

Request for Insurance

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

Your Duty of Disclosure

Insurance Contracts Act 1984

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

You have the same duty to disclose those matters to the insurer before such a contract of life insurance is extended, varied or reinstated.

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

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

It also applies if you seek to extend, vary or reinstate the Contract.

Non-disclosure

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

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

Your Duty of Disclosure continues until the Contract of Life Insurance has been accepted by the insurer and confirmation in writing is issued.

It also applies if you seek to extend, vary or reinstate the Contract.

Checklist

To ensure that we are able to process your application quickly and efficiently please check that you have completed the following steps:

- | | |
|---|---|
| <input type="checkbox"/> Personal details | All personal information has been provided. |
| <input type="checkbox"/> Employment details | All employment information has been provided. |
| <input type="checkbox"/> Insurance details | You have selected the product you are requesting insurance to be applied to and provided the relevant insurance details in Section 3 . |
| <input type="checkbox"/> Declaration | Read the declaration, sign and date it, and notify us of your consent as required. |
| <input type="checkbox"/> Medical Authority | Sign and date both medical authorities on page 14 . |
| <input type="checkbox"/> Health and medical history | All questions have been answered and the relevant questionnaires have been completed. |
| <input type="checkbox"/> Return completed form and ALL questionnaires to MLC. | Return a completed form to MLC with all relevant questionnaires. |

Section 1 Personal details

Person whose life is to be insured

Title

Mr Mrs Miss Ms Other

First name

Middle name

Family name

Date of birth (DD/MM/YYYY)

Male

Female

Maiden name (if applicable)

Contact address for notices

Unit number

Street number

Street name

Suburb

State

Postcode

Mobile phone

Home telephone

Business telephone

Email

Facsimile

Section 2 Insurance products

Please select which MLC product your application is for:

- MLC MasterKey Business Super – Please complete **Section 3a**
- MLC MasterKey Business Super Family Members – Please complete **Section 3b**
- MLC MasterKey Personal Super – Please complete part **Section 3c**

Account number

Section 3 Insurance details

a MLC MasterKey Business Super Members

Type of insurance being applied for:

Death only **OR** Death and TPD

AND/OR

Income Protection

OR

The insurance arrangements established by your employer (if you select this option **go to Section 4**)

Amount of insurance being applied for (Please tick):

A fixed dollar amount for Death If so fill in the amount \$

A fixed dollar amount for TPD* If so fill in the amount \$

A multiple of your salary If so fill in the amount \$

A percentage of your salary multiplied by the number of years to your retirement If so fill in the salary % %

* When applying for Death and TPD, the TPD amount cannot exceed the Death cover amount.

Note: If you are requesting insurance above your existing level, you can select one of the above insurance which will replace your current insurance.

Amount of Income Protection Insurance being applied for:

Percentage of your current annual salary

75% Other % (up to a maximum of 75%)

Are you applying for a super contribution benefit?

Yes **Complete below**

No **Proceed to Benefit Period**

What percentage of super contributions do you wish to insure?

% (between 1–15%)

Note: This means if you request 5% you will receive this amount in addition to your monthly income payments as super contributions. The maximum monthly combined benefit is \$30,000. Refer to the PDS for further information.

Benefit Period:

2 years **OR** to age 65

Waiting Period:

30 days 60 days 90 days 180 days*

* Only available to age 65

Go to Section 4

Section 3 Insurance details continued

b MLC MasterKey Business Super Family Members

Type of insurance being applied for:

Death only **OR** Death and TPD*

Amount of insurance being applied for:

A fixed dollar amount for Death

If so fill in the amount

\$

A fixed dollar amount for TPD*

If so fill in the amount

\$

* When applying for Death and TPD, the TPD amount cannot exceed the Death cover amount.

Go to Section 4

c MLC MasterKey Personal Super Members

Type of insurance being applied for:

Death only **OR** Death and TPD*

Amount of insurance being applied for:

A fixed dollar amount for Death

If so fill in the amount

\$

A fixed dollar amount for TPD*

If so fill in the amount

\$

* When applying for Death and TPD, the TPD amount cannot exceed the Death cover amount.

Amount of Income Protection insurance being applied for:

Percentage of your current annual salary

75% Other % (up to a maximum of 75%)

Are you applying for a super contribution benefit?

Yes **Complete below**

No **Proceed to Benefit Period**

What percentage of super contributions do you wish to insure?

% (between 1–15%)

Note: This means if you request 5% you will receive this amount in addition to your monthly income payments as super contributions.

The maximum monthly combined benefit is \$30,000. Refer to the PDS for further information.

Benefit Period:

2 years **OR** to age 65

Waiting Period:

30 days 60 days 90 days 180 days*

* Only available to age 65

Go to Section 4

Section 4 Employment details

1 Name of employer or trading name

2 What is your current occupation?

a Main occupation

b Industry

c What professional or trade qualification do you have?

d On what basis are you employed?

Full-time Part-time Casual
 Contractor Fixed-term employment

Note: Fixed-term employment means you are employed for a fixed-term period of employment (for a minimum contract of 3 months) determined at the commencement of your employment and where you are in receipt of leave, sick leave, superannuation and other benefits normally associated with full-time employment.

e Date you started with your **current** employer.

(DD/MM/YYYY)

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3 What is your Annual Salary?

\$ OR hourly rate if casual \$

Note: Annual Salary is your income derived from your occupation, excluding superannuation, director's fees, overtime payments, penalty or shift allowances, investment income, etc.

4 Will your Annual Salary continue at or beyond this level?

No Please provide details

Yes

5 What is the average number of hours you worked per week over the last year? hrs

6 Please include below the approximate percentage (%) of time spent in the duties of your main occupation. If you select 'Other' please specify the duties you perform.

Nature of duty	% time
Administration or Clerical (eg filing, computer work, office duties, etc)	
Light manual work only (ie driving with deliveries, lifting under 5 kg, etc)	
Supervisor of manual work	
Caring for dependants (only for Total and Permanent Disability (TPD) and occupation is 'home duty')	
Manual work (eg cleaning, lifting over 5 kg, carpentry, plumbing, etc)	
Other (please specify):	
Total	100%

7 Do you have a second occupation?

No

Yes Please provide details in questions **a-g** below

a Occupation	b Name of employer or trading name	
<input type="text"/>	<input type="text"/>	
c Duties		
<input type="text"/>		
d Hours worked per week	e Amount of time in this occupation	
<input type="text"/>	<input type="text"/> years	<input type="text"/> months
f What was your Annual Salary before tax for the last 12 months from your second occupation?		\$ <input type="text"/> pa
g Has this income been included in the Annual Salary shown in Question 3 of this application?		<input type="checkbox"/> No <input type="checkbox"/> Yes

Section 4 Employment details continued

8 Are you self-employed or do you own all or part of the business in which you are employed?

No

Yes Please complete questions **a** to **e** below

a Have you been self employed in your current business for more than 12 months? No Yes

b On what basis do you operate your business? Sole Trader Company Partnership Trust

c What percentage interest/shareholding do you have in the business? %

d How many employees (other than yourself) do you have?

e Has your business had a net operating loss in either of the last two years? No
 Yes Please provide last two years' financial accounts for all entities

Section 5 Additional details

1 Travel

Do you have any intention of travelling or residing outside Australia?

No

Yes Please complete the table below:

Date(s) of departure(s)	Duration of stay(s)	Destination(s)	Purpose of stay(s) (eg holiday, business, residing)

2 Have you ever made a claim or received benefits in regard to any illness, injury or condition?

No

Yes Please provide details in the table below

Benefit type	Benefit amount	Reason for claim	Time off work	Date finalised

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

No

Yes Please provide details below

Company	Benefit type	Date started	Benefit amount	Waiting / benefit periods	Policy number	To be replaced
			\$			No <input type="checkbox"/> Yes <input type="checkbox"/>
			\$			No <input type="checkbox"/> Yes <input type="checkbox"/>
			\$			No <input type="checkbox"/> Yes <input type="checkbox"/>
			\$			No <input type="checkbox"/> Yes <input type="checkbox"/>
			\$			No <input type="checkbox"/> Yes <input type="checkbox"/>

Section 6 Sports and Pastimes

1 Do you now or do you intend to take part in any of the following activities?

No

Yes Please tick all that apply and provide details below

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

Other hazardous pursuits (eg body contact sports, mountain climbing, abseiling, downhill mountain biking)

If you ticked any of these boxes, please complete the **Pastimes Questionnaire** located on page 19.

If you ticked any of these boxes, please provide full details of each below

Activity

Location

Recreational Professional Competitive

Events/hours per year:

Other details

Activity

Location

Recreational Professional Competitive

Events/hours per year:

Other details

Section 7 Health and medical history

- 1 What is the name and address of your usual doctor or medical centre? (If no usual doctor, then the last doctor you last visited). If you have known this doctor for less than 12 months, please also advise the previous doctor's details at **Question 18 on page 12**.

This question must be completed

a Doctor's name or medical centre			
<input type="text"/>			
b Address			
<input type="text"/>			
<input type="text"/>		State	Postcode
<input type="text"/>		<input type="text"/>	<input type="text"/>
c Business number		d How long have you been attending this practice?	
<input type="text"/>		<input type="text"/> years <input type="text"/> months	
e Please provide details of your last check-up or consultation.			
Date of last consultation		Reason for last check-up or consultation	
<input type="text"/>		<input type="text"/>	
f Result			
<input type="text"/>			
g Medication prescribed, referral given or tests ordered			
<input type="text"/>			
<input type="text"/>			

- 2 Have you ever had, or been told you had, or ever sought advice or treatment from a doctor, counsellor or other health professional for any of the following:

No

Yes Please tick all that apply below and complete the relevant Underwriting Questionnaire(s) located on **pages 19–27** of this form.

- | | |
|--|--|
| <input type="checkbox"/> Stress, anxiety, depression, post traumatic stress disorder (PTSD) or any other mental health disorder | ▶ Please complete the Mental Health Questionnaire located on page 21 |
| <input type="checkbox"/> High blood pressure | ▶ Please complete the High Blood Pressure Questionnaire located on page 22 |
| <input type="checkbox"/> High cholesterol | ▶ Please complete the High Cholesterol Questionnaire located on page 23 |
| <input type="checkbox"/> Asthma | ▶ Please complete the Asthma Questionnaire located on page 24 |
| <input type="checkbox"/> Skin cancer, tumour, cyst, lesion or mole | ▶ Please complete the Skin Lesion Questionnaire located on page 25 |
| <input type="checkbox"/> Back or neck strain/sprain or pain, sciatica, whiplash, spondylitis, fracture or any back, neck or spinal problem | ▶ Please complete the Back Questionnaire located on page 26 |
| <input type="checkbox"/> Any bone/joint fractures, muscle, ligament or tendon injuries, tenosynovitis, gout, arthritis or osteoporosis | ▶ Please complete the Joint/Musculoskeletal Questionnaire located on page 27 |

Section 7 Health and medical history continued

3 Are you carrying the Human Immunodeficiency Virus (HIV) which causes AIDS, antibodies to that virus, or are you suffering from AIDS or any AIDS related condition? No
Yes

4 In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?

No
Yes

A private and confidential questionnaire will be mailed to you upon submission of this application

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

- sex with someone you know or suspect to be HIV positive
- sex with an intravenous drug user
- sex without a condom with a sex worker
- anal intercourse without a condom (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years).

5 Do you wish MLC to arrange all medical requirements?

No Go to next question

Yes Blood tests, Mini Health check or Express check required:
Go to next question and complete the Pathology request form on page 15.
Medical Exam/Health Evaluation required: Go to Section 8.

6 Have you arranged or do you intend to arrange medical requirements in connection with this application?

No Go to next question

Yes The following has/will be arranged:

- Mini Health Check. Go to question 7.
- Blood Test. Go to question 7.
- Medical/Health Evaluation arranged with:
 - Usual doctor/GP. Go to Section 8.
 - Para medical (Nurse). Go to Section 8.
 - Consultant (Specialist). Go to Section 8
- ECG.
- Other:

7 Do you drink alcohol?

No

Yes Number of standard drinks: per day OR per week

Note: 1 standard drink = 1 glass of beer/wine/nip of spirit

8 Have you smoked tobacco or any other substance or used any nicotine-containing product in the last 12 months?

No

Yes What type? eg cigarettes, gum, patch

Daily quantity

9 What is your height/weight? cm kg

Section 7 Health and medical history continued

10 Do you have or have you ever had any of the following?

Condition		No	Yes
a	Heart complaint		
b	Epilepsy or any neurological disorder		
c	Stroke or vascular disorder		
d	Lung complaint		
e	Diabetes, bowel, kidney or bladder disorder		
f	Alcohol or drug dependence		
g	Professional advice to reduce alcohol consumption		
h	Migraine, persistent headache or chronic fatigue		
i	Disorder of the reproductive system (eg prostate, ovary), or sexually transmitted disease		
j	Cancer or leukaemia		
k	Haemophilia or blood disorder		
l	Liver disorder, hepatitis or test indicating past or present hepatitis infection		
m	Any allergies, skin disorder, or disorder of the eyes, ears, nose or throat		
n	Any other operation, disability, illness or injury, medical investigation or test (eg genetic test, mammogram, ultrasound, ECG) not already mentioned		

If you answered 'Yes' to any item in this question please provide details below.

Question	Illness, injury, condition or test	Test result	When did it start?	When did it end?	Type of treatment and when treatment end	How long off work?	Have you completely recovered?	Name and address of institution and attending person

11 Other than already stated, have you in the last 5 years:

a Taken any prescribed medication on a regular or ongoing basis? (other than for colds or flu)

No

Yes Please provide details in the table below:

b Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist?

No

Yes Please provide details in the table below:

Provide details below. If there is not enough space here, please list at question 18 on page 12.

Question	Illness, injury, condition or test	Test result	When did it start?	When did it end?	Type of treatment and when treatment end	How long off work?	Have you completely recovered?	Name and address of institution and attending person

Section 7 Health and medical history continued

12 Do you now have any other disability, illness, injury or symptoms not already mentioned?

No

Yes **Please provide details in the table below:**

13 Do you contemplate seeking any advice, test, investigation or treatment?

No

Yes **Please provide details in the table below:**

Provide details below. If there is not enough space here, please list at question 18 on page 12.

Question	Illness, injury, condition or test	Test result	When did it start?	When did it end?	Type of treatment and when treatment end	How long off work?	Have you completely recovered?	Name and address of institution and attending person

Males: Go to Question 17

Females only

14 Have you had any complications of pregnancy or childbirth?

No

Yes **Please provide details**

15 Are you currently pregnant?

No

Yes Date due:

16 Have you ever had an abnormal pap smear?

No

Yes When Treatment

Date and result of most recent pap smear

17 Have any of your parents, brothers or sisters (living or dead) suffered from any of the following?

- Cancer (specify type and site)
- Heart disease
- Stroke
- Diabetes
- Kidney disease
- Rheumatoid arthritis
- Huntington's disease
- Motor neurone disease
- Muscular dystrophy
- Familial polyposis
- Any other hereditary disorder
- Multiple sclerosis

No

Yes **Please provide details below.**

Relationship	Medical condition	Cancer type and site	Age condition began	Age at death (if applicable)

Section 8 Your agreement and declaration

Read this section carefully before signing.

My decision to apply for insurance under MLC MasterKey Business Super or MLC MasterKey Personal Super is based on the Product Disclosure Statement 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 the Duty of Disclosure set out on **page 1** and the Interim Accident Insurance Certificate on **page 17**. I understand that, until MLC accepts this application and issues a policy (or, in the case of an addition to an existing policy, a revised Schedule), I have a duty to disclose every matter which I know, or could reasonably be expected to know, is relevant to MLC's acceptance of this application and that if I fail to comply with my duty of disclosure MLC may (as permitted by law) cancel this policy or reduce the benefits under it;
- (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) Where this application is for insurance cover under a superannuation fund, I will provide MLC or the Trustee or any appointed Administrator with any information which relates to my membership of that fund which they may request;
- (e) This insurance application is not effective until MLC accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;
- (f) I was actively at work performing the normal duties of my occupation when I applied for this insurance;
- (g) All statements and declarations given by me on this form are true and correct; and
- (h) The information contained in this application may be released to the Trustee which has arranged this group insurance, or to an administrator appointed by the Trustee for the purposes of administering this insurance or the superannuation fund under which it is provided.

I authorise MLC to:

- (a) Collect further medical information from any doctor, medical centre, hospital or any other health service provider identified by me in this application for the purpose of assessing my application for insurance; and
- (b) Provide my personal, financial and medical information (whether provided in this application or otherwise subsequently collected by MLC 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
- (c) Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undergone in connection with this application to my usual doctor or medical centre as nominated at **Section 7, Health and Medical History**; and
- (d) Provide a copy of the HIV Antibodies test to my usual doctor or medical centre as nominated at **Section 7, Health and Medical History** 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 MLC and any third party referred to in paragraphs (a), (b), (c) and (d) 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 NAB's privacy policy and agree that any member of the NAB Group may collect, use, disclose and handle my personal information in a manner set out in the Group's privacy policy available on mlc.com.au

I give my consent to: (please tick as required)

Yes my financial adviser to provide information to MLC, on my behalf, concerning my pastime activities, occupation and financial status, for the purpose of expediting the assessment of my application for insurance.

I give my consent to: (please tick as required)

If my application is declined or approved on non-standard acceptance terms

Yes MLC to disclose to my financial adviser any personal medical information or finding that results in my application for insurance being accepted on non-standard or amended terms, or declined. I understand that MLC will not provide copies of medical or other reports pertaining to my application for insurance to my financial adviser without first obtaining my specific consent to do so.

I acknowledge that MLC MasterKey Business Super or MLC MasterKey Personal Super does not represent a deposit with or liability of NAB Limited or any other member of the National Group of companies (other than a liability of MLC Limited). Neither NAB Limited, nor any other company in the National Group of Companies (other than MLC Limited as insurer) guarantees or accepts liability in respect of MLC MasterKey Business Super or MLC MasterKey Personal Super.

Have you completed or were you requested to complete any Questionnaires in this Application Form?

No Please make sure you have completed and signed the Application Form from **page 1 to 18**.

Yes Please complete the relevant Questionnaires and return the completed Application Form and Questionnaires to us.

Signature of Applicant

	Date (DD/MM/YY)
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Please also complete the medial authority on page 14.

Pathology Request for Insurance

This must be completed when a blood test is required.

Title	Surname (Family name) (please print)	Given name	Sex	Date of birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Policy name		Family doctor or hospital – name and address		
<input type="text"/>		<input type="text"/>		
Policy/Account number		Postcode		
<input type="text"/>		<input type="text"/>		

Report and account to	Collection date and time	Tests require
MLC MasterKey Business Super / Personal Super PO Box 200 North Sydney NSW 2059 Phone: 132 652	Date of appointment <input type="text"/> Time of appointment <input type="text"/> am/pm	<input type="checkbox"/> Multiple Biochemical Analysis 20 <input type="checkbox"/> HIV Antibodies <input type="checkbox"/> Hepatitis B and C serology <input type="checkbox"/> Other (specify) <input type="text"/>

Members 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 MLC (see over) on the implication of the test and understand its significance. I authorise the sending of a copy of the test results to MLC Limited and to my family doctor as shown above.

No
 Yes

Member's signature

Date (DD/MM/YY)

Adviser details

Adviser's name	Adviser's number	Telephone number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Information about the HIV Antibody Blood Test

To fully assess this application for insurance, we may request you undergo an HIV antibody blood test. This test could be arranged through your own doctor, by consulting a doctor arranged by us or directly with the pathology laboratory. This test is completely voluntary. However, if you refuse the test, it could affect our willingness to accept this application.

Acquired Immune Deficiency Syndrome (AIDS) is a viral disease caused by the Human Immunodeficiency Virus (HIV) which destroys some of the white blood cells in our bodies. These white blood cells help protect our bodies against infection and cancers. Some people infected with HIV therefore suffer infections or cancers and, in some cases, direct damage to the brain by the virus. The most recent evidence suggests that the virus will persist in the body indefinitely. As yet, there is no cure for AIDS.

Following infection, there may be mild flu-like symptoms or no symptoms at all. The body subsequently manufactures antibodies to the virus, usually within 8 to 12 weeks, but occasionally longer. These antibodies can be detected by a blood test and this is the test proposed. The infected individual may remain free of symptoms for many years, but during this time may pass on the infection to others. The first symptoms may include weight loss, fever, swollen glands, diarrhoea, coughs, cancer or nervous system diseases.

A positive result

If the result of the HIV antibody test is positive, this means:

1. You have been infected by HIV,
2. You can pass this infection:
 - (a) to any unprotected sexual partner,
 - (b) to anyone receiving your blood, donated organs or semen,
 - (c) if you are an intravenous drug user, to anyone sharing syringes or needles with you,
 - (d) if you are a woman, to a baby during pregnancy, and perhaps at birth or by breast feeding.

There is no evidence that the virus can be spread by other types of contact, such as touching, sharing eating utensils, coughing, sneezing or from mosquito bites.

3. Full AIDS is notifiable throughout Australia. In some States and Territories, HIV infection and other early stages of the disease are also notifiable to the health authority. In most cases, notification is by name and address, though in some States, it is by code.

4. Knowing that you are HIV antibody positive has legal consequences in all States and Territories, although they vary. It may exclude you from some jobs and from access to some services. It can be an offense to knowingly transmit the virus or put someone at risk of infection through sexual activity. There are quarantine provisions which may be used if the authorities consider it appropriate.
5. In many cases, the full effects of AIDS will develop at some stage and the long-term outlook is still uncertain. As a result, life and disability insurance is unlikely to be available to anyone infected with HIV.

If the result of the test is positive, it is important that you receive appropriate counselling from a doctor. You are asked to nominate your family doctor to give you this counselling in the consent declaration contained in the Application form attached to this brochure. You may wish to nominate an alternative doctor. We will pass a positive result on to that doctor for onward communication to you.

A negative result

If the result of the HIV antibody test is negative, this means, either that you have not been infected or that you have been infected recently but your body has not yet had time to manufacture antibodies. However, you should be alert to the risk of becoming infected and refrain from activities which make that possible – particularly unsafe sexual practices and sharing of syringes or needles.

The choice is yours

You may choose not to have the test for a variety of reasons, eg you may feel you would not be able to cope with the knowledge of a positive result and the medical implications which follow, or you may be concerned about the social implications (discrimination, stigma, etc). You may feel that you would like more information first, in which case you are advised to seek advice from your own doctor. If you do not have one, or would prefer advice from elsewhere, you should see a specialist counsellor on the subject. Government and community organisations provide AIDS counselling services. If you choose to have the test arranged by us, we are concerned to protect your privacy. The result will be sent under confidential cover to our Chief Medical Officer. A positive result will not be transferred to our general records on your application for insurance.

Interim Accident Insurance Certificate

We provide Interim Accident insurance, at no extra cost, while your application or increase of insurance is being considered.

When will we pay?

We'll pay the benefit of the Interim Accident insurance for claims arising from an Accident while you're waiting for your insurance application to be accepted.

Death and TPD insurance

We'll pay the Interim Accident benefit if you die as a result of Injury, provided your death occurs within 365 days of the injury.

If your application includes TPD insurance, we'll pay the benefit for:

- quadriplegia
- major brain injury; or
- the total and irreversible inability to perform at least two of the following daily living activities:
 - bathing and showering
 - dressing
 - moving from place to place, including into and out of bed or a chair
 - eating and drinking, or
 - using the toilet.

We'll pay the lowest of:

- \$1,000,000
- the benefit you applied for, or
- the benefit we allow under our assessment guidelines.

Income Protection insurance

The Interim Accident benefit will be paid if you:

- applied for or are increasing your Income Protection insurance, and
- are Totally Disabled as a result of a bodily injury that's caused by Accident.

We'll pay the lowest of:

- \$15,000 a month
- the benefit you applied for, or
- the Income Protection benefit we allow under our assessment guidelines.

This benefit will be paid each month you're continuously Totally Disabled after the end of the waiting period you applied for, up to a maximum of two years.

When does Interim Accident insurance start?

New insurance (including family member insurance) starts the date we receive your properly completed application, provided we've received contributions into your account.

We pay one benefit

We won't pay more than one benefit under this Interim Accident Insurance for any one Accident to you.

When won't we pay?

In addition to our standard exclusions (outlined in the current MLC Master Policy, PDS and Insurance Guide), we won't pay a benefit under this insurance for death or disability arising from or contributed to by:

- an Injury occurring before the date of your insurance application or increase, or
- you engaging in any hazardous Occupation, pastimes or sports that we wouldn't insure under our normal assessment guidelines.

Also, we won't pay if:

- the insurance applied for would have been declined under our assessment guidelines, or
- you lodge a claim for an event or condition that would have been excluded in the underwriting process or in the insurance provided to you.

When does Interim Accident insurance end?

Your Interim Accident insurance will end on the earliest of:

- 180 days after the start of your Interim Accident insurance for Death and TPD insurance
- 90 days after the start of your Interim Accident Disability insurance for Income Protection insurance
- when we let you know your application or increase has or hasn't been accepted, or
- when you withdraw your application.

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Pastimes Questionnaire

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 What type of diving do you do?

Scuba Snorkel Hookah Other—Please provide details

4 Please advise the following:

Average number of dives per year	Average depth of dives	Maximum depth and number of times attained	Average duration of dives	Maximum duration of dives
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5 Do you ever dive alone?

Yes
No

6 Do you dive in caves, potholes or wrecks?

Yes ▶ Please provide details

No

7 Do you use mixed gases or a rebreather to dive?

Yes ▶ Please provide details

No

8 Have you ever had an accident whilst diving or suffered an injury?

Yes ▶ Please provide details

No

Pastimes Questionnaire (continued)

Motor Racing

1 What types, classes, and engine capacity of vehicles do you race or intend to race?

2 What types of racing do you participate in? (eg stock car, circuit racing, road racing etc, and number of events each year)

3 Do you compete as: Amateur Professional Competitive

4 What maximum speed is reached? km

5 How many times do you race per year?

Aviation

1 Do you hold an aviation licence?

Yes Type of licence and period of time held

No

2 Do you intend to change the scope of your licence, or engage in any other form of aviation other than as shown below?

Yes Please provide details

No

3 Please complete number of flying hours in the following table:

	Last year		Future average	
	Crew	Passenger	Crew	Passenger
Commercial Airline				
Charter				
Private				
Aero Club/Flying School				
Agriculture				
Ultralight				
Helicopter				

Mental Health Questionnaire

1 Please indicate the conditions you have had or received treatment or counselling for.

- | | |
|---|---|
| <input type="checkbox"/> Stress, sleeplessness, chronic tiredness | <input type="checkbox"/> Post traumatic stress disorder (PTSD) |
| <input type="checkbox"/> Anxiety including generalised anxiety, reactive or grief anxiety, panic or phobic disorder | <input type="checkbox"/> Attention Deficit and/or Hyperactivity Disorder (ADD / ADHD) |
| <input type="checkbox"/> Eating disorder including anorexia nervosa, bulimia | <input type="checkbox"/> Schizophrenia or any other psychotic disorder |
| <input type="checkbox"/> Depression including major depression, dysthymia | <input type="checkbox"/> Other—please provide details in the box below. |
| <input type="checkbox"/> Manic depressive illness, bipolar disorder | <input type="checkbox"/> |
| <input type="checkbox"/> Alcohol or other substance abuse or addiction | <input type="checkbox"/> |

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

Symptoms	Date from — Date to	Time off work

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

4 Has any reason for your condition been identified?

Yes Please provide details

No

5 Have you ever received any counselling or treatment for this condition? (eg medication, cognitive behaviour therapy)

Type of treatment	Date commenced (DD/MM/YYYY)	Date ceased (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

6 Do you continue to experience symptoms?

Yes Please describe your symptoms

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

7 Have you had any recurrence of this condition or suffered from or had symptoms of a similar condition?

Yes Please provide details

No

8 Please provide the name and address of health professionals, including counsellors consulted and the date first and last consulted.

Name	Address	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

High Blood Pressure Questionnaire

1 When were you first told you had high blood pressure and what was your blood pressure level at that time?

Date (DD/MM/YYYY)

Reading

2 What was your last blood pressure reading and when was it taken?

Date (DD/MM/YYYY)

Reading

3 Is this reading consistent with other checks?

Yes

No

What is your typical reading?

4 How often are you required to attend your doctor for review/check-up?

Monthly

Quarterly

Twice Yearly

Annually

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 currently taking medication for your blood pressure?

Yes Please provide medication and dosage

No Please go to question 8

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

Yes Please provide details and then go to question 9

When was it changed?

What was changed?

Why was it changed?

No Please go to question 9

8 Have you ever been prescribed medication for blood pressure?

Yes When and why did you cease taking it?

No How has the condition been managed?

9 Please provide the name and address of doctor, hospital or health professional consulted for your blood pressure and date last attended

Name

Address

Date (DD/MM/YYYY)

High Cholesterol Questionnaire

1 When were you first told you had raised cholesterol and what was your cholesterol level at that time?

Date (DD/MM/YYYY)

Reading

2 What was your last cholesterol reading and when was it taken?

Date (DD/MM/YYYY)

Reading

3 Is this reading consistent with other checks?

Yes

No

What is your typical reading?

4 How often are you required to attend your doctor for review/check-up?

Monthly

Quarterly

Twice Yearly

Annually

5 Have you undergone or been referred for any other investigations, eg ECG (resting or exercise)?

Yes Please provide dates, tests done and results

Date (DD/MM/YYYY)

Test

Results

No

6 Are you currently taking medication for your cholesterol?

Yes Please provide medication and dosage

No Please go to question 8

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

Yes Please provide details and then go to question 9

When was it changed?

What was changed?

Why was it changed?

No Please go to question 9

8 Have you ever been prescribed medication for cholesterol?

Yes When and why did you cease taking it?

No How has the condition been managed?

9 Please provide the name and address of doctor, hospital or health professional consulted for your cholesterol and date last attended

Name

Address

Date (DD/MM/YYYY)



Asthma Questionnaire

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

2 How many episodes of asthma do you have per year?

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

4 Are you taking medication or have you used any medication (including steroids) within the last 12 months?

Yes Please provide the name of medications and date ceased (if applicable)

No

5 Have you ever been hospitalised for this condition or needed to attend a hospital or doctor for urgent medical treatment?

Yes Please provide the name of hospitals, doctors and dates

Name	Address of hospital/doctors surgery	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

No

6 Have you lost any days from work as a result of asthma in the last 12 months?

Yes Please advise the number of days:

No

7 Is your asthma related to or aggravated by your occupation?

Yes Please provide details

No

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

Name	Address	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Skin Lesion Questionnaire

1 Site of lesion(s)

2 Type of lesion(s)

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

3 Number of lesion(s)

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

5 Were the lesion(s) removed?

- Yes Please go to question 7
No Please provide details below

6 Have you been advised to attend for any further treatment or follow-up?

- Yes Please go to question 11
No Please go to question 11

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

8 How were 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 Benign 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 lesions and the date last consulted.

Name	Address	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>



Back Questionnaire

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

2 What is/was the cause of your back/neck disorder?

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 What was the date of your last symptoms? (DD/MM/YYYY)

6 Have you had an x-ray, scan or other test?

Yes Please provide details
No

7 What treatment have you had?

Medication Physiotherapy Surgery Chiropractor
 Other—Please provide details

8 Have you made a complete recovery?

Yes How long have you been free of all symptoms? Please go to question 12
No

9 What are your current symptoms?

10 How often do you experience symptoms?

11 Does this condition cause any restriction in your daily activities?

Yes Please provide details
No

12 Have you taken time off work?

Yes Please advise when and how long were you off work?
No

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

Name	Address	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Joint/Musculoskeletal Questionnaire

1 Which joint(s) or area(s) of the body is/are affected?

Left Right

2 What is/was the exact nature of the disorder including symptoms?

3 What is/was the cause of the condition?

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

5 What was the date of your last symptoms? (DD/MM/YYYY)

6 Have you had an x-ray, scan or other test?

Yes Please provide details

No

7 What treatment have you had?

Medication Surgery Physiotherapy

Other—please provide details

8 Have you made a complete recovery?

Yes How long have you been free of all symptoms? Please go to question 12

No

9 What are your current symptoms?

10 How often do you experience symptoms?

11 Does this condition cause any restriction in your daily activities?

Yes Please provide details

No

12 Have you taken time off work?

Yes Please advise when and how long you were off work?

No

13 Please provide the name and address of any doctors, hospitals or other health professionals consulted and the date last consulted.

Name	Address	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

