

# MLC MasterKey

## Request for insurance/personal statement

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

### Your duty to take reasonable care not to make a misrepresentation

#### About this application

When you apply for life insurance cover, the Insurer conducts a process called underwriting. It's how the Insurer decides whether they can cover you, and if so on what terms and at what cost.

The Insurer will ask questions they 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 cover. The information you give the Insurer in response to the Insurer's questions is vital to the Insurer's decision.

#### The duty to take reasonable care not to make a misrepresentation

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

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

#### What can the Insurer do if you do not meet your legal duty?

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

If you do not meet your legal duty, this can have serious impacts on your insurance cover. For example, the Insurer may:

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

This may also result in a claim being declined or a benefit being reduced.

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

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

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

Before the Insurer exercises any of these remedies, the Insurer will explain their reasons, how to respond and provide further information, and what you can do if you disagree.

#### Guidance for answering the Insurer's questions

You are responsible for the information provided to the Insurer. When answering their questions, please:

- think carefully about each question before you answer. If you're unsure of the meaning of any question, please ask us before you respond.
- answer every question.
- answer truthfully, accurately and completely. If you're unsure about whether you should include information, please include it. Don't assume the Insurer will contact your doctor for any medical information.
- 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.

## Changes before your insurance cover starts

Your duty to take reasonable care not to make a misrepresentation continues until the time your insurance cover starts.

Before your insurance cover starts, the Insurer may ask whether there have been any changes that would cause you to answer the Insurer's questions differently.

## If you need help

It's important that you understand this information and the questions the Insurer asks. Ask us or your adviser for help if you have difficulty understanding the process of buying insurance cover or answering the Insurer's 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.

## 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 Disablement cover (TPD), or
- \$200,000 critical illness (trauma) cover, or
- \$4,000 a month, Income Protection 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 genetic test result you can provide this information regardless of the amount of cover applied for.

# For completion by the Life to be Insured

## Section 1 Member 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)

Residential address (your residential address can't be a PO Box)

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Postal address if different to your residential address (the postal address shown can't be your financial adviser's address.)

Unit number

Street number

PO Box

Suburb

State

Postcode

Country

## Section 2 Insurance details

Fund/Policy name

Account number

(MLC MasterKey Business Super members only)

Please specify the type of insurance cover being applied for. Please refer to the Insurance Guide/documentation issued to you when you joined the plan to ensure you are eligible to apply for the cover selected below. Please enter the **total** amount of insurance being applied for under this policy, including any existing insurance.

### Death and Total and Permanent Disablement (TPD)

You can either nominate your own amounts of cover<sup>1</sup> including any existing insurance below or select the Lifestage cover level on the next page (MLC MasterKey Super Fundamentals only).

| Type of Insurance                     | Amount |
|---------------------------------------|--------|
| Death                                 | \$     |
| Total and Permanent Disablement (TPD) | \$     |
| Income Protection (amount per month)  | \$     |

## Section 2 Insurance details continued

### Income Protection

Amount of Income Protection insurance being applied for:

Percentage of your current annual salary:  75%  % Other (up to a maximum of 75%)

**Income protection benefit period:** (please select)  2 years  5 years  to age 65

**Waiting period:** (please select)  30 days  60 days  90 days  180 days<sup>2</sup>

Are you applying for a Superannuation Contribution Benefit? This will provide an additional benefit of up to 15% of your monthly income paid into a complying superannuation fund of your choice.

No  Yes  % (between 1–15%)

### MLC MasterKey Super Fundamentals (only)

Complete the nominated amount above or select the lifestage cover below.

#### Choose an MLC Lifestage cover level<sup>3</sup>

##### Life stage

- Half the standard cover  
 Standard cover  
 Double the standard cover

If you currently have MLC Lifestage insurance which you obtained when joining MLC MasterKey Super Fundamentals, your premium isn't based on your individual circumstances. If you'd like to be assessed by the Insurer for individual factors such as your medical history, employment and pastimes, please check this box.

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

2 Only applies for benefit period of 5 years or to age 65.

3 For more information on how this works, and the level of cover available for your age, please see the **Insurance Guide** in the MLC MasterKey Product Disclosure Statement at [mlc.com.au](http://mlc.com.au)

## Section 3 Adviser details (only if applicable)

Adviser name

Adviser phone number

Adviser email

I am lawfully authorised to advise on, and deal in, the MLC MasterKey policy under an Australian Financial Services Licence. I do not provide these services on behalf of the Insurer ABN 90 000 000 402 AFSL 230694.

### Signature of the financial adviser listed above

|   |                      |
|---|----------------------|
|  | Date (DD/MM/YYYY)    |
|   | <input type="text"/> |

## 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 your duty to take reasonable care not to make a misrepresentation when you apply for cover with us, and we 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

I declare that:

- I will provide honest answers throughout this application, and
- I am aware that the Insurer can check my answers at any time after the policy is issued, and
- providing false or incorrect information may result in the Insurer altering or voiding my 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/<br>Benefit periods | Policy number | To be replaced*  |
|---------|--------------|--------------|----------------|-----------------------------|---------------|--|
|         |              |              | \$             |                             |               | 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"/> No <input type="checkbox"/> |

\*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

## Section 7 Occupation and financial

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

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

|   |                      |
|---|----------------------|
| a) Main job   | b) Industry          |
| <input type="text"/>  | <input type="text"/> |
| c) Name of employer or trading name   |                      |
| <input type="text"/>  |                      |
| d) Professional or trade qualifications   |                      |
| <input type="text"/>  |                      |
| e) If you have less than 12 months with the employer above, please provide name of last employer, job and time with that employer |                      |
| <input type="text"/>  |                      |
| <input type="text"/>  |                      |

3 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 5kg, using hand tools and/or, operation of light machinery.   |                    |
| Heavy manual work: includes carrying, lifting, pushing, pulling more than 5kg, the operation of heavy machinery and/or, driving a commercial vehicle.  |                    |
| Other (please specify).  |                    |
| <b>Total</b>   | <b>100%</b>        |

4 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

## Section 7 Occupation and financial continued

5 Date you started with your employer

6 On what basis are you employed?

- a) Full-time
- b) Permanent part-time (more than 15 hours per week)
- c) Casual\*
- d) Fixed term contract employment\*
- e) Seasonal or contract\*
- f) Permanent part-time (less than 15 hours per week)

\* Refer to the relevant Insurance Guide for definitions of these employment types.

7 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.

8 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

9 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) for 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 Travel and pastimes

10 Are you an Australian citizen or permanent resident, or a New Zealand citizen living in Australia?

Yes  Go to question 12

No  Please provide details including how long you have lived in Australia, the visa you hold and the expiry date of that Visa.

|  |
|--|
|  |
|  |
|  |

11 Have you applied for permanent residency?

Yes  Please provide details

|  |
|--|
|  |
|  |

No  Reason for not applying

|  |
|--|
|  |
|  |

12 In the next 12 months, do you have definite plans to live or travel outside Australia?

Yes  Please complete the table below

| Date(s) of departure | Duration of stay | Destination(s) | Purpose of stay (e.g. holiday, business, residing) |
|----------------------|------------------|----------------|--|
|                      |                  |                |  |
|                      |                  |                |  |
|                      |                  |                |  |

No

13 Do you currently take part in, or have definite plans to take part in any of the following sports or activities?

If you answer Yes to any of the following questions, you must also complete the relevant Supplementary Underwriting Questionnaire found on the Acenda website at [acenda.com.au/memberforms](http://acenda.com.au/memberforms)

Yes  Please tick all that apply

- Scuba Diving
- Motor car or motor cycle sport?
- Private flying, gliding, parachuting or ballooning
- Football (any code)
- Professional or semi-professional sport
- Mountaineering or rock climbing
- Other hazardous pursuits or activities including horse riding, martial arts, combat sports or sailing?

If you ticked any of these boxes, please complete the **Pastimes questionnaire**

No

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## Section 10 Doctor's details

### 14 Do you have a usual doctor?

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

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

Name of doctor or medical centre

Address

Suburb

State

Postcode

Country

Telephone

Email

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

years  months

When did you last attend?

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### 16 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?

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## Section 11 Height and weight details

### 17 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

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### 18 In the last 12 months, have you lost more than 10kg (22lbs)?

Yes  Please provide details

No

## Section 12 Habits and lifestyle

Individual lifestyle choices play an important part in our lives. 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.

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

Please select all that apply.

- |  |                              |
|--|------------------------------|
| <input type="checkbox"/> Regular smoker (smoke each day)                               | ▶ Go to <b>19a</b>           |
| <input type="checkbox"/> Occasional smoker (smoke each week/ month / year)             | ▶ Go to <b>19a &amp; 19b</b> |
| <input type="checkbox"/> Social smoker (smoke with friends / family / colleagues)      | ▶ Go to <b>19a &amp; 19b</b> |
| <input type="checkbox"/> User of e-cigarettes or vaping                                | ▶ Go to <b>19c</b>           |
| <input type="checkbox"/> User of nicotine-replacement products like patches, gum, etc. | ▶ Go to <b>19c</b>           |
| <input type="checkbox"/> Non-smoker (you have not smoked at all)                       | ▶ Go to <b>20</b>            |

19a 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

19b 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

19c How often do you use nicotine replacement products (e.g. 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

20 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

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

- Daily     Weekly     Monthly     Less than monthly     Never

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## Section 12 Habits and lifestyle continued

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

This includes any drug swallowed inhaled or injected. Do 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:

|              |
|--------------|
| <br><br><br> |
|--------------|

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**23** Have you ever attended a health professional, support group or received medical advice, counselling or treatment about any type of dependency, addiction or substance abuse?

Yes  Please provide details

|              |
|--------------|
| <br><br><br> |
|--------------|

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 paid.

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 Physical wellbeing

### Physical wellbeing - in the last 5 years

24 In the last five years, have you been diagnosed with, had symptoms of, or had treatment or medication for (select all that apply):

If you answer Yes to any of the following questions, you must also complete the relevant Supplementary Underwriting Questionnaire found on the Acenda website at [acenda.com.au/memberforms](https://acenda.com.au/memberforms)

- .....
- |   |                                |  |
|---|--------------------------------|--|
| <b>a</b> Asthma   | ▶ Yes <input type="checkbox"/> | ▶ Please complete the <b>Asthma</b> questionnaire                |
|   | No <input type="checkbox"/>    |  |
| .....   |                                |  |
| <b>b</b> High blood pressure  | ▶ Yes <input type="checkbox"/> | ▶ Please complete the <b>High Blood Pressure</b> questionnaire   |
|   | No <input type="checkbox"/>    |  |
| .....   |                                |  |
| <b>c</b> High Cholesterol   | ▶ Yes <input type="checkbox"/> | ▶ Please complete the <b>High Cholesterol</b> questionnaire      |
|   | No <input type="checkbox"/>    |  |
| .....   |                                |  |
| <b>d</b> Skin lesions such as moles, naevus, keratosis or sun spots | ▶ Yes <input type="checkbox"/> | ▶ Please complete the <b>Cyst/Mole/Skin Lesion</b> questionnaire |
|   | No <input type="checkbox"/>    |  |
| .....   |                                |  |

If you answer **yes** to any of the following questions, you must also complete the **Further information table** on page 16 of this application form.

.....

**e Skin conditions such as**

- Persistent rash, eczema, psoriasis
- Dermatitis or skin allergies
- None of these

.....

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

- Haemochromatosis,
- Varicose veins or Deep vein thrombosis (DVT)
- Pulmonary embolism
- Anaemia
- None of these

.....

**g Respiratory conditions such as**

- Sleep apnoea
  - COVID-19, Long/Post COVID syndrome
  - Pneumonia
  - Recurrent bronchitis
  - None of these
- .....

## Section 13 Physical wellbeing continued

**h Muscle, bone, ligament, cartilage or tendon injuries such as**

- Sprains or tears
- Repetitive strain injury (RSI)
- Carpal tunnel syndrome
- Fractured or broken bones or joints
- None of these

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

- Persistent headaches or migraines
- Vertigo, fainting or dizziness
- Head injuries such as concussion, fractured skull or brain damage
- None of these

**j Stomach, Bowel, gall bladder or digestive system conditions such as**

- Diverticulitis
- Irritable bowel syndrome (IBS)
- Haemorrhoids
- Reflux or stomach ulcer
- Any type of Hernia
- Gall stones
- None of these

**k Thyroid conditions such as**

- Hypothyroidism
- Hyperthyroidism including Grave's disease
- Goitre
- Thyroiditis
- None of these

**l Any of the following conditions**

- Low Blood pressure
- Impaired fasting glucose
- Any sexually transmitted infections
- None of these

**m Males only**

**Kidney, bladder or reproductive conditions such as**

- Prostate conditions such as prostatitis or enlarged prostate
- Kidney or bladder conditions such as kidney infections or kidney stones
- Urinary tract infections (UTI), cystitis or blood in urine
- None of these

**n Females only**

**Kidney, bladder, breast or reproductive conditions such as**

- Kidney or bladder conditions such as kidney infections or kidney stones,
- Urinary tract infections (UTI), cystitis or blood in urine
- Polycystic ovarian syndrome, endometriosis, abnormal cervical or pap smear, uterine polyps and fibroids or pelvic inflammatory disease
- Breast lumps, fibroadenomas or breast cysts (exclude any normal tests that do not require follow up in the next 12 months)
- Any pregnancy related conditions that you have not already told us about
- None of these

**Are you currently pregnant?**

- Yes - please provide due date (DD/MM/YYYY)
- No

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

## Section 13 Physical wellbeing continued

### Physical wellbeing - in your lifetime

- 25 Other than what you have already told us, have you ever been diagnosed with, had symptoms of, or had treatment or medication for (please select all that apply):

If you answer Yes to any of the following questions, you must also complete the relevant Supplementary Underwriting Questionnaire found on the Acenda website at [acenda.com.au/memberforms](http://acenda.com.au/memberforms)

**a Skin cancers** such as

Melanoma, Basal cell carcinoma (BCC) or squamous cell carcinoma (SCC)

Yes   
No

Please complete the **Cyst/Mole/Skin Lesion** questionnaire

**b Bone or joint** conditions such as

Gout or arthritis, Osteoporosis.  
Any joint or bone surgery

Yes   
No

Please complete the **joint/musculoskeletal** questionnaire

**c Back or neck conditions** such as

Back or neck pain, Sciatica or whiplash,  
Fractured spine, scoliosis or any back surgery

Yes   
No

Please complete the **Back/Neck** questionnaire

**d Mental Health conditions** such as

Stress, anxiety, or depression,  
Post traumatic stress disorder (PTSD) or panic attacks.  
Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD),  
Schizophrenia, eating disorder, attempted suicide or any other mental health disorder

Yes   
No

Please complete the **Mental Health** questionnaire

If you answer **yes** to any of the following questions, you must also complete the **Further information table** on page 16 of this application form.

**e Cancers or tumours** such as

- Any form of cancer or tumour, benign or malignant  
 Leukaemia or lymphoma  
 None of these

**f Brain or neurological conditions** such as

- Epilepsy  
 Stroke, transient ischaemic attack (TIA), brain haemorrhage  
 Paralysis, multiple sclerosis (MS), motor neurone disease (MND)  
 Alzheimer's disease or dementia  
 None of these

**g Cardiovascular or Heart conditions** such as

- Angina, heart attack  
 Heart murmur, heart palpitations or irregular heartbeat  
 Heart valve disease or heart related chest pain  
 None of these

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## Section 13 Physical wellbeing continued

**h Lung or breathing conditions such as**

- Emphysema
  - Chronic obstructive pulmonary disease (COPD)
  - Silicosis
  - None of these
- 

**i Liver or pancreas conditions such as**

- Fatty liver, cirrhosis of the liver, hepatitis (excluding hepatitis A if fully recovered)
  - Pancreatitis
  - Any type of diabetes
  - Polycystic kidney disease (PCKD)
  - None of these
- 

**j Autoimmune conditions such as**

- Rheumatoid arthritis or psoriatic arthritis
  - Ankylosing spondylitis
  - Lupus
  - None of these
- 

**k Bowel conditions such as**

- Crohn's disease
  - Ulcerative colitis
  - Bowel polyps
  - None of these
- 

**l Chronic fatigue or chronic pain related conditions**

- Chronic Fatigue
  - Chronic pain
  - Fibromyalgia
  - None of these
- 

**m Eye or Ear conditions such as**

- Blindness or partial blindness
  - Cataracts, keratoconus
  - Retinal detachment or glaucoma
  - Tinnitus or Meniere's disease
  - Deafness or cholesteatoma
  - None of these
- 

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

- Human immunodeficiency virus (HIV) or AIDS
  - None of these
-





## Section 14 General medical continued

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

- |  |  |
|--|--|
| <input type="checkbox"/> Seek medical advice               | ▶ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Have tests and or investigations* | ▶ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Have treatment                    | ▶ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Have surgery or an operation      | ▶ Yes <input type="checkbox"/> No <input type="checkbox"/> |

\*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 30, please go to question 33

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

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

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

|  |
|--|
|  |
|--|

## Section 15 Family history

33 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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart disease or stroke         | <input type="checkbox"/> Multiple Sclerosis               | <input type="checkbox"/> Huntington's disease          |
| <input type="checkbox"/> Cancer and/or Melanoma          | <input type="checkbox"/> Parkinson's disease              | <input type="checkbox"/> Motor Neurone disease         |
| <input type="checkbox"/> Familial Polyposis of the colon | <input type="checkbox"/> Cardiomyopathy                   | <input type="checkbox"/> Any other hereditary disorder |
| <input type="checkbox"/> Alzheimer's Disease             | <input type="checkbox"/> Muscular dystrophy               |  |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Polycystic Kidney Disease (PCKD) |  |

| Family member<br>(e.g. mother, brother) | Condition | If cancer, type and site | Age condition began |
|---|-----------|--------------------------|---------------------|
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## Section 17 Declaration

### Read this section carefully before signing.

My decision to apply for insurance under MLC MasterKey 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;
- (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;
- (j) If your account balance is under \$6,000 and/or you're under 25 years old you need to elect in writing to have insurance cover. Completing this form will be considered your written election; and
- (h) I elect to be provided with the insurance specified in this application, and for the insured benefit to be provided, even if my account balance in this product/fund is less than \$6,000 and/or I'm under 25 years old.

#### 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 Insignia Financial Group's Privacy Policy and the Acenda Privacy Policy and agree that Acenda, and any member of the Insignia Financial Group, may collect, use, disclose and handle my personal information in a manner set out in these policies, available at [mlc.com.au](http://mlc.com.au).

#### 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@acenda.com.au](mailto:enquiries.group@acenda.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.

#### Member's signature



#### Date (DD/MM/YY)

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## Section 17 Declaration continued

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

No  Please return this application form.

Yes  Please complete and return this application form together with the completed questionnaires. The questionnaires can be found on the Acenda website [acenda.com.au/memberforms](https://acenda.com.au/memberforms)

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## Send us your form

**Mail:**

MLC

PO Box 200

North Sydney NSW 2059

If you have any questions, please contact your financial adviser or call the MLC Client Service Centre **13 26 52** any business day between 8.00am and 6pm (AEST/AEDT).

For details on MLC's range of products and services, visit [mlc.com.au](https://mlc.com.au)

(DO NOT DETACH)

# 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, **Acenda**, 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 four 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 18 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 **Acenda**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **Acenda** 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.
- **Acenda** 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 **Acenda** 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)

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**Signature of Life Insured**

**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 **Acenda**, or to third parties they engage, only if **Acenda** 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:

- **Acenda** 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 **Acenda** 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)

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**Signature of Life Insured**

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Insurance is issued by Nippon Life Insurance Australia and New Zealand Limited ABN 90 000 000 402 AFSL 230694, trading as Acenda (the Insurer). The Insurer is a member of the Nippon Life Group. Any reference to 'Acenda', 'we', 'us' and 'our' means the Insurer.