12 Habits and Lifestyle

Individual lifestyle choices play an important part in our lives. To get to know you better, these questions will help us better understand you and your lifestyle.

They are important for us to ask to be able to give you the best possible cover for your life insurance.

18 In the last 12 months, have you been a:

Please select all that apply.

☐ Regular smoker (smoke each day)	Go to **18a**
☐ Occasional smoker (smoke each week/ month / year)	Go to **18a & 18b**
☐ Social smoker (smoke with friends / family / colleagues)	Go to **18a & 18b**
☐ User of e-cigarettes or vaping	Go to **18c**
☐ User of nicotine-replacement products like patches, gum, etc.	Go to **18c**
☐ Non-smoker (you have not smoked at all)	Go to **19**

18a How many cigarettes, including roll-ups, cigars or pipes do you smoke on average?

Please do not guess.

☐ 41 or more a day ☐ 31-40 a day ☐ 21-30 a day ☐ 11-20 a day ☐ 1-10 a day
☐ Less than 7 a week ☐ Less than one a month

18b When was the last time you smoked tobacco, cigarettes, cigars, or any other nicotine containing substances?

☐ In the past month ☐ In the past 6 months ☐ In the past 12 months ☐ 1-5 years ago ☐ 6-10 years ago
☐ More than 10 years ago ☐ Never

18c How often do you use nicotine replacement products (eg patches, gum, mints, other nicotine containing products like e-cigarettes or vaping)?

☐ Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Twice a year
☐ Yearly Other ☐ I don't use these products

19 Do you drink alcohol?

Yes ☐ How many standard drinks do you consume on average?

Quantity: ☐ ☐ per day ☐ per week ☐ per month ☐ per year

A standard drink = 1 nip (30ml) spirits, 100ml wine, 10oz/285ml beer
2 standard drinks = a pint (568 ml), a large glass of wine (200ml)

No ☐

20 How often do you have six or more standard drinks on one occasion?

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never

Many people have been advised to reduce or stop drinking alcohol at some point in their lives.

21 Have you ever been concerned about your level of alcohol consumption or been advised to reduce or stop drinking alcohol by a healthcare professional for any reason?

Yes ☐ Please provide details

No ☐

Section 12 Habits and Lifestyle continued

Many people have tried recreational drugs, legal highs or drugs not prescribed to you by a doctor at least one point in their lifetime.

22 **In the last 10 years, how often have you taken recreational drugs, legal highs or drugs not prescribed to you by a doctor?**

This includes any drug swallowed inhaled or injected, but does not include vitamins, supplements, over-the-counter medications or the oral contraceptive pill.

☐ Frequently (more than 6 times per year) ☐ Occasionally (more than 3 times per year) ☐ Some weekends or holidays

☐ A few times ☐ Once ☐ Never

If you have used drugs in the last 10 years, please provide details including the type of drug and when you last took them:

23 **In the last 10 years, have you misused or been addicted to any prescription or over-the-counter drug(s) (such as pain killers or sedatives), even if they were prescribed for you?**

Yes ☐ Please provide details

No ☐

24 **Have you ever received advice, counselling or treatment for drug dependence?**

Yes ☐ Please provide details

No ☐

The following questions will help us understand your mental and physical wellbeing. These are important questions to answer accurately to avoid your insurance policy being altered or voided, which could result in a claim not being payable.

Please do your best to answer all questions to the best of your ability and do not guess.

Depending on the answers you provide we may need to check with your doctor.

Section 13 Supplementary Underwriting Questionnaires

Mental Health

Mental health conditions are common, with about 8.7 million Australians experiencing mental ill health in their lifetime.

We know that mental health can change over time and can be caused by specific events or factors out of your control. Therefore, the purpose of these questions is to understand your own individual experiences with mental health.

25 **At any point in your life, have you experienced any of the following common symptoms related to mental health?**

Common symptoms may include: stress, anxiety, depression, prolonged sadness or tearfulness, persistent sleeplessness or prolonged change in appetite, poor concentration, excessive anger, hostility or violence, thoughts of suicide, self-harm, not participating in usual enjoyable activities, relying on alcohol and sedatives, withdrawing from close family and friends, not getting things done at work/school or not going out anymore.

☐ At one time in my life ☐ On a few occasions in my life ☐ Regularly ☐ No

If you answered **No**, please go to **Section 14**. If you selected any other response, please complete the **Supplementary Mental Health Questionnaire at the back of this application form**.

Section 14 Supplementary Underwriting Questionnaires

Physical wellbeing

We all get sick from time to time, but some illnesses can have an ongoing impact on your physical wellbeing.

The following questions will help us understand your **overall physical wellbeing** so we can accurately assess if you can be insured or if any special terms need to apply. If you answer **Yes** to any of the following questions, you must also complete the relevant **Supplementary Underwriting Questionnaires at the back of this application form**.

26 In your lifetime, have you had symptoms of, been diagnosed with, or had treatment or medication for:

Please select the most relevant responses. Please do not guess.

☐ High blood pressure	Yes ☐ / No ☐	If yes, please complete the **High Blood Pressure** questionnaire
☐ High cholesterol	Yes ☐ / No ☐	If yes, please complete the **High Cholesterol** questionnaire
☐ Asthma	Yes ☐ / No ☐	If yes, please complete the **Asthma** questionnaire
☐ Skin lesions such as a crusty non-healing mole, new spots, freckles or any moles changing in colour, thickness or shape over a period of weeks to months, keratosis, sunspots, Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), skin cancer or melanoma ☐ Any other skin lesion that you have not already told us about	Yes ☐ / No ☐	If yes, please complete the **Skin Lesion** questionnaire
☐ Back or neck strain/sprain or pain, sciatica, whiplash, spondylitis, fracture or spinal fusion ☐ Any other back or neck condition that you have not already told us about	Yes ☐ / No ☐	If yes, please complete the **Back/ Neck Disorder** questionnaire
☐ Any bone/joint fractures, muscle, ligament or tendon injuries, repetitive strain injury (RSI), carpal tunnel syndrome, tenosynovitis, gout, arthritis, osteopenia or osteoporosis ☐ Any other bone, muscle, ligament or tendon condition that you have not already told us about	Yes ☐ / No ☐	If yes, please complete the **Joint/Musculoskeletal** questionnaire

Section 15 Medical History

If you answer **yes** to any of the following questions, you must also complete the **Further information table** on page 14 of this application form.

27 **In your lifetime, have you had symptoms of, been diagnosed with, or had treatment or medication for:**

Please select the most relevant response. Please do not guess.

a **Skin conditions such as**

- ☐ Persistent rash, eczema, psoriasis, dermatitis, skin allergies
- ☐ Any other skin condition or disorder of the skin that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

b **Blood or blood vessel conditions such as**

- ☐ Varicose veins, deep vein thrombosis (DVT), pulmonary embolism
- ☐ Haemochromatosis, haemophilia, anaemia
- ☐ Human Immunodeficiency Virus (HIV), AIDS, or any AIDS or HIV-related conditions
- ☐ Any other blood or blood vessel condition that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

c **Cardiovascular or heart conditions such as**

- ☐ Angina, heart attack, chest pain, heart murmur, heart palpitations or irregular heartbeat
- ☐ Valve diseases, stenosis, regurgitation, rheumatic fever
- ☐ Any other cardiovascular or heart conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

d **Eye or ear conditions such as**

Do not include conjunctivitis with full recovery, colour blindness, or long or short sightedness that has been corrected either with surgery, contact lenses or glasses.

- ☐ Cataracts, glaucoma, blindness, keratoconus, retinal detachment, uveitis
- ☐ Tinnitus, deafness, Meniere's disease, labyrinthitis, vertigo, cholesteatoma
- ☐ Any other eye or ear conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

e **Respiratory conditions such as**

- ☐ Sleep apnoea
- ☐ Bronchitis, pneumonia, emphysema or Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Any other respiratory, lung or breathing disorder that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

f **Stomach, bowel, colon or liver conditions such as**

- ☐ Irritable bowel syndrome (IBS), bleeding from the bowel, haemorrhoids, bowel polyps
- ☐ Crohn's disease, ulcerative colitis or diverticulitis
- ☐ Reflux, hernia, ulcer or gall bladder conditions
- ☐ Hepatitis (excluding hepatitis A if fully recovered) fatty liver or cirrhosis of the liver
- ☐ Any other stomach, bowel, colon or liver conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

g **Diabetes, pancreatic or thyroid conditions such as**

- ☐ Type 1 or Type 2 diabetes, impaired fasting glucose, pregnancy related diabetes, sugar in your urine or low or high blood sugar
- ☐ Pancreatitis
- ☐ Hypothyroidism, hyperthyroidism, Graves' disease, goitre and thyroiditis
- ☐ Any other diabetic, pancreatic or thyroid conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

h **Brain, nerve or neurological conditions such as**

- ☐ Persistent headaches or migraines, fainting or dizziness
- ☐ Neuritis, epilepsy or seizures, Alzheimer's disease or dementia
- ☐ Stroke, transient ischaemic attack (TIA), brain haemorrhage
- ☐ Paralysis, multiple sclerosis (MS) or motor neurone disease (MND)
- ☐ Any other brain, nerve or neurological conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14

No ☐

i **Cancer or tumours such as**

- ☐ Leukaemia, lymphoma, mesothelioma, myeloma, sarcoma
- ☐ Any form of cancer or tumours (benign or malignant)
- ☐ Any other cancer condition that you have not already told us about

Yes ☐ Please provide details in table on page 14
No ☐

j **Chronic fatigue or chronic pain related conditions such as**

- ☐ Chronic fatigue syndrome, chronic pain syndrome or fibromyalgia
- ☐ Any other chronic fatigue or chronic pain related conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14
No ☐

k **Autoimmune conditions such as**

- ☐ Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or lupus
- ☐ Any other autoimmune conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14
No ☐

l **Sexually transmitted infection such as**

- ☐ Gonorrhoea, herpes, syphilis
- ☐ Any other sexually transmitted infections or conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14
No ☐

m **HIV risk**

- ☐ Have you been in any situations that may have put you at risk of contracting HIV

Example situations include:
Needle stick injury, sex without a condom with someone you know or suspect to be HIV positive, an intravenous drug user or a sex worker, anal intercourse without a condom (except with one other person, and neither of you have had sex with another person in the last three years)

Yes ☐ Please provide details in table on page 14
No ☐

n **Males only**

Kidney, bladder or reproductive conditions such as

- ☐ Polycystic kidney disease, recurrent kidney infections, kidney stones, nephritis, urinary tract infection (UTI), cystitis or blood in urine
- ☐ Prostatitis or enlarged prostate
- ☐ Any other kidney, bladder or reproductive condition that you have not already told us about

Yes ☐ Please provide details in table on page 14
No ☐

o **Females only**

Kidney, bladder, breast or reproductive conditions such as

- ☐ Polycystic kidney disease, recurrent kidney infections, kidney stones, nephritis, urinary tract infection (UTI), cystitis or blood in urine
- ☐ Polycystic ovarian syndrome, endometriosis, abnormal pap smear, polyps and fibroids, pelvic inflammatory disease
- ☐ Breast lumps, fibroadenomas or breast cysts. Excluding any normal test results that don't require follow up in the next 12 months
- ☐ Any other kidney, bladder, breast or reproductive condition that you have not already told us about

Yes ☐ Please provide details in table on page 14
No ☐

Are you pregnant?

Due date (DD/MM/YYYY):

Yes ☐ Please provide due date
No ☐

Do you have a history of pregnancy complications?

- ☐ Any other pregnancy related conditions that you have not already told us about

Yes ☐ Please provide details in table on page 14
No ☐

Further information

If you answered 'Yes' to any question in Section 15 (question 27), please provide details below

Question	Symptom	Date symptoms started	Date of last symptoms	Type of treatment and any test results	Degree of recovery	Time off work	Name and address of doctor, hospital or health professional consulted

Section 16 General Medical

Thank you for your time and answers so far. We want to now check if there is anything else we should know to help us better understand your overall wellbeing.

Other than what you have already told us, in the last **5 years** have you

We do not need to know about:

- **Colds, flu or minor viral illnesses that were short, isolated occurrences or medications for these conditions, or annual check-ups where the results were normal.**
- **Childhood illnesses such as chicken pox, measles, mumps, tonsillitis or tonsillectomy, appendicitis or appendectomy, unless you have not made a complete recovery.**

28 Seen a doctor or other health professional* such as psychologist, osteopath, physiotherapist

Yes ☐ Please provide details in the table on page 16

No ☐

29 Required tests or investigations* such as blood test, x-ray, MRI, ECG or biopsy

Yes ☐ Please provide details in the table on page 16

No ☐

30 Had treatment, taken medication or herbal medicines

Yes ☐ Please provide details including the results in the table on page 16

No ☐

31 Had a fracture or broken bone

Yes ☐ Please provide details in the table on page 16

No ☐

32 Had surgery or an operation

Yes ☐ Please provide details in the table on page 16

No ☐

33 Had to go to hospital for an accident or medical condition

Yes ☐ Please provide details in the table on page 16

No ☐

34 Are you waiting for any medical test or investigation results?

Yes ☐ Please provide details

No ☐

35 In the **last 12 months** have you been referred to a specialist or for medical tests, treatment or surgery?

Yes ☐ Please provide details

No ☐

* Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing.

Section 16 General Medical continued

If you answered 'Yes' to any question in Section 16 (questions 28–33), please provide details below

Question	Condition, reason or test	Date started	Date of last symptoms	Type of treatment and any test results	Degree of recovery	Time off work	Name and address of doctor, hospital or health professional consulted

36 In the next 12 months, do you plan to:

☐ Seek medical advice	Yes ☐	No ☐
☐ Have tests and or investigations* such as blood test, x-ray, MRI, ECG or biopsy	Yes ☐	No ☐
☐ Have treatment	Yes ☐	No ☐
☐ Have surgery or an operation	Yes ☐	No ☐

*Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing.
If you answered 'No' to all parts of question 36, please go to question 39

37 When do you plan on seeking medical advice? (DD/MM/YYYY)

38 What is the reason(s) for these tests, treatment(s) or surgery/operation?

Section 17 Family History

39 Have any of your immediate blood relatives (parents, brothers or sisters) suffered from any of the following conditions?

No ☐

Yes ☐ Please tick all that apply and provide details in the following table

- ☐ Heart disease or stroke
- ☐ Breast or ovarian cancer
- ☐ Melanoma
- ☐ Bowel cancer
- ☐ Familial Polyposis (FAP)
- ☐ Any other cancer not otherwise listed (specify type and site)
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Haemochromatosis
- ☐ Muscular dystrophy
- ☐ Polycystic Kidney Disease (PCKD)
- ☐ Huntington's disease
- ☐ Motor neurone disease
- ☐ Any other hereditary disorder

Family member (eg mother, brother)	Condition	If cancer, type and site	Age condition began

Section 18 Further Information

If you use this page to provide further information, please note the page and question number the additional information refers to.

Page no.	Question no.	Further information

Section 19 Declaration

Read this section carefully before signing.

My decision to apply for insurance under MLC Group Insurance is based on the Product Disclosure Statement and/or Policy Document for the relevant product that I have received and my understanding of the information it contains.

I understand and agree that:

(a) I have read and understand the duty to take reasonable care not to make a misrepresentation;

(b) The answers to the questions in this application and any other relevant personal statement(s) and questionnaires are true and complete, and the answers given form the basis of the contract;

(c) If any answers to the application questions are not in my own handwriting, I certify that I have checked them and they are correct;

(d) I consent to notices relating to my application to be sent to the email address or the mobile number provided by me and I acknowledge that my personal and sensitive information may be sent to that email address.

(e) Where this application is for insurance cover under a superannuation fund, I will provide the Insurer or the trustee or any appointed adviser, intermediary or administrator with any information which relates to my membership of that fund which they may request;

(f) This insurance application is not effective until the Insurer accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;

(g) I was actively at work performing the normal duties of my occupation when I applied for this insurance;

(h) All statements and declarations given by me on this form are true and correct; and

(i) The information contained in this application may be released to the trustee which has arranged this group insurance, or to an adviser, intermediary or administrator appointed by the trustee for the purposes of administering this insurance or the superannuation fund under which it is provided.

I authorise the Insurer to:

(a) Provide my personal, financial and medical information (whether provided in this application or otherwise subsequently collected by the Insurer with my consent) to any medical professional, medical facility, reinsurer, assessor, adviser or any other confidential service provider, now or at any time in the future, for the purpose of issuing or administering this insurance, and assessing any claim made in respect of this insurance; and

(b) Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undertaken in connection with this application to my usual doctor or medical centre as nominated at Question 12 of Section 10, Doctor's details; and

(c) Provide a copy of the HIV Antibodies Blood test to my usual doctor or medical centre as nominated at Question 12 of Section 10, Doctor's details unless I have nominated an alternative doctor to receive the results, in which case I authorise the results to be provided to the alternative doctor specified.

I also authorise the Insurer and any third party referred to in paragraphs (a), (b) and (c) of this authority, to transfer any such information outside the State, Territory or jurisdiction in which the information was collected in order to give effect to this authority.

Privacy

I acknowledge that I have access to the Insurer's privacy policy and agree that the Insurer may collect, use, disclose and handle my personal information in a manner set out in the Group's privacy policy available on **mlcinsurance.com.au**

I acknowledge that where my Employer (or former Employer) or the trustee of my superannuation fund has appointed an adviser, intermediary or administrator to arrange and/or administer the group insurance policy on their behalf, my personal information, including my pastime activities, occupation and financial status will be provided to the Insurer for the purpose of expediting the assessment of this application for insurance.

Consent

I consent that where my application is declined, loaded and/or an exclusion is applied, the Insurer may disclose any personal medical information or finding that resulted in my application being declined, loaded and/or having an exclusion applied, to the adviser, intermediary or administrator providing services in relation to this group insurance.

I understand that I can withdraw this consent at any time by contacting the Insurer on **1800 652 447** or email **enquiries.group@mlcinsurance.com.au**

Where, in the Insurer's opinion, your medical information or our findings are of a personal or sensitive nature, the Insurer reserves the right to withhold disclosure of this information to the appointed adviser, intermediary or administrator.

Signature of Life Insured

X

Date (DD/MM/YY)

Section 19 Declaration continued

Have you completed or were you requested to complete any questionnaires in this application form?

No ☐ Please return pages 1 to 22 of the completed form

Yes ☐ Please return pages 1 to 45 of the completed form INCLUDING any completed questionnaires.

Send us your form

Please return the completed form to:

Hostplus
Locked Bag 5046
Paramatta NSW 2124

or email **info@hostplus.com.au**

(DO NOT DETACH)

LIFE INSURANCE

Authority to release medical information

(to be completed in All cases)

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, **MLC Life Insurance**, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Section 20 Authority to release medical information (to be completed in ALL cases)

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **MLC Life Insurance**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **MLC Life Insurance** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **MLC Life Insurance** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MLC Life Insurance** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Signature of Life Insured

X

Date (DD/MM/YY)

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **MLC Life Insurance**, or to third parties they engage, only if **MLC Life Insurance** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- **MLC Life Insurance** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MLC Life Insurance** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Full name of Life Insured (please print)

Previous name (if applicable)

Date of birth (DD/MM/YYYY)

Signature of Life Insured

X

Date (DD/MM/YY)

Pathology Request for Insurance

This must be completed when a blood test is required.

LIFE INSURANCE

Life Insured's Details

Title

Surname (Family Name) (please print)

Given names

Sex

Date of birth (DD/MM/YYYY)

Policy name

Policy number

Family doctor or hospital – name and address

Postcode

Report and account to	Collection date and time	Tests required
Chief Medical Officer PO Box 23455 Docklands Vic 3008 Phone: 1800 652 447	Date of appointment Time of appointment am/pm	☐ Multiple Biochemical Analysis 20 (Chol. (HDL & LDL), Trigs., Glucose, Creat., Uric acid, LFTs, Electrolytes), and Hepatitis B and C serology ☐ HIV Antibodies ☐ Other (specify)

Life Insured's consent (not to be signed prior to attendance)

I give my consent to the tests nominated above including any reflex testing for Hepatitis B and C to be performed. Where one is for the presence of antibodies to the AIDS virus (HIV). I acknowledge that I have read the material provided by the Insurer (see over) on the implication of the test and understand its significance. I authorise the sending of a copy of the test results to the Insurer and to my family doctor as shown above.

Yes ☐

No ☐

Signature of Life Insured

X

Date (DD/MM/YY)

HIV Antibody Blood Test

In accessing this application for insurance we may ask you to have a blood test to check your overall health, and to test for HIV. This is because we need to understand your state of health when taking out a life insurance policy.

The test can be done by your own doctor, by appointment with a doctor or paramedical nurse arranged by us, or directly with the pathology laboratory.

This test is voluntary, however, if you choose not to have the test, it could affect our decision to accept this application based on the other information you have provided to us.

AIDS/HIV

- Acquired Immune Deficiency Syndrome (AIDS) is a viral disease caused by the Human Immunodeficiency Virus (HIV).
- HIV weakens and destroys some of the white blood cells in our bodies – these cells help protect our bodies against infection and cancer.
- Evidence suggests that the virus will be in the body indefinitely but there are now effective treatment options available called antiretroviral therapy (ART).

A negative result

A negative result means you have not been infected or you have been infected recently but your body is not yet displaying the infection.

A positive result

A positive result means you have been infected by HIV.

Knowing that you are HIV positive has legal consequences which vary across all States and Territories. Because the long-term outlook for HIV and developing AIDS is unknown, most insurance is unlikely.

What happens to the results?

- You'll be asked to nominate your family doctor – or an alternative – to be sent the result by us and provide you with counselling.
- This will be in the consent declaration in the Application Form attached to this brochure.
- If the test is arranged by us the result is sent to us, MLC, confidentially to protect your privacy.
- If it's positive, you will receive proper counselling from a doctor.

Your choice

There may be several reasons you choose not to have this test including the impact of a potentially positive result on the HIV test.

If you need more information before deciding, you are advised to seek advice from your own doctor, or a specialist HIV counsellor. Government and community organisations provide counselling services.

Supplementary Pastimes Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life Insured.

Underwater diving

1 Do you hold a diving qualification?

Yes ☐ Type of qualification and time held

No ☐

2 Are you an Amateur or Professional Diver?

Amateur ☐

Professional ☐ State nature of work:

3 Which of the following diving activities do you participate in or intend to participate in?

☐ Scuba ☐ Snorkel ☐ Hookah ☐ Free diving (without breathing apparatus)

☐ Scuba "try dives" only when on holidays

☐ Other - Please provide details

4 What is the maximum depth to which you usually dive (in metres)?

5 Do you participate in any of the following diving activities?

☐ Cave or pot hole diving ☐ Internal exploration of wrecks ☐ Ice diving ☐ Diving in lakes

☐ Diving for mines ☐ Diving alone ☐ Mixed gases diving:

☐ None of these

- ☐ Nitrox
- ☐ Heliox
- ☐ Other

6 Have you ever had an accident or injury while diving? (eg Barotrauma, Decompression Sickness, Air Embolus)

Yes ☐ Please provide details

No ☐

Motor car, cycle or boat racing

7 What type of vehicle do you race or intend to race? (class, engine capacity)

8 What types of racing do you participate in? (eg stock car, circuit racing, road racing etc)

9 Do you compete as: ☐ Amateur ☐ Professional /Sponsorship ☐ Competitive

10 What maximum speed is reached? km/h

11 How many times do you race per year?

12 Are you a member of a motor racing club?

Yes ☐ Please provide details

No ☐

Aviation

13 Do you hold an aviation licence?

Yes ☐ Type of licence (eg student, private, instructor's licence)

No ☐

14 Please complete number of flying hours for the type of aviation activity you participate in or intend to participate in:

	Last year		Future average	
	Crew	Passenger	Crew	Passenger
Commercial Airline				
Charter				
Private flying - fixed wing, charter				
Private flying - helicopters				
Autogyros				
Aero Club/Flying School				
Agriculture				
Ballooning				
Gliding				
Hang-gliding (non powered)				
Ultralights, Microlights, powered hang-gliders or powerchuting				
Parachuting or skydiving				
Paragliding or parascending				
Other activity				

Aviation continued

15 Have you ever had an aviation accident, air safety violation or had your licence revoked?

Yes ☐ Please provide details

No ☐

16 Do you fly within Australian and New Zealand air space only?

Yes ☐

No ☐ Please describe the regions of the world in which you fly

Hazardous pursuits

17 Do you engage in or do you intend to engage in any other hazardous pursuits, activities or sports? (eg polo, competitive judo, mountain climbing, mountain biking, downhill biking)

Yes ☐ Please provide details below (eg type of pastime or sporting code, level of participation, number of events per year)

No ☐

Football

18 What code of football do you participate in?

☐ Australian Rules Football ☐ Rugby League ☐ Rugby Union ☐ Gridiron
☐ Indoor Soccer ☐ Outdoor Soccer ☐ Touch Football

19 At what level do you participate in your sport?

☐ Recreational and amateur purposes only ☐ Competition (match payments)

☐ Semi-pro competitor
Games per year
Location/League

☐ Professional competitor
Games per year
Location/League

Football continued

20 Have you suffered any injuries as a result of the activity?

Yes ☐ Please provide details

No ☐

Mountaineering and rock climbing

21 Which type of climbing do you participate in?

☐ Hiking, trekking or tramping ☐ Abseiling ☐ Indoor rock climbing

☐ Bouldering or scrambling ☐ Mountain or rock climbing ☐ Ice or glacier climbing

☐ Other, please specify

22 Do you do any solo climbing?

Yes ☐

No ☐

23 What is the maximum height you climb to?

Return to Question 11 on page 7

Supplementary Asthma Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life Insured.

1 When did you experience your first episode/symptoms of asthma? (DD/MM/YYYY)

2 How often do you have symptoms of asthma (wheezing, coughing, shortness of breath, or a tight chest)?

- ☐ Less than 2 days a week
- ☐ More than 2 days but less than 7 days
- ☐ Every day

3 What was the date of your most recent episode/symptoms of asthma? (DD/MM/YYYY)

4 Do you take any, or have you been prescribed, any of the following medications?

Select all that apply:

- ☐ Inhaler every day to prevent symptoms (Preventer)
- ☐ Inhaler when you have symptoms (Reliever)
- ☐ Steroid tablets or liquids (eg Prednisone)
- ☐ I don't use any medication

5 How often are you required to use any oral steroid medication?

Frequency

Dose

☐ I do not use any oral steroid medication

6 In the last 5 years, have you had to:

b. Stay overnight in hospital due to your asthma?

Yes ☐
No ☐

c. Attend the emergency department or urgent care due to your asthma?

Yes ☐
No ☐

If you answered yes to any of the above, please provide details, names of hospitals, doctors and dates in the box below

Details	**Name and address of hospital/doctors surgery**	**Date** (DD/MM/YYYY)

7 In the last 2 years, how many days have you taken off work due to your asthma?

Number of days

8 In the last 12 months:

a. Has your asthma been made worse by your occupation?

Yes ☐
No ☐

b. Has your asthma been triggered by your occupation?

Yes ☐
No ☐

c. Have you been unable to carry out your usual daily activities due to your asthma?

Yes ☐
No ☐

If you answered yes to any of the above, please provide details in the box below

9 In the last 12 months, have you been a:

Please select all that apply.

- ☐ Regular smoker (smoke each day)
- ☐ Occasional smoker (smoke each week/ month/ year)
- ☐ Social smoker (smoke with friends/ family/ colleagues)
- ☐ User of e-cigarettes or vaping
- ☐ User of nicotine-replacement products like patches, gum, etc
- ☐ Non-smoker (you have not smoked at all)

10 Please provide the names and addresses of any doctors, hospitals or other health professionals you've consulted for your asthma and the date last consulted.

Name	**Address of hospital/doctors surgery**	**Date** (DD/MM/YYYY)

Return to question 26 on page 11.

Supplementary Cyst / Mole / Skin Lesion Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life Insured.

1 Site of lesion(s)

2 Is the skin lesion(s) diagnosed as any of the following?

- ☐ Melanoma
- ☐ Squamous cell carcinoma (SCC)
- ☐ Basal cell carcinoma (BCC)
- ☐ Solar keratosis
- ☐ Lipoma
- ☐ Cyst
- ☐ Mole/Naevus
- ☐ Other - please provide details

3 How many skin lesions have you had removed in total?

4 Date(s) of diagnosis (DD/MM/YYYY)

5 Was the lesion(s) removed?

Yes ☐ Please go to question 7

No ☐ Please provide details below (eg still present, disappeared without surgery) and go to question 6

6 Are you awaiting further follow-up, investigation or treatment?

Yes ☐ Please go to question 11

No ☐ Please go to question 11

7 Date lesion(s) removed (DD/MM/YYYY)

8 How was the lesion(s) removed?

☐ Diathermy (burnt off) ☐ Cryotherapy (frozen off) ☐ Cut off (surgically removed)

☐ Other - please provide details

9 Were the lesion(s) reported to be:

☐ Malignant or cancerous ☐ Benign or normal ☐ Unknown

Please forward copies of any histology reports you have

10 Since the original removal, have you been required to undergo re-excision or has the lesion(s) recurred or regrown?

Yes ☐ Please provide details

No ☐

11 Please provide the name and address of any doctors, hospitals or other health professionals consulted for your skin lesion(s) and the date last consulted.

Name	**Address of hospital/doctors surgery**	**Date** (DD/MM/YYYY)

12 Do you attend routine check ups with your GP or specialist?

☐ I was not required to attend routine checks
☐ I attend check ups once a year or less often
☐ I attend check ups every 6 months
☐ I attend check ups 3 times or more every year
☐ I was advised to have routine check ups but I have not attended

Return to question 26 on page 11.

Supplementary High Blood Pressure Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life Insured.

1 When was your blood pressure first noticed to be raised? (DD/MM/YYYY)

2 When was your blood pressure last checked? (DD/MM/YYYY)

3 Do you know the result of your last blood pressure reading?

Yes ☐ Please confirm last reading

No ☐ Which of the following statements best describes your last blood pressure reading?

☐ Normal ☐ Low ☐ High ☐ Don't know

4 Is your blood pressure being monitored regularly? (at least once every 6 months either at your doctor's clinic or on a home monitor)

Yes ☐

No ☐

5 Have you undergone or been referred for any other investigations, eg ECG (resting or exercise), echocardiogram, 24-hour Holter monitoring, urinalysis?

Yes ☐ Please provide dates, tests done and results

Date (DD/MM/YYYY)	Test	Results

No ☐

6 Are you awaiting any further tests or investigations for high blood pressure?

Yes ☐ If yes, please provide which test, date of tests or investigations.

Date (DD/MM/YYYY)	Test/Investigation

No ☐

7 Are you currently on prescribed medication or any treatment to control your blood pressure?

Yes ☐ Please provide medication or treatment and dosage

Medication or treatment	Dosage

No ☐ Please go to question 9

8 Has your medication or treatment (type or dosage) changed within the last 12 months?

Yes ☐ Please provide details and then go to question 10

When was it changed? (DD/MM/YYYY)

What was changed?

Why was it changed?

No ☐ Please go to question 10

9 Have you ever been advised to take medication or treatment for your blood pressure?

Yes ☐ When and why did you stop taking it?

No ☐ How has the condition been managed?

10 Have you ever not taken, or stopped medication or treatment without your doctor's approval?

Yes ☐ Please provide full details

No ☐

11 In the last 5 years, have you been hospitalised due to your blood pressure?

Yes ☐ Please provide full details

No ☐

12 Have you had any of the following conditions in association to your blood pressure? Please select all that apply

☐ Heart Disease ☐ Stroke or mini-stroke (TIA) ☐ Diabetes ☐ Kidney problems ☐ Eye problems

13 In the last 12 months, have you been a:

Please select all that apply.

- ☐ Regular smoker (smoke each day)
- ☐ Occasional smoker (smoke each week/ month/ year)
- ☐ Social smoker (smoke with friends/ family/ colleagues)
- ☐ User of e-cigarettes or vaping
- ☐ User of nicotine-replacement products like patches, gum, etc
- ☐ Non-smoker (you have not smoked at all)

14 Please provide the name and address of any doctors, hospitals or other health professionals consulted for your blood pressure and date last consulted.

Name	**Address of hospital/doctors surgery**	**Date** (DD/MM/YYYY)

Return to question 26 on page 11.

High Cholesterol Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life Insured.

1 When was your cholesterol first noticed to be raised? (DD/MM/YYYY)

2 When was your cholesterol last checked? (DD/MM/YYYY)

3 Do you know the result of your last cholesterol reading?

Yes ☐ Please confirm last reading

No ☐ Did your doctor or nurse tell you whether your last cholesterol reading was high, normal or low?

- ☐ High and needs to be reduced
- ☐ Satisfactory but slightly raised
- ☐ Normal
- ☐ Low
- ☐ Don't know

4 Is your cholesterol being monitored regularly? (at least once every 6 months either at your doctor's clinic or on a home monitor)

Yes ☐

No ☐

5 Have you had any of the following?

- ☐ Kidney problems, protein in your urine
- ☐ Angina, heart attack, stroke, TIA (transient ischaemic attack)
- ☐ blocked or narrowed arteries in your legs
- ☐ An ECG or heart test that was abnormal or needed further investigation
- ☐ Chest pain that required attendance at an Accident and Emergency department or any clinic or hospital
- ☐ Eye problems as a result of your condition
- ☐ None of these

6 Are you awaiting specialist referral, tests or investigations or the results of any tests or investigations for your cholesterol?

Yes ☐ Please provide dates, tests done and results in the boxes below

Date (DD/MM/YYYY)	Test	Results

No ☐

7 Are you currently on prescribed treatment to control your cholesterol?

Yes ☐ Please provide medication and dosage

No ☐ Please go to question 9

8 Has your treatment changed in the last 12 months?

Yes ☐
- ☐ Advised to start or increase treatment
- ☐ Advised to attend a review within 6 months
- ☐ Treatment remained the same or has been decreased
- ☐ Treatment was stopped
- ☐ Advised to attend a review in 6 month's time or later
- ☐ Referred to a specialist
- ☐ Discharged from follow up

No ☐

9 In the last 12 months, have you been a:
(Please select all that apply.)

- ☐ Regular smoker (smoke each day)
- ☐ Occasional smoker (smoke each week/ month/ year)
- ☐ Social smoker (smoke with friends/ family/ colleagues)
- ☐ User of e-cigarettes or vaping
- ☐ User of nicotine-replacement products like patches, gum, etc
- ☐ Non-smoker (you have not smoked at all)

10 Please provide the names and address of any doctors, hospitals or other health professionals consulted for your cholesterol and date last consulted.

Name	**Address of hospital/doctors surgery**	**Date** (DD/MM/YYYY)

Return to question 26 on page 11.

Supplementary Mental Health Questionnaire

Complete this questionnaire only if requested to do so. To be completed by the Life Insured.
If there is not enough space here please complete additional details at Section 18, page 17.

We know that mental health can change over time and can be caused by specific events or factors out of your control. Therefore, the purpose of these questions is to understand your own individual experiences with mental health.

1 At any point in your life, have you experienced any of the following common symptoms or conditions related to mental health?

- ☐ Stress, sleeplessness, chronic tiredness
- ☐ Anxiety including generalised anxiety, reactive or grief anxiety, panic or phobic disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression, dysthymia
- ☐ Manic depressive illness, bipolar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress disorder (PTSD)
- ☐ Attention deficit and/or hyperactivity disorder (ADD / ADHD)
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Other - Please provide details in the box below

2 Please describe your symptoms including the date they started and how long they lasted and time off work.

Common symptoms may include: prolonged sadness or tearfulness, persistent sleeplessness or prolonged change in appetite, poor concentration, excessive anger, hostility or violence, thoughts of suicide, self-harm, not participating in usual enjoyable activities, relying on alcohol and sedatives, withdrawing from close family and friends, not getting things done at work/ school or not going out anymore.

Symptoms	**Date from** (DD/MM/YY)	**Date to** (DD/MM/YY)	**Time off work**

3 Please describe how this condition has affected you, including any limitations to your ability to work or daily activities.

4 Has any reason for your condition been identified?

Yes ☐ Please provide full details

No ☐

5 Do you continue to experience symptoms?

Yes ☐ Please describe your symptoms

No ☐ When did you **last** experience symptoms? (DD/MM/YYYY)

6 Have you ever received any counselling, medication or treatment for this condition? This may include anti-psychotics, antidepressants, anti-anxiety medication, or herbal medications.

Yes ☐ Please provide details below

Details of counselling/medication/treatment	**Date started** (DD/MM/YYYY)	**Date stopped** (DD/MM/YYYY)

No ☐

7 Has there been any change to your medication in the last year?

Yes ☐ Please describe the change. Was it an increase, decrease, change in type or something else?

No ☐

8 Have you ever received counselling, therapy such as cognitive behavioural therapy (CBT), or acceptance and commitment therapy (ACT), or support for alcohol or drug abuse?

This may have been provided by your usual doctor, a psychologist, psychiatrist or counsellor.

Type of counselling	**Date started** (DD/MM/YYYY)	**Date stopped** (DD/MM/YYYY)

9 Have your ever been hospitalised or needed treatment as an inpatient?

Yes ☐ Please provide details

No ☐

10 Have you ever taken an overdose of drugs, attempted suicide, or attempted to harm yourself?

Yes ☐ Please provide details

No ☐

11 Please provide the names and addresses of health **professionals, including counsellors** consulted and the date first and last consulted.

Name	Address of hospital/doctors surgery	Date (DD/MM/YYYY)

Go to question 26 on page 11.

Supplementary Back/Neck Disorder Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life Insured.

1 What type of back/neck pain or condition have you experienced? (select all that apply)

- ☐ Muscular
- ☐ Sciatica
- ☐ Whiplash
- ☐ Disc (including prolapsed disc, disc protrusion, disc degeneration)
- ☐ Facet joint
- ☐ Other disc condition - Please specify
- ☐ Other back/neck condition - Please specify

2 Is the back/neck condition associated with any other medical condition (eg ankylosing sponditilis, osteoarthritis, fracture etc)?

Yes ☐ Please confirm what condition it is associated with

No ☐

3 What area of the back is/was affected?

☐ Neck (Cervical) ☐ Upper/middle back (Thoracic) ☐ Lower back (Lumbar)

4 What is/was the exact nature of the back/neck disorder, including symptoms?

5 When did you first experience back/neck symptoms? (DD/MM/YYYY)

6 When did you last experience back/neck symptoms? (DD/MM/YYYY)

7 For how long did you have symptoms of this condition?

Days	
Months	

8 How many episodes have you had of back/neck symptoms?

☐ Once ☐ More than once

9 If you have experienced back/neck symptoms more than once, please confirm how many episodes of symptoms you've experienced for this condition. How long did each episode last?

Number of symptom episodes	Length of episode	Date (DD/MM/YYYY)

10 Are you fully recovered (this means no ongoing symptoms, no treatment, discharged from any further review and a complete return to your normal work or daily activities)?

Yes ☐

No ☐

11 What are your current symptoms?

12 Have you had an x-ray, scan, ultrasound or other test for your back/neck pain?

Yes ☐ Please provide name of tests and date/s performed

Name of tests	Date (DD/MM/YYYY)

No ☐

13 Are you undergoing or awaiting hospital referral, scans, imaging or other tests, the results of any scans, imaging or other tests or surgery for this condition?

Yes ☐ Please provide name of tests and dates

Details	Date (DD/MM/YYYY)

No ☐

14 What treatment have you had?

☐ Medication ☐ Physiotherapy ☐ Surgery ☐ Chiropractic

☐ Other (Please provide details)

15 When did you last have treatment or receive any form of therapy (eg chiropractic maintenance, physical therapy) for this condition?

16 How frequently are/were you required to have treatment?

17 Are your symptoms caused by or made worse by your job?

Yes ☐

No ☐

18 What is your current job?

19 How many days in total have you taken off work or had restrictions in daily activities because of this condition in the last 5 years?

20 Are you currently off work or receiving disability benefits due to this condition?

Yes ☐ Please provide details

No ☐

21 Please provide the name and address of any doctors, physiotherapists, chiropractors or other health professionals consulted and the date last consulted.

Name	Address of hospital/doctors surgery	Date (DD/MM/YYYY)

Return to question 26 on page 11.

Supplementary Joint/Musculoskeletal Questionnaire

Complete this questionnaire only if requested to do so.
To be completed by the Life Insured.

1 Which of the following joints or areas of the body are affected by your condition or having symptoms?

- ☐ Ankle ☐ Left ☐ Right
- ☐ Elbow ☐ Left ☐ Right
- ☐ Hip ☐ Left ☐ Right
- ☐ Knee ☐ Left ☐ Right
- ☐ Shoulder ☐ Left ☐ Right
- ☐ Wrist ☐ Left ☐ Right

2 What is/was the nature of the joint disorder, including symptoms and doctor's diagnosis, if known?

3 Is your condition caused by any of the following:

- ☐ Ankylosing spondylitis
- ☐ Bursitis or frozen joint/area
- ☐ Fibromyalgia
- ☐ Fracture
- ☐ Gout
- ☐ Muscle, tendon, cartilage or ligament injury, tear or other condition
- ☐ Osteoarthritis or osteoporosis
- ☐ Rheumatoid or psoriatic arthritis
- ☐ Other - please specify

4 When did you first experience symptoms? (DD/MM/YYYY)

5 When did you last experience symptoms? (DD/MM/YYYY)

6 On how many separate occasions have you experienced symptoms of this condition?

7 How often do you experience symptoms?

8 Please select all of the tests or investigations you have had for this condition or symptoms:

- ☐ Aspiration
- ☐ Blood tests
- ☐ Bone or bone density scan
- ☐ CT scan
- ☐ Keyhole surgery or arthroscope
- ☐ MRI
- ☐ Nerve or muscle tests
- ☐ Ultrasound
- ☐ X-ray
- ☐ None required
- ☐ Other - please specify

9 Have you fully recovered and resumed your usual activities or job with no ongoing restrictions?

Yes ☐

No ☐ Is your condition:

☐ improving ☐ stable ☐ getting worse

10 What are your current symptoms?

11 What treatment have you had?

- ☐ Medication
- ☐ Surgery
- ☐ Physiotherapy
- ☐ Other - please provide details

12 Are you still undergoing treatment?

Yes ☐

No ☐ When did you last have treatement? (DD/MM/YYYY)

13 Do you have residual pain, limitations of movement or restrictions in daily activities due to this condition?

Yes ☐ Please provide details

No ☐

14 Are you awaiting hospital referral, investigation or surgery for your condition?

Yes ☐

No ☐

15 In total, how much time off your normal work or daily activities have you had for this condition in the last 2 years?

16 Please provide the names and addresses of any doctors, physiotherapists, chiropractors or other health professionals consulted and the date last consulted.

Name	Address of hospital/doctors surgery	Date (DD/MM/YYYY)

Return to question 26 on page 11.

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