Request for Insurance Application

MLC MasterKey Business Super
MLC MasterKey Personal Super
MLC MasterKey Super Fundamentals

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

Your Duty of Disclosure

When you apply for a life insurance policy, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

You have the same duty before you extend, vary or reinstate the policy.

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If someone other than you will be the life insured under the policy, any failure by that person to comply with the above duty will be treated as failure by you.

If you request life insurance inside super, the Trustee obtains this insurance from us in relation to you. In this circumstance, we rely on the disclosures that you or the Trustee makes to us.

If you do not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate policies of life insurance. If they do, we may apply the following rights separately to each type of cover.

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the policy within 3 years of entering into it.

If we choose not to avoid the policy, we may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have. However, if the policy provides cover on death, we may only exercise this right within 3 years of entering into the policy.

If we choose not to avoid the policy or reduce the amount you have been insured for, we may, at any time vary the policy in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the policy provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the policy as if it never existed.

Information about genetic tests

If you have had a genetic test, you only need to disclose this to us if your total insurance cover (including both the cover being applied for and any existing individual and group insurance cover with all life insurers in aggregate) will be more than any one of the following:

- $500,000 Death cover, or
- $500,000 Total and Permanent Disablement (TPD) cover, or
- $200,000 critical illness (trauma) cover, or
- $4,000 per month income protection cover or salary continuance cover or business expenses cover.

If you have taken a genetic test as part of a medical research study conducted by an accredited university or medical research institution, you do not need to disclose your results if:

- The test results have not been, and will not be, provided to you, or

- you have specifically asked not to receive the test results.

Your cover may have been arranged through a financial adviser or directly with a life insurance company or may be cover that is held under a group arrangement.

If you have had a favourable (negative) genetic test result, you may choose to provide this information regardless of the amount of cover applied for.

Checklist

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

☐ **Personal details**	All personal information has been provided.
☐ **Employment details**	All employment information has been provided.
☐ **Insurance details**	You have selected the product you are requesting insurance to be applied to and provided the relevant insurance details in **Section 2**.
☐ **Declaration**	Read the declaration, sign and date it, and notify us of your consent as required.
☐ **Medical Authority**	Sign and date both medical authorities on **page 15**.
☐ **Health and medical history**	All questions have been answered and the relevant questionnaires have been completed.
☐ **Return completed form and ALL questionnaires to us.**	Return a completed form to us with all relevant questionnaires.

1. Personal details

Person whose life is to be insured

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Full given name(s)

Surname

Date of birth (DD/MM/YYYY)

Male ☐ Female ☐

Account number

Residential address (PO Box is not acceptable)

Unit number

Street number

Street name

Suburb

Postcode

State

Country

Mobile phone

Home telephone

Business telephone

Email (please provide your email so notices relating to your application can be sent to you)

Facsimile

2. Insurance details

This insurance application relates to my:

MLC MasterKey Business Super account or MLC MasterKey Personal Super account ☐ **Please complete part A**

MLC MasterKey Super Fundamentals account ☐ **Please complete part B**

A. MLC MasterKey Business Super or MLC MasterKey Personal Super

Please enter the **total** amount of insurance being applied for under this policy, including any existing insurance.

Type of Insurance	Amount
Death	$
Total and Permanent Disablement (TPD)[1]	$

☐ or – Continue your existing insurance arrangement above the automatic acceptance limit. This is only available to MLC MasterKey Business Super members excluding MLC MasterKey Personal Super and family members

2. Insurance details continued

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[2]

Are you applying for a super 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%)

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.

Now go to Section 3.

B. MLC MasterKey Super Fundamentals

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[3], including any existing insurance **OR** **Choose an MLC Lifestage cover level[4]**

Type of Insurance	Amount
Death	$
Total and Permanent Disablement (TPD)	$

Lifestage
☐ 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.

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[5]

Are you applying for a super 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%)

3 When applying for Death and TPD, the TPD cannot exceed the Death cover amount.
4 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 Super and Pension Fundamentals Product Disclosure Statement at **mlc.com.au/pds/mkspf**
5 Only applies for benefit period of 5 years or to age 65.

Now go to Section 3.

3. Employment details

1. Name of employer or trading name

2. What is your current occupation?

Main occupation

Industry

What professional or trade qualification do you have?

On what basis are you employed?

- ☐ Full-time
- ☐ Part-time < 15 hours
- ☐ Contractor
- ☐ Part-time > 15 hours
- ☐ Casual
- ☐ 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.

Date you started with your **current** employer (DD/MM/YYYY)

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?

Yes ☐

No ☐ Please provide details

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 below

Occupation

Name of employer or trading name

Duties

Hours worked per week

Amount of time in this occupation

years | months

What was your Annual Salary before tax for the last 12 months from your second occupation? $ pa

Has this income been included in the Annual Salary shown in Question 3 of this application? ☐ No ☐ Yes

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

No ☐

Yes ☐ **Complete questions below**

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

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

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

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

Has your business had a net operating loss in either of the last two years? No ☐

Yes ☐ Provide last two years' financial accounts for all entities

4. Additional details

1. Travel

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

No ☐

Yes ☐ **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 ☐ **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 Limited (other than this application), including benefits under superannuation and/or insurance benefits provided by your employer?

No ☐

Yes ☐ **Provide details in the table below**

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

5. 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

If you ticked any of these boxes, please complete the **Pastimes Questionnaire** located on page 18.

☐ 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 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

6. Health and medical history

1. What is the name and address of your usual doctor or medical centre? (If no usual doctor, then the 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 17 on page 13.

This question must be completed

Name of Medical Practitioner

Unit number | Street number | Street name

Suburb | Postcode | State | Country

Business number

How long have you been attending this practice?

Years | Months

Date of last consultation

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 ☐ Tick all that apply below and complete the relevant Underwriting Questionnaire(s) located on **pages 20-26** of this form.

Stress, anxiety, depression, post traumatic stress disorder (PTSD) or any other mental health disorder	☐	Complete the **Mental Health** Questionnaire located on **page 20**
High blood pressure	☐	Complete the **High Blood Pressure** Questionnaire on **page 21**
High cholesterol	☐	Complete the **High Cholesterol** Questionnaire on **page 22**
Asthma	☐	Complete the **Asthma** Questionnaire on **page 23**
Skin cancer, tumour, cyst, lesion or mole	☐	Complete the **Skin Lesion** Questionnaire on **page 24**
Back or neck strain/sprain or pain, sciatica, whiplash, spondylitis, fracture or any back, neck or spinal problem	☐	Complete the **Back** Questionnaire on **page 25**
Any bone/joint fractures, muscle, ligament or tendon injuries, tenosynovitis, gout, arthritis or osteoporosis	☐	Complete the **Joint/Musculoskeletal** Questionnaire on **page 26**

*See page 1 for information about genetic testing.

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?

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).

No ☐
Yes ☐ A private and confidential questionnaire will be mailed to you upon submission of this application

5. Do you wish MLC Limited to arrange all medical requirements?

No ☐
Yes ☐

6. 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

7. 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 _____

8. What is your height/weight? cm kg

9. 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 biopsy, mammogram, ultrasound, ECG) not already mentioned *Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing	☐	☐

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

10. 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 ☐ **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 ☐ **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

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

No ☐

Yes ☐ **Provide details in the table below**

12. Do you contemplate seeking any advice, test*, investigation or treatment?

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

No ☐

Yes ☐ **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

13. 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 ☐ **Provide details in the table below**

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

Males: Go to Question 17

Females: please answer questions 14–16 below

14. Have you had any complications of pregnancy or childbirth?

No ☐
Yes ☐ **Provide details**

15. Are you currently pregnant?

No ☐
Yes ☐ **Due date**

16. Have you ever had an abnormal pap smear?

No ☐
Yes ☐ When

Treatment

Date and result of most recent pap smear

6. Health and medical history continued

17. Further information

You can use this space to provide further information.
Please note the page and question number the additional information refers to.

Page no.	Question no.	Further information

7. Your agreement and declaration*

*See page 1 for information about genetic testing.

Read this section carefully before signing.

My decision to apply for insurance under MLC MasterKey Business Super, MLC MasterKey Personal Super or MLC MasterKey Super Fundamentals 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 **Insurance Guide**. I understand, until MLC Limited 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 Limited's acceptance of this application and that if I fail to comply with my duty of disclosure MLC Limited 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 Limited 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 Limited 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 performing, or capable of actively performing, all of the duties of my usual occupation with my employer for at least 30 hours per week, free from any limitation due to Illness or Injury, 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.

Note: The law requires that:

On 1 April 2020: insurance cover must be cancelled if:

- your account balance in this product/fund is less than $6,000; and
- you have never had an account balance of at least $6,000 on or after 1 November 2019;

unless you elect in writing that you want to keep your insurance cover, even if your super account balance is less than $6,000.

From 1 April 2020: 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.

i. 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 MLC Limited 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 Limited 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 Limited 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 the Group's privacy policy and agree that the Trustee may collect, use, disclose and handle my personal information in a manner set out in the privacy policy available on **mlc.com.au/privacy**

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

Yes ☐ my financial adviser to provide information to MLC Limited, 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 Limited 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 Limited 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 an investment with NULIS Nominees (Australia) Limited is not a deposit or liability of, and is not guaranteed by, NAB.

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 17**.

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

Signature of Applicant

✗	Date (DD/MM/YY)

Please also complete the medical authority on page 15.

Medical Authority

Authority to obtain a report from a medical practitioner or hospital.

I request and authorise you to supply MLC Limited and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer such information to another State, Territory or jurisdiction.
A photocopy of this authorisation shall be as valid as the original.

Print name

If you changed your name at the time of your marriage, what is your maiden name?

Signature of applicant

X Date (DD/MM/YY)

8. Adviser details (Adviser use only)

Adviser name

Adviser phone number

Your Client's NAB Customer MEID (if known)

Adviser address (PO Box is not acceptable)

Unit number

Street number

Street name

Suburb

Postcode

State

Country

Adviser email

I agree to NULIS Nominees (Australia) Limited 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 MasterKey Business Super, MLC MasterKey Personal Super or MLC MasterKey Super Fundamentals 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) or NULIS Nominees (Australia) Limited (ABN 80 008 515 633) (AFSL 236465).

Trustee
NULIS Nominees (Australia) Limited
ABN 80 008 515 633 AFSL 236465

Fund
MLC Super Fund
ABN 70 732 426 024

Insurer
MLC Limited
ABN 90 000 000 402 AFSL 230694

9. Send us your form

Please mail your completed, signed and dated form to:

MLC
PO Box 200
North Sydney NSW 2059

If you have any questions, please speak with your financial adviser or call us on **132 652** on Monday to Friday between 8.00 am and 6.00 pm (AEST/AEDT).

Pathology Request for Insurance

This must be completed when a blood test is required.

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Full given name(s)

Surname

Date of birth (DD/MM/YYYY)

Male ☐ Female ☐

Family doctor or hospital name address (PO Box is not acceptable)

Doctors name

Unit number

Street number

Street name

Suburb

Postcode

State

Country

Report and account to	Collection date and time	Tests required
MLC PO Box 200 North Sydney NSW 2059 Phone: 132 652	Date of appointment Time of appointment am/pm	☐ Multiple Biochemical Analysis 20 ☐ HIV Antibodies ☐ Hepatitis B and C serology ☐ Other (specify)

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 (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

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.

Pastimes Questionnaire

Diving

1. Do you hold a diving qualification?

No ☐

Yes ☐ Type of qualification and time held

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

5. Do you ever dive alone?

No ☐

Yes ☐ Please provide details

6. Do you dive in caves, potholes or wrecks?

No ☐

Yes ☐ Please provide details

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

No ☐

Yes ☐ Please provide details

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

No ☐

Yes ☐ Please provide details

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?**

   No ☐

   Yes ☐ Type of licence and period of time held

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

   No ☐

   Yes ☐ Provide details

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.

- ☐ 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, 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?

- ☐ No
- ☐ Yes ▶ Please provide details

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)

6. Do you continue to experience symptoms?

- ☐ No ▶ When did you **last** experience symptoms? (DD/MM/YYYY)
- ☐ Yes ▶ Please describe your symptoms

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

- ☐ No
- ☐ Yes ▶ Please provide details

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)

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?

☐ No

☐ Yes — Provide dates, tests done and results

Date (DD/MM/YYYY) | Test | Results

6. Are you currently taking medication for your blood pressure?

☐ No

☐ Yes — Provide medication and dosage

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

☐ No

☐ Yes — Provide details

Date it was changed (DD/MM/YYYY) | What was changed? | Why was it changed?

8. Have you ever been prescribed medication for blood pressure?

☐ No — How has the condition been managed?

☐ Yes — When and why did you cease taking it?

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)?

☐ No

☐ Yes ▶ Provide dates, tests done and results

Date (DD/MM/YYYY) | Test | Results

6. Are you currently taking medication for your cholesterol?

☐ No

☐ Yes ▶ Provide medication and dosage

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

☐ No

☐ Yes ▶ Provide details

Date it was changed (DD/MM/YYYY) | What was changed? | Why was it changed?

8. Have you ever been prescribed medication for cholesterol?

☐ No ▶ How has the condition been managed?

☐ Yes ▶ When and why did you cease taking it?

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?

No ☐

Yes ☐ Provide the name of medications and date ceased (if applicable)

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

No ☐

Yes ☐ Provide the name ofhospitals, doctors and dates

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

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

No ☐

Yes ☐ Please advise number of days

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

No ☐

Yes ☐ Provide the name of medications and date ceased (if applicable)

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)

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—provide details

3. Number of lesion(s) removed?

4. Date(s) of diagnosis

(DD/MM/YYYY)

5. Were the lesion(s) removed

Yes ☐ Date lesion(s) removed (DD/MM/YYYY)

No ☐ Provide details below

6. How were the lesion(s) removed?

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

☐ Other—provide details

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

No ☐

Yes ☐

8. Were the lesion(s) reported to be:

☐ Malignant ☐ Benign ☐ Unknown

Please forward copies of any histology reports you have.

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

No ☐

Yes ☐ Provide details

10. Please provide the name and address of doctor, hospital or health professional consulted for your skin lesions and date last attended

Name	Address	Date (DD/MM/YYYY)

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?

☐ No

☐ Yes ▶ Provide details

7. What treatment have you had?

☐ Medication ☐ Physiotherapy ☐ Surgery ☐ Chiropractor

☐ Other—provide details

8. Have you made a complete recovery?

☐ No

8a What are your current symptoms?

8b How often do you experience symptoms?

8c Does this condition cause any restriction in your daily activities?

☐ No

☐ Yes ▶ Provide details

☐ Yes ▶ How long have you been free of all symptoms?

9. Have you taken time off work?

☐ No

☐ Yes ▶ Provide advise when and how long you were off work

10. 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)

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?

☐ No

☐ Yes ▶ Provide details

7. What treatment have you had?

☐ Medication ☐ Physiotherapy ☐ Surgery ☐

☐ Other—provide details

8. Have you made a complete recovery?

☐ No

8a What are your current symptoms?

8b How often do you experience symptoms?

8c Does this condition cause any restriction in your daily activities?

☐ No

☐ Yes ▶ Provide details

☐ Yes ▶ How long have you been free of all symptoms?

9. Have you taken time off work?

☐ No

☐ Yes ▶ Advise when and how long you were off work

10. 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)

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