Resolution Life

Personal Statement

Information sheet

When to use this form

Use this form to apply for an increase or alteration to your existing Firstcare- Lifetime Protection, Whole of Life, Endowment, Investment Linked, Term Life Insurance, CrisisCare, or Portfolio Plan.

What you need to tell us

When you apply for insurance

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

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

The Duty to Take Reasonable Care Not to Make a Misrepresentation

Read this if you are applying for insurance as the policy owner, if you will be an insured person under a policy owned by someone else, or if you will be an insured person under a superannuation plan.

Your legal duty

When you apply for insurance and up until your application is accepted by the insurer, there is a legal Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer.

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

You have the same duty if anything changes, or you remember more information, while we're processing your application.

If you want to change your insurance cover at any time, extend it or reinstate it, you'll also have the same Duty to Take Reasonable Care Not to Make a Misrepresentation to the insurer at that time.

You are responsible for all answers given, even if someone assists you with your application.

We may later investigate the answers given in your application, including at the time of a claim.

Where a **policy** owned by one person covers the life of another person, it's important that the other person does not make a misrepresentation when providing information to the insurer. If the other person does make a misrepresentation, then it may be treated as a failure by the owner of the **policy** in their Duty to Take Reasonable Care Not to Make a Misrepresentation. Therefore, you must take reasonable care not to make a misrepresentation when giving us information whether you're the owner of the **policy** or an **insured person** under it.

If you do not meet your legal duty

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

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

If there is a failure to comply with the Duty to 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). These are intended to put the insurer in the position it would have been in if the duty had been met. Therefore, if the person who answers our questions does not take reasonable care not to make a misrepresentation, it can have serious consequences for your insurance, such as those explained below:

- we may **treat the contract (or your cover) as if it never existed**.
- we may **reduce the amount you've been insured for** – to reflect the premium you've been paying. There is a link between the premium you pay and your level of cover. If you fail to tell us something, your premiums may have been too low. The insurer may reduce the amount you've been insured for, taking into account the premium you would have had to pay if you'd told us everything you should have. For Death cover the insurer can only reduce the amount you've been insured for within three years of your cover starting.

- we may **vary your cover** – to take into account the information you didn't tell us and put the insurer in the same position as it would've been if you'd told us. Variations could mean, for example, that waiting periods, exclusions or premiums may be different. The insurer can't make variations to Death cover.

Your total insurance cover forms one insurance contract. If you don't meet your legal duty, the insurer may treat your different types of cover as separate contracts when it takes action to address this.

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

- whether the person who answered our questions took reasonable care not to make a misrepresentation. This depends on all of the relevant circumstances. This includes how clear and specific our questions were and how clear the information we 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 cover, and if so, on what terms;
- whether the misrepresentation was fraudulent; and
- in some cases, how long it has been since the cover started.

Before we exercise any of these remedies, we will let you know our reasons and the information we rely on and give you an opportunity to provide an explanation.

If we decide to exercise one of these remedies, we will advise you of our decision and the process to have this reviewed or make a complaint if you disagree with our decision.

Guidance for answering our questions

When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question that we ask you.
- Do not assume that we will contact your doctor for any medical information.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it or check with us.
- Review your application carefully. If someone else helped prepare your application (for example, your adviser), please check every answer (and make corrections if needed) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask about any changes that mean you would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

After your cover starts

If, after the cover starts, you think you may not have met your duty, please contact us immediately.

Genetic test approach

You only need to tell us about any genetic testing you've had or intend having if the total combined sum insured with all life insurers for the benefit(s) being applied for is over the Genetic Test Standard financial limits. You can choose to tell us about a genetic test that you have had where the result was favourable.

However, you must tell us if you're experiencing symptoms of, or are having treatment for, a medical condition including any genetically inherited condition. You must also tell us of any family history of a medical condition as asked for in the relevant question in this form.

Note: Resolution Life complies with the Genetic Test Standard, a copy of the standard can be found at **fsc.org.au/resources/standards**.

Your privacy

Personal information

We may collect personal information directly from you or from your financial adviser.

We may also collect personal information if it is required or authorised by law, including the *Superannuation Industry (Supervision) Act 1993*, the *Corporations Act 2001* and the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006*.

Our main purpose in collecting personal information from you is so we can establish and manage your plan. If you choose not to provide the information necessary to process your application, then we may not be able to process it.

We may also collect and use any of your personal information, including sensitive information, collected and held by the Resolution Life Group if you authorise us to do so.

We may also use this information for related purposes—for example, enhancing customer service, product options and providing you with ongoing information about opportunities that may be useful for your financial needs through direct marketing. These may include investment, retirement, financial planning, banking, credit, life and general insurance products and enhanced customer services that may be made available by us, other members of the Resolution Life Group, or by your financial adviser. Please contact us if you do not want your personal information used for direct marketing purposes.

We usually disclose information of this kind to:

- other members of the Resolution Life Group
- your financial adviser or broker (if any)
- the owner of the plan (if applicable)
- external service suppliers who may be located in Australia or overseas, who supply administrative, financial or other services to assist the Resolution Life Group in providing Resolution Life Financial Services. A list of countries where these providers are likely to be located can be accessed via our Privacy Policy
- the Australian Transaction Reports and Analysis Centre (AUSTRAC) where required by our anti-money laundering compliance plan

– the Australian Taxation Office (ATO) to conduct searches on the ATO's Lost Member Register for lost super
– anyone you have authorised or if required by law.

Sensitive information

If sensitive information, such as health information, is collected in relation to this financial product, then additional restrictions apply. Resolution Life may collect health information using a third party provider. The primary purpose for obtaining this health information is for the insurer, Resolution Life, to assess your application for new or additional insurance. Resolution Life may also use this information for directly related purposes—for example, deciding whether more information is needed, arranging reinsurance, assessing further applications and processing claims.

Resolution Life may disclose this type of health information to:

– your financial adviser or broker (if any)
– the Trustee or other members of the Resolution Life Group
– the owner of the plan (if applicable)
– Resolution Life's reinsurers
– 'doctors'
– any person Resolution Life considers necessary to help either assess claims or resolve complaints
– anyone you have authorised or if required by law.

If you are an 'insured person', aspects of your health information may be provided to the owner of your plan in resolving terms of acceptance or if the standard plan rates are varied.

If you are an 'insured person', Resolution Life and/or their health screening provider may also speak to a third party for the sole purpose of arranging a health screening appointment. This third party may include a spouse, family member, personal assistant, financial adviser or other relevant party.

Under the current Resolution Life Privacy Policy, you may access personal information about you held by the Resolution Life Group. The Resolution Life Privacy Policy sets out the Resolution Life Group's policies on management of personal information, including information about how you can access your personal information, seek to have any corrections made on inaccurate, incomplete or out-of-date information, how you can make a complaint about privacy, and information about how Resolution Life deals with such complaints. The Resolution Life Privacy Policy can be obtained online at **resolutionlife.com.au** or by calling our Customer Service Centre on 133 731.

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Please keep this information sheet for your records—
don’t return it with your completed form(s).

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Resolution Life

Personal Statement

Use this form to apply for an increase or alteration to your existing Firstcare- Lifetime Protection, Whole of Life, Endowment, Investment Linked, Term Life Insurance, CrisisCare, or Portfolio Plan.

Your answers will help Resolution Life to assess your application for insurance.

You are requested to supply answers to the below questions truthfully, accurately and completely.

If there is more than one insured person, please provide a separate Personal statement for each insured person.

Please print in CAPITAL LETTERS and place a cross ☐✗ in any applicable boxes.

Details

Title

Surname

Given name(s)

Gender ☐ Male ☐ Female

Date of birth D D M M Y Y Y Y

May we phone or email you if we need to clarify any details contained in this statement? ☐ No ☐ Yes

If 'Yes', please provide preferred contact details:

Phone number

Preferred contact time am/pm ☐ Any

Preferred contact day ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Any

Email address

1. Residence details

a. Are you an Australian citizen or a permanent resident of Australia?

☐ Yes > go to **question 1c**

☐ No > proceed to **question 1b**

b. Are you a New Zealand citizen?

☐ Yes > proceed to **1c**

☐ No >

i. Which country has issued your current passport?

ii. How long have you lived in Australia? years months

iii. What type of visa do you hold?

iv. Have you applied for an Australian permanent residency visa? ☐ No ☐ Yes

If **'No'** do you intend applying for an Australian permanent residency? ☐ No ☐ Yes

If you do, please advise the date you can make that application. D D M M Y Y Y Y

If applicable, do you have your family residing with you in Australia? ☐ No ☐ Yes

If **'Yes'**, please provide us details:

1. Residence details (continued)

c. In the next 12 months, do you intend to leave Australia and go live in another country? ☐ No ☐ Yes

If 'Yes', please provide details:

Where	Duration

2. Travel

a. Do you have any definite plans to travel overseas, other than New Zealand, in the next 12 months? ☐ No ☐ Yes

If 'Yes':

i. What countries will you travel to?

ii. What is the purpose of travel?

iii. When is the planned departure and duration?

3. Sports activities

Have you in the last 12 months, do you currently, or do you intend to take part in any of the following activities?

a. **Aviation** (other than as a fare paying passenger on a licensed public service) ☐ No ☐ Yes

b. **Motor racing** (including car, bike and boat) ☐ No ☐ Yes

c. **Underwater diving** ☐ No ☐ Yes

d. Football ☐ No ☐ Yes

e. **Motor bike riding**, including quad bike riding and trail bike riding ☐ No ☐ Yes

f. Any other hazardous activity, pursuit or sport not previously disclosed (including, but not limited to: rock climbing, hang-gliding, ocean racing, martial arts, horse riding, or any other motor sports) ☐ No ☐ Yes

If you answered 'Yes' to an activity in bold complete the specific questionnaire in section 15. For any other activities complete the 'other activities' questionnaire in section 15.

4. Doctor information

a. Name and address of your usual doctor (if you do not have a usual doctor, then the last doctor that you saw)

Name	Address	Phone number

If you have known your doctor for less than two years, please provide details of the previous doctor.

Name	Address	Phone number

b. Date of last consultation with any doctor

D D M M Y Y Y Y

c. Name of doctor that you saw (if same as above, write 'As above')

d. Please advise reason for your last consultation

e. Please advise results/outcome of your last consultation

4. Doctor information (continued)

f. Were you referred for further tests, investigations or referred to a specialist? ☐ No ☐ Yes

If 'Yes', please provide full details:

5. Insurance details

a. Has any insurer ever indicated that they would not offer you insurance, or would apply loadings, restrictions or exclusions? ☐ No ☐ Yes

If 'Yes', please provide full details:

b. Have you ever made a claim or received benefits in regard to any illness, injury, or condition? ☐ No ☐ Yes

If 'No', go to question 6.

If 'Yes',

i. Please provide full details (eg type of claims and condition claimed for):

ii. Has the claim been finalised? ☐ No ☐ Yes

If 'Yes', please specify the date the claim was finalised: D D M M Y Y Y Y

6. Habits

a. Have you smoked tobacco or any other substance, used e-cigarettes, nicotine patches or nicotine replacement products within the last 12 months? ☐ No ☐ Yes

If 'Yes', please advise which of the following apply and quantity consumed.

☐ Cigarettes **Quantity per:** day week month

☐ Tobacco pipes **Quantity per:** day week month

☐ Cigars **Quantity per:** day week month

☐ Nicotine replacement products

☐ E-cigarettes

☐ Other **Please specify:**

If you have indicated above that you use nicotine replacement products, e-cigarettes or any other substance, please answer questions b and c.

b. How often are or were these nicotine patches, e-cigarettes or other nicotine products used, replaced or refilled?

c. What strength are or were they? mgs

d. Do you consume alcohol? ☐ No ☐ Yes

If 'Yes', please advise number of standard drinks[1] per:

day week month

e. Have you ever used cocaine, marijuana, ecstasy, heroin or any other recreational drugs, or drugs not prescribed by a doctor? (You do not need to tell us about any paracetamol, anti-histamines or any other over-the-counter medication) ☐ No ☐ Yes

If 'Yes', please advise details including type, frequency and date(s) of usage:

6. Habits (continued)

f. Have you ever received treatment or been recommended for treatment by a doctor or other medical facility for the use of drugs or alcohol? ☐ No ☐ Yes

If 'Yes', please advise details including date(s) of treatment:

1 A standard drink = 1 x nip/30ml spirits, 1 x 100ml glass of wine, 1 x sherry glass of port/sherry, 1 x 250ml glass of beer.

7. Height and weight

a. Height

cm or ft ins

b. Weight

kg or st lbs

b. Has your weight varied in the last 12 months? ☐ No ☐ Yes

If 'Yes', please advise which of the following and provide the amount and reason:

☐ Gain ☐ Loss

Amount kg

Reason

8. Medical history

If you answer 'Yes' to any of the conditions in bold, complete the relevant health questionnaires in section **14**.
If you answer 'Yes' to conditions which are not bold, provide details in the Additional Information table on the following page.

Have you ever had symptoms of, been told you had, or received advice from any health professionals including but not limited to doctors, specialists, counsellors or chiropractors for any of the following:

a. **High blood pressure, chest pain, high cholesterol, stroke** or any **heart or vascular disorder**? ☐ No ☐ Yes

b. **Asthma, bronchitis** or **any other lung disorder?** ☐ No ☐ Yes

c. **Epilepsy**, seizure disorder, multiple sclerosis, paralysis, migraine, dizziness, neuritis or any other neurological disorder? ☐ No ☐ Yes

d. **Kidney stones**, nephritis, passing blood in the urine or any other kidney or bladder disorder? ☐ No ☐ Yes

e. Hepatitis, haemochromatosis, cirrhosis or any liver or gall bladder disorder? ☐ No ☐ Yes

f. **Diabetes**, sugar in urine, thyroid or pancreatic disorder? ☐ No ☐ Yes

g. Indigestion, reflux, **ulcer or hernia**? ☐ No ☐ Yes

h. Colitis, passing blood from the bowel, any change to your usual bowel habits or any other bowel disorder? ☐ No ☐ Yes

i. Anaemia, leukaemia, haemophilia, received a blood transfusion or any other blood disorder? ☐ No ☐ Yes

j. Cancer, tumour, **lump**, **cyst** or **skin lesion** of any kind? ☐ No ☐ Yes

k. **Back** or **neck pain**, **injury** or **disorder including slipped disc**, **sciatica**, **whiplash** or any other condition of the **neck**, **middle** or **lower back**? ☐ No ☐ Yes

l. **Repetitive strain injury**, chronic fatigue syndrome, fibromyalgia, or muscle strain? ☐ No ☐ Yes

m. **Disorder**, **pain** or **injury** of the **wrist**, **elbow**, **shoulder**, **hip**, **knee**, **ankle** or any other **joints**, or **arthritis** or **gout**? ☐ No ☐ Yes

n. **Depression, adjustment disorder, post-traumatic stress disorder, post natal depression, major depression** or any other **mood or depressive disorder**? ☐ No ☐ Yes

o. **Panic attacks, anxiety, attention deficit disorder, eating disorder, obsessive compulsive disorder** or any other **anxiety disorder**? ☐ No ☐ Yes

p. **Schizophrenia, psychotic** or **personality disorder, manic** or **bipolar disorder** or any other **mental health disorder**? ☐ No ☐ Yes

q. **Stress, fatigue, insomnia** or **sleeplessness**? ☐ No ☐ Yes

r. **Psoriasis**, **eczema**, **dermatitis** or any other **skin condition**? ☐ No ☐ Yes

s. Sleep apnoea or any other sleep disorder? ☐ No ☐ Yes

t. Any impairment of sight not corrected by glasses or contact lenses? ☐ No ☐ Yes

u. Any ear disorder such as hearing loss or tinnitus? ☐ No ☐ Yes

v. Have you ever had an occupational needle stick injury? ☐ No ☐ Yes

8. Medical history (continued)

w. i. Have you, or do you intend to participate in any activity that increases your chances of contracting the HIV virus? This would include things such as working or engaging in sexual intercourse with a sex worker or intravenous drug user or someone you suspect or know to be HIV positive, or engaging in anal sexual intercourse. If you have answered '**Yes**' to this question, Resolution Life will contact you for further information. ☐ No ☐ Yes

ii.. Are you suffering from AIDS, or infected with HIV, or are you carrying antibodies to the HIV virus? If you have answered '**Yes**' to this question, Resolution Life will contact you for further information. ☐ No ☐ Yes

x. Have you had any other disorder or impairment, taken any medication, had any preventative or prophylactic treatment (eg mastectomy) or undergone any medical or surveillance tests (eg ultrasounds or colonoscopies) or surgery either in Australia or overseas not mentioned above? ☐ No ☐ Yes

y. Do you intend to seek any medical advice, undergo any tests or investigations or surgery either in Australia or overseas in the future? **Important:** Please refer to the **genetic test approach** in the **information sheet** when answering this question. ☐ No ☐ Yes

Males only

z. Disorder or problem of the prostate or testicle including prostate enlargement, abnormal PSA (Prostate Specific Antigen), difficulty or urgency in passing urine, increase in night urination? ☐ No ☐ Yes

If 'Yes' to z, please provide full details:

Females only

aa. i. Have you ever had an **abnormal cervical screening** or **pap smear test**, **positive HPV test** or any gynaecological condition? ☐ No ☐ Yes

ii. Have you ever had a breast ultrasound or mammogram? ☐ No ☐ Yes

iii. Have you ever had a **breast lump**, **thickening**, **unexplained pain** or **change in the breast** or **nipples** (even if you have not seen a doctor about it)? ☐ No ☐ Yes

iv. Have you ever had complications with a past or current pregnancy? ☐ No ☐ Yes

v. Are you currently pregnant? ☐ No ☐ Yes

If 'Yes', expected date of delivery? DDMMYYYY

Additional information (required if 'Yes' answered for conditions not in bold)

Question letter	Condition/test/ reason	Date first started	Date of last symptoms	Have you completely recovered?	Full details of treatment	Full name and address of doctor or hospital
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		
		/ /	/ /	☐ No ☐ Yes		

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

Other medical history

ab. Have you, within the last month, **travelled overseas** or **had contact with someone who has recently returned from overseas** or **been exposed to someone suffering/later diagnosed with COVID-19 (also known as coronavirus)**? ☐ No ☐ Yes

ac. Have you been **tested for COVID-19**? ☐ No ☐ Yes

If you answered '**Yes**' to any condition in bold text above, you should also complete the COVID-19 health questionnaire in section **14**.

9. Family history

a. Have any first-degree blood related family members (father, mother, brother, sister or your children) been diagnosed or suffered from any of the following?

☐ No, unknown/adopted—go to next question.

☐ Yes—please cross all that apply and provide the details further below:

☐ Breast and/or ovarian cancer
☐ Lynch syndrome, familial polyposis or bowel/colon cancer
☐ Diabetes
☐ Heart attack
☐ Haemochromatosis
☐ Multiple sclerosis
☐ Motor neurone disease
☐ Alzheimer's disease or any other type of dementia
☐ Any hereditary disorder or condition that runs in families
☐ Prostate cancer
☐ Polycystic kidney disease, renal cell cancer or kidney
☐ cancer Stroke
☐ Cardiomyopathy
☐ Muscular dystrophy
☐ Parkinson's disease
☐ Huntington's disease
☐ Any other cancer or any other heart condition

Provide details for each box you've crossed:

Family member (eg mother, brother)	Condition	If cancer, type/site	Age at diagnosis	Age at death (if applicable)

b. Are you required to have any regular screening due to your family history? ☐ No ☐ Yes

If 'Yes', please complete the table below:

Type of regular screening eg mammogram, Prostate Specific Antigen, colonoscopy	How often is this screening performed?	Date of last test	Results (including any abnormality)	Doctor consulted
		/ /		
		/ /		
		/ /		
		/ /		

c. Are any tests or investigations pending? ☐ No ☐ Yes

If 'Yes', please give details of which tests are pending and when these will be performed:

10. Occupation and income details (This section must be completed for all applications)

a. What is your current occupation?

b. How many hours per week do you work in your main occupation? hours

c. How many weeks per year do you work in your main occupation? weeks

d. Do you have any other occupation? ☐ No ☐ Yes

If 'Yes', please provide details (including type of occupation, duties, number of hours worked per week and the income earned in the last 12 months):

e. Do you have any definite plans to change your occupation? ☐ No ☐ Yes

If 'Yes', please provide details:

10. Occupation and income details (This section must be completed for all applications) (continued)

f. i. Have you ever been bankrupt or made a Part IX Debt Agreement or Part X Personal Insolvency Agreement? ☐ No ☐ Yes

If 'Yes', please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable:

ii. Has any business that you have, or have had ownership of, ever been liquidated or been placed under administration? ☐ No ☐ Yes

If 'Yes', please provide details including when, cause, date of discharge, and if there are any pending legal proceedings, if applicable:

g. What is your current annual income? (income earned through personal exertion, less any expenses incurred whilst earning that income)? $

11. Additional occupation and income details

! To be completed only if applying for Total and Permanent Disablement, Permanent incapacity, Income Protection, Temporary Salary Continuance, Temporary incapacity or Business Overheads Insurance.

a. Name of your business or employer

b. Address of your business or employer

c. Do you hold any professional/trade qualifications? ☐ No ☐ Yes

If 'Yes', give details:

Type	Institution where qualification was obtained

d. What are the main duties of your occupation?

Duties (eg office work, sales, supervision, manual work, explosives handling)	% of time	Main location (eg office, on-site, driving, underground, offshore, underwater, at heights or at home)	% of time
	100%		**100%**

To be completed if applying for Income Protection, Temporary Salary Continuance, Temporary incapacity or Business Overheads Insurance

e. Has your main occupation and/or employment status changed in the last 3 years? ☐ No ☐ Yes

If 'Yes', please provide details of your previous occupation, duties and dates of change:

Occupation and duties	Employment status	Date from	Date to
		/ /	/ /
		/ /	/ /
		/ /	/ /

11. Additional occupation and income details (continued)

f. Do you have any definite plans to take extended leave (eg parental or study leave) in the near future? ☐ No ☐ Yes

If 'Yes', please provide full details including type and length of leave and your intentions on returning to work:

g. Do you have definite plans to change your working arrangements to part-time, casual or self-employed? ☐ No ☐ Yes

If 'Yes', please provide full details including current and future employment status:

h. Are you self-employed (including sole trader, in a partnership or employee of your own company or trust)? ☐ No ☐ Yes

If 'Yes', please complete the questions for SELF-EMPLOYED (i to m)
If 'No', please complete the questions for EMPLOYEE (n to q)

SELF-EMPLOYED: sole trader, partnership, employee of own company or trust

i. How long have you been self-employed? ____ years ____ months

j. Please select which of the following applies:
☐ sole trader ☐ in a partnership ☐ employee of your own company or trust

k. i. What is the percentage of the business that you own? ____ %

ii. How many employees do you have in the business? ____ employee(s)

l. Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If 'Yes', please provide for how long and the source (eg salary, investment income, company profits), and if this is for an investment property, please advise if the property is positively or negatively geared:

m. Please indicate your share of the business income/expenses, etc for the last two financial years for which tax returns, assessment notices and accounts are available.

Tax year ending	Gross income A	Expenses incurred B	Net profit or loss before tax A–B=C	Any salary or wages D	Any director's fees, and/or drawings E	Your total income C+D+E=F
30 / 06 /	$	$	$	$	$	**$**
30 / 06 /	$	$	$	$	$	**$**

Did your business contribute to a complying superannuation fund on your behalf? ☐ No ☐ Yes

If 'Yes', what amount or percentage? $ ____ or ____ %

EMPLOYEE – with no ownership interest in your employer's business:

n. What is your base annual salary from your main occupation (including salary packaged items)? $ ____

o. Please give details of your total remuneration package from all sources currently and for the last two financial years.

	Current $	Last financial year $	Year immediately prior to last $
Salary			
Bonuses			
Commissions			
Regular overtime			
Superannuation			
Total			

p. What rate of superannuation guarantee is your employer contributing on your behalf? ____ %

q. Would any of your income continue if you were unable to work? ☐ No ☐ Yes

If 'Yes', please provide for how long, and the source (eg sick leave in excess of 100 days, salary, investment income, company profits) and if this is for an investment property, please advise if the property is positively or negatively geared:

12. Declaration and signature

I acknowledge and declare that:

- I have read and understood the section entitled 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the **Information sheet**, and understand that any cover issued by the insurer will be based on the answers I provide to questions in this form and any other questions that are asked before the insurer advises me in writing that it has issued a policy.
  I understand that if the questions are not answered truthfully, accurately and completely the insurance I have applied for may be avoided (treated as if it never existed) or altered and if I have made a claim under the insurance it may not be payable or be reduced. If someone has assisted me to complete this form (such as my financial adviser) I have checked every answer (and if necessary made corrections) before this form is submitted.
- I have read the privacy information in the **Information sheet** and I agree to the various uses and exchanges of my personal information as set out in that section.
- I authorise any insurer (including companies related to Resolution Life), to disclose to Resolution Life, and for Resolution Life Group to collect, any information they have on my health, medical history, pastimes, work history, or anything else that Resolution Life considers to be relevant to assessing or underwriting this cover or assessing any claim under it. I understand that, under Government Privacy legislation, I may access a copy of this information from Resolution Life. I have been advised by Resolution Life of the ways this information may be used, and to whom it may be disclosed, and approve those purposes.
- I consent to Resolution Life and/or their health screening provider to speak to a third party for the sole purpose of arranging a health screening appointment. This third party may include a spouse, family member, personal assistant, financial adviser or other relevant party.

Signature

✗

Date

D D M M Y Y Y Y

Signature of my parent/guardian if I am under age 16
(Parent/guardian if applicable)

✗

Date

D D M M Y Y Y Y

13. Financial adviser information (To be completed by financial adviser)

If this application has been discussed with an Underwriter prior to submission, provide the following:

Underwriter's name

Date

D D M M Y Y Y Y

Discussion details

Pre-arranged medical tests

- ☐ Doctor Medical Exam
- ☐ Blood Test
- ☐ Express check
- ☐ Paramedical Exam Exercise
- ☐ ECG
- ☐ Other (please specify):

Financial adviser notes

14. Health questionnaires

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

1. High blood pressure (hypertension)

a. When was high blood pressure first diagnosed? D D M M Y Y Y Y

b. What was your blood pressure reading at that time?

c. What was your blood pressure when last tested?

Date	Blood pressure reading	Have treatments changed since this result?
/ /		
/ /		

d. Have you taken medication to control your blood pressure? ☐ No ☐ Yes

If 'Yes', please provide details of medication, ie type, dose and when taken.

e. Are you currently on the same medication as detailed above? ☐ No ☐ Yes

If 'No', please provide details of current treatment.

f. Have you had any medical investigations relating to your high blood pressure? ☐ No ☐ Yes

If 'Yes', please provide details.

g. Do you have any complications as a result of your blood pressure? ☐ No ☐ Yes

If 'Yes', please provide details.

h. Does your usual doctor have details of your blood pressure and treatment? ☐ No ☐ Yes

If 'No', please provide the name and address of the doctor who has records of your investigations and treatment.

Name	Medical provider	Address

2. High cholesterol

a. When were you first diagnosed with high cholesterol? D D M M Y Y Y Y

b. What was your cholesterol level at this time?

c. What was your cholesterol level when last tested?

Date	Cholesterol reading	Have treatments changed since this result?
/ /		
/ /		

d. Have you ever taken medication to reduce your cholesterol? ☐ No ☐ Yes

If 'Yes', please provide details of medication, ie type, dose and when taken.

2. High cholesterol (continued)

e. Are you currently on the same medication as detailed above? ☐ No ☐ Yes

If 'No', please provide details of current treatment.

f. Does your usual doctor have details of your cholesterol results and treatment? ☐ No ☐ Yes

If 'No', please provide the name and address of the doctor who has records of your investigations and treatment.

Date	Medical provider	Address
/ /		

3. Mental health disorders

a. Which of the following mental health disorder(s) do you have or have you had or received treatment or advice for? (please select all that apply)

- ☐ Anxiety, generalised anxiety or panic disorder
- ☐ Adjustment disorder or post traumatic stress disorder
- ☐ Obsessive compulsive disorder or attention deficit disorder
- ☐ Anorexia, bulimia or any other eating disorder
- ☐ Post natal depression
- ☐ Depression, including major depression, mood or any other depressive disorder
- ☐ Manic depression or bipolar disorder
- ☐ Schizophrenia or any other psychotic or personality disorder
- ☐ Alcohol or substance abuse disorder
- ☐ Other, please provide details:

b. Please describe your symptoms:

c. What do you think caused your symptoms?

d. When did you first experience symptoms and how long did they last?

e. Has this condition(s) ever required you to take time off work or does/did it impact your ability to perform your normal duties at work? For example, did you need to reduce the number of hours you worked or were your responsibilities or duties changed in any way? ☐ No ☐ Yes

If 'Yes', please provide details including time away from work and if there were any changes to your duties:

f. Has this condition(s) ever affected your relationships, your ability to socialise with friends or family, **your ability to sleep, eat, exercise or play sport?** ☐ No ☐ Yes

If 'Yes', please provide details:

14. Health questionnaires (continued)

3. Mental health disorders (continued)

g. How many episodes of this condition have you experienced? For example, if you were depressed and recovered twice in three years we would say you had two episodes of depression.

h. When was the last time you experienced symptoms?

i. Have you ever received any treatment for this condition? ☐ No ☐ Yes

If 'Yes', please provide the details in the table below:

Type of treatment, eg counselling or medication etc	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

j. Have you or are you being treated for this condition by a general practitioner, psychologist, psychiatrist, counsellor or any other therapist? ☐ No ☐ Yes

If 'Yes', please provide details in the table below:

Field of practice, eg Psychologist or therapist etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /
			/ /
			/ /

k. Are you still receiving treatment for this condition(s)? ☐ No ☐ Yes

If 'No', please advise when you stopped treatment and was it at the direction of your treating health professional?

l. Have you ever not followed the advice of your treating health professional in relation to prescribed medication or other recommended treatment for this condition(s)? ☐ No ☐ Yes

If 'Yes', please provide details:

m. Have you ever been hospitalised or admitted as an in-patient at a hospital or clinic for this condition(s)? ☐ No ☐ Yes

If 'Yes', please provide details in the table below:

Name of hospital/clinic	Dates of hospitalisation	Treatment received
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

14. Health questionnaires (continued)

3. Mental health disorders (continued)

n. Have you ever thought about or tried to harm yourself or take your own life? ☐ No ☐ Yes

If 'Yes', please provide the name and address of your doctor that would have the details:

o. Have any first-degree blood related family members (father, mother, brother, sister) had a mental health disorder? ☐ No ☐ Yes

Note: You are only required to disclose family information relating to first-degree blood related family members—living or deceased (father, mother, brother, sister).

If 'Yes', please provide details:

4. Stress, fatigue, insomnia and/or sleeplessness questionnaire

a. Which of the following do you have or have you had or received treatment or advice for? (Please select all that apply)

i. ☐ Stress
ii. ☐ Fatigue
iii. ☐ Insomnia and/or sleeplessness

b. Did you see a doctor or other health professional for this condition(s)? ☐ No ☐ Yes

c. Were you diagnosed with anxiety, depression or any other mental health disorder? ☐ No ☐ Yes

If 'Yes', please go to the mental health disorders questionnaire in section 3.

If 'No', please continue to complete this questionnaire.

d. Did this condition(s) affect you to the point where you experienced any of the following? (Please select all that apply)

i. ☐ Physical symptoms such as headache, dizziness, soreness or irritability
ii. ☐ You found it difficult to go to work or were unable to go to work
iii. ☐ It had an impact on your relationships
iv. ☐ Your ability to sleep, eat, or think clearly
v. ☐ Problems with concentration, memory or tiredness during the day
vi ☐ It caused you to use alcohol or drugs that were not prescribed for you by a doctor

If you have answered 'Yes' to any of the above, please provide full details including how much time you had away from work:

e. What do you think caused your symptoms?

f. When did you first experience symptoms and how long did they last?

g. When was the last time you experienced symptoms?

h. How many episodes of this condition have you experienced? For example, if you were stressed and recovered twice in three years we would say you had two episodes of stress.

i. Have you ever been treated for this condition(s)? ☐ No ☐ Yes

If 'Yes', please provide full details including type of treatment, name of medication (if applicable) and dates the treatment started and ceased:

14. Health questionnaires (continued)

4. Stress, fatigue, insomnia and/or sleeplessness questionnaire (continued)

j. Please advise how often you see or saw your treating health professional for this condition and provide their name(s) and address(es):

5. General medical condition

a. Name of condition

Cause if known

b. Date your condition first began D D M M Y Y Y Y

Date of last symptoms D D M M Y Y Y Y

c. How often do you have symptoms?

Describe your symptoms

d. Have you ever taken medication for this condition? ☐ No ☐ Yes

If 'Yes', please provide details (including name, dose and frequency):

e. Are you still taking this medication? ☐ No ☐ Yes

f. Have you ever had any other treatment (eg physiotherapy, surgery, etc) or been in hospital or received emergency treatment for this condition? ☐ No ☐ Yes

If 'Yes', please provide details:

g. Are any tests, surgery or treatment planned or scheduled in relation to this condition? ☐ No ☐ Yes

If 'Yes', please provide details:

h. Are there any residual complications or disabilities resulting from this condition? ☐ No ☐ Yes

If 'Yes', please provide details:

i. Have you ever been absent from work or incapacitated as a result of this condition? ☐ No ☐ Yes

If 'Yes', please provide details:

j. Does your usual doctor have details of this condition? ☐ No ☐ Yes

If 'Yes', please provide details:

k. **Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to this condition:**

Date	Medical provider	Address
/ /		

6. Abnormal cervical screening or pap smear test or positive HPV test

a. Please indicate in box(es), the relevant condition(s) and or result(s) you've had or received treatment for:

- ☐ Intermediate risk result
- ☐ Higher risk result
- ☐ Unsatisfactory result
- ☐ Carcinoma
- ☐ Human Papilloma Virus (HPV)
- ☐ CIN 1
- ☐ CIN 2
- ☐ CIN 3
- ☐ Atypia or change (caused by infection or irritation)
- ☐ Other abnormality

b. What date was the condition(s) diagnosed?

Condition(s)	Date
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

c. Did you receive any treatment? ☐ Yes ☐ No

If 'Yes' please confirm dates, type of treatment (eg colposcopy, biopsy, laser, LLETZ/loop excision) and results?

d. Have you had a follow up cervical screening or pap smear test? ☐ Yes ☐ No ☐ Awaiting follow up

If 'Yes', please provide all dates and results since the abnormal result?

e. Provide details of your most recent visit to a doctor or hospital relating to the condition/result:

Date D D M M Y Y Y Y

Medical provider

Address

f. When is your next screening due?

7. Breast investigation or symptoms

a. Test performed:

☐ Mammogram ☐ Breast ultrasound ☐ Other – name of test

b. When was this test performed? D D M M Y Y Y Y

c. What was the reason for the test?

d. What were the results of test?

e. Were any follow ups required (including other tests or consultations with specialists)? ☐ No ☐ Yes

f. Have you had the required follow ups? ☐ No ☐ Yes

If 'Yes', what were the results?

If 'No', when will you have this follow up?

D D M M Y Y Y Y

8. Respiratory disorders (eg asthma, bronchitis etc)

a. Name of condition

b. How long has it been since you last experienced symptoms (including but not limited to, shortness of breath, coughing, chest tightness or wheezing)?

c. Do you use any inhalers? ☐ No ☐ Yes

If 'Yes', how often do you take your medication?

Medicine (eg Ventolin)	Dose	Frequency

d. Have you ever required treatment with oral steroids, or been admitted to hospital in the past 12 months as a result of this condition? ☐ No ☐ Yes

If 'Yes', how many times have you used oral steroids or been hospitalised for this condition in the past 12 months?

Please provide details of your most recent visit to a doctor, hospital or other therapist for anything related to your condition:

Date	Medical provider	Address
/ /		

9. Cyst/mole/skin lesion

a. Please indicate in the appropriate box(es) the condition(s) you have had, or received treatment for:

☐ Mole or naevi
☐ Hyperkeratosis or solar keratosis
☐ Sebaceous (fatty) cyst
☐ Basal Cell Carcinoma (BCC)
☐ Squamous Cell Carcinoma (SCC)
☐ Melanoma
☐ Other lesions (please describe below):

b. Please advise the location(s) of the skin lesion(s):

c. i. Has the lesion been fully removed? ☐ No ☐ Yes

If 'Yes', please advise the method and date(s) of removal (eg frozen, 'burnt', lasered off or surgically removed):

ii. **If surgically removed please also advise the pathology results?**

iii. **If 'No', please advise the reason why it has not been removed?**

d. Are any follow ups required? ☐ No ☐ Yes

If 'Yes', please advise details including frequency

14. Health questionnaires (continued)

e. Give details of your most recent visit to a doctor or hospital relating to this condition:

Date	Medical provider	Address
/ /		

10. Back or neck

a. What was the diagnosis given for your pain/disorder?

If no diagnosis, proceed to question b.

b. What part(s) of the back were or are affected? (Select all that apply)

i. ☐ Neck

ii. ☐ Middle

iii. ☐ Lower

c. Have you experienced any of the following? (Select all that apply): ☐ No ☐ Yes

i. ☐ Radiation or spread of pain down either the leg or arm (including shooting, stabbing or burning pain)

ii. ☐ Loss of feeling

iii. ☐ Loss of strength

iv. ☐ Pins and needles

If 'Yes', give details:

d. i. When did you first have symptoms?

Date D D M M Y Y Y Y

ii. When was the last time you had symptoms?

Date D D M M Y Y Y Y

iii. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?

iv. When you have symptoms how long do they last (eg a couple hours, 1 day, 2 weeks, ongoing)?

e. When you have pain, how would you rate your pain? Scale 0–5 with 0 being no pain and 5 being the worst pain you ever felt?

f. i. Do you know the cause of your pain? ☐ No ☐ Yes

If 'Yes', proceed to question ii

If 'No', proceed to question g.

ii. What do you think was the cause of your pain? (Select all that apply):

a. ☐ Work

b. ☐ Sport

c. ☐ Other

d. ☐ Unknown

If you selected any of the above, please provide details:

10. Back or neck (continued)

g. i. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes

If 'Yes', please provide the details of the total number of days or weeks you had off work

ii. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation to as a result of your pain/ disorder?**If 'Yes', please provide the details** ☐ No ☐ Yes

If you have answered yes to g(i) or g(ii) please complete g(iii)

iii. Please advise which statements apply to you: (Select all that apply)

I had time off work or restricted hours or duties because:

a. ☐ My work aggravated my pain
b. ☐ My work is too heavy for me
c. ☐ I think my work may cause further injury or pain
d. ☐ Other – please advise:

If you selected any of the above—please provide details:

h. i. Were you able to carry out daily activities such as washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes

If 'No', please provide the details:

ii. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes

If 'Yes', please provide the details:

i. Have you ever had investigations such as an x-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes

If 'Yes', please provide details in the table below:

Date	Investigation	Results[i]	Part of body (eg lower back)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession.

10. Back or neck (continued)

j. i. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes

If 'Yes', please provide details in the table below:

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

ii. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes

If 'Yes', please provide the details in the table below:

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

k. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes

If 'Yes', please provide details:

11. Disorder or injury of the joints

a. What was the diagnosis given for your pain/disorder?

If no diagnosis, proceed to question b.

b. Please complete one questionnaire for each joint affected
Note: If both left and right joints are affected please complete one questionnaire for each

joint In which joint did you or do you have the pain, injury or disorder? (Select boxes)

☐ Shoulder ☐ right ☐ left ☐ Elbow ☐ right ☐ left
☐ Wrist ☐ right ☐ left ☐ Hip ☐ right ☐ left
☐ Knee ☐ right ☐ left ☐ Ankle ☐ right ☐ left

☐ Other – please advise which joint right/left:

c. Have you experienced any of the following? (Select all that apply): ☐ No ☐ Yes

i. ☐ Radiation or spread of the pain
ii. ☐ Loss of feeling or strength
iii. ☐ Loss of range of movement
iv. ☐ Pins and needles
v. ☐ Weakness or instability
vi. ☐ Swelling or
vii. ☐ Other – please advise:

If you selected any of the above, give details:

11. Disorder or injury of the joints (continued)

d. i. When did you first have symptoms?

Date D D M M Y Y Y Y

ii. When was the last time you had symptoms?

Date D D M M Y Y Y Y

iii. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years, ongoing)?

iv. When you have symptoms how long do they last (eg a couple hours, 1 day, 2 weeks, ongoing)?

e. When you have pain, how would you rate your pain? Scale 0–5 with 0 being no pain and 5 being the worst pain you ever felt?

f. i. Do you know the cause of your pain? ☐ No ☐ Yes

If 'Yes', proceed to ii

If 'No', proceed to question g.

ii. What do you think was the cause of your pain? (Select all that apply):

a. ☐ Work
b. ☐ Sport
c. ☐ Other
d. ☐ Unknown

If you selected any of the above, provide details:

g. i. Has the pain/disorder ever required you to take time off work? ☐ No ☐ Yes

If 'Yes', please provide the details of the total number of days or weeks you had off work

ii. Have you been advised to or did you have to reduce the number of hours you worked, change your duties or occupation to as a result of your pain/disorder? ☐ No ☐ Yes

If 'Yes', please provide the details

If you have answered yes to g(i) or g(ii) please complete g(iii)

iii. Please advise which statements apply to you: (Select all that apply)

I had time off work or restricted hours or duties because:

a. ☐ My work aggravated my pain
b. ☐ My work is too heavy for me
c. ☐ I think my work may cause further injury or pain
d. ☐ Other – please advise:

Please provide details:

11. Disorder or injury of the joints (continued)

h. i. Were you able to carry out daily activities such as, washing, dressing, sleeping, lifting, reading, housework, driving, exercising or playing sport? ☐ No ☐ Yes

If 'No', please provide the details:

ii. Did the pain/disorder ever affect your relationships, ability to socialise with friends or family? ☐ No ☐ Yes

If 'Yes', please provide the details:

i. Have you ever had investigations such as an x-ray, CT Scan or MRI for this pain/disorder? ☐ No ☐ Yes

If 'Yes', please provide details in the table below:

Date	Investigation	Results[i]	Part of body (eg right shoulder)
/ /			
/ /			
/ /			

(i) Please attach a copy of any reports that you may have in your possession.

j. i. Have you ever been treated for this pain/disorder by a General Practitioner, Osteopath, Physiotherapist, Chiropractor, specialist or any other alternative health practitioner? ☐ No ☐ Yes

If 'Yes', please provide details in the table below:

Field of practice, eg Surgeon, Osteopath etc	Name	Address	Date of last consultation
			/ /
			/ /
			/ /

ii. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)? ☐ No ☐ Yes

If 'Yes', please provide the details in the table below:

Type of treatment	Name of medication (if applicable)	Dosage/frequency of treatment	Date started	Date ceased
			/ /	/ /
			/ /	/ /
			/ /	/ /

k. Are any tests, surgery or treatment planned or scheduled? ☐ No ☐ Yes

If 'Yes', please provide details:

12. Diabetes

a. Which of the following best describes your condition:

- ☐ Type 2 Diabetes
- ☐ Glucose Intolerance
- ☐ Type 1 Diabetes
- ☐ Diabetes Insipidus
- ☐ Gestational Diabetes
- ☐ Insulin Resistant
- ☐ Not sure

14. Health questionnaires (continued)

12. Diabetes (continued)

b. How long ago were you diagnosed with this condition?

c. How is this condition treated?

- ☐ Diet
- ☐ Oral medication
- ☐ Insulin
- ☐ Other

Please advise details including name of medication, dosage used per day:

d. Do you have any complications as a result of your diabetes (eg eye, kidney or nerve problems, high blood pressure or vascular disease etc)? ☐ No ☐ Yes

If 'Yes', please provide details:

e. Have you ever suffered from a diabetic or insulin coma, or required hospitalisation due to your diabetes or any related condition? ☐ No ☐ Yes

If 'Yes', please provide details:

f. When did you last have this condition checked by a medical practitioner?

g. What was the date and the result of your last Glycosylated Haemoglobin test?

h. For gestational diabetes – what was the date and result of your last Glucose Tolerance test?

i. Please provide your doctor's details, including name and address:

Date	Doctor	Address
/ /		

13. Occupational needle stick injury

a. Have you had any tests performed due to this needle stick injury? ☐ No ☐ Yes

If 'Yes', please advise details of test(s) performed and the results if known:

b. Are any tests pending due to your needle stick injury? ☐ No ☐ Yes

If 'Yes', please advise what test(s) are to be performed and when this is to occur:

14. Health questionnaires (continued)

14. COVID-19 (coronavirus) questionnaire

a. Which of the following apply to the potential risks you've been exposed to within the last month (select all that apply)?

☐ Travelled overseas

☐ Had contact with someone who has recently returned from overseas

☐ Was exposed to someone who suffered and was later diagnosed with COVID-19

b. When did you or the other person return from overseas or when were you exposed?

D D M M Y Y Y Y

c. Have you completed the required 14 days of self-quarantine/isolation? ☐ No ☐ Yes

d. Have you developed any symptoms such as fevers, sore throat, cough, headaches or shortness of breath? ☐ No ☐ Yes

If 'Yes' please provide details

e. i. If you've been tested for COVID-19 what was the result?

☐ Negative

☐ Positive

ii. If you tested **'positive'** did you have a following COVID-19 test result which was negative? ☐ No ☐ Yes

iii. If you tested **'positive'** were you hospitalised? ☐ No ☐ Yes

If 'Yes' please provide details in the table below:

Period in hospital	Hospital name and address	Treatment received	Did you spend time in intensive care?
/ / to / /			☐ No ☐ Yes If **'yes'**, number days days

f. If you had symptoms or tested **'positive'** to COVID-19, have you fully recovered with no continuing or residual symptoms or complications? ☐ No ☐ Yes

If 'No' please provide details:

15. Sporting activities questionnaires

If you need more room to provide your answers, please provide a separate signed and dated page(s) and attach to your application.

1. Underwater diving

a. Which of the following best describes your participation in this activity, please select all that apply:

☐ Scuba ☐ Enriched Air ☐ Mixed Gases ☐ Snorkel ☐ Other Diving Activity

b. Do you have recognised diving qualifications eg PADI, FAUI or NAUI and/or relevant qualifications for mixed gases? ☐ No ☐ Yes

If 'Yes', please provide details of all diving qualifications you have obtained:

c. How many dives do you perform per annum?

d. What is the maximum depth to which you dive (In metres)?

15. Sporting activities questionnaires (continued)

1. Underwater diving (continued)

e. Do you dive:

In caves	☐ No ☐ Yes	At night	☐ No ☐ Yes
In dams or lakes	☐ No ☐ Yes	Potholing	☐ No ☐ Yes
In ice	☐ No ☐ Yes	Internal exploration of wrecks	☐ No ☐ Yes

If 'Yes', please provide details including frequency:

f. Do you ever dive alone or participate in depth record attempts? ☐ No ☐ Yes

If 'Yes', please provide details including number of dives and location of the dives:

2. Motor sport on land or on water

a. Are you a professional or sponsored driver? ☐ No ☐ Yes

Please indicate in the appropriate box(es) the activity(ies) you take part in:

☐ Bicycles ☐ Jet ski racing ☐ Trucks
☐ Boats ☐ Karts/go karts ☐ Motorcycles
☐ Car ☐ Other (specify below):

b. Provide details of your involvement

Category	
Class	
Vehicle	
Fuel	
Engine capacity	
No. of events last 12 mths	
No. of events next 12 mths	
Maximum speed	
No. of vehicles per event	

c. Competition licence type Issuing body Years held

d. Do you have definite plans to compete overseas? ☐ No ☐ Yes

If 'Yes', please provide details:

e. Do you participate or intend to participate in record attempts, testing of prototypes or testing of vehicles? ☐ No ☐ Yes

If 'Yes', please provide details:

f. Have you ever had a motor sport accident, or has your competition licence ever been suspended? ☐ No ☐ Yes

If 'Yes', please provide details:

15. Sporting activities questionnaires (continued)

3. Aviation

a. Please indicate the activity(ies) you take part in:

Type of flying[1]	Fixed wing or helicopter	No. of hours past 12 months	No. of hours next 12 months

b. Type of aircraft that you usually fly?

c. Licence type ____ Years held ____

d. Name of your pilot's club or association:

e. Air navigation order under which your flying is controlled:

f. Do you have any definite plans to upgrade or change your licence? ☐ No ☐ Yes

g. Do you have any definite plans to fly outside of Australia, or take off or land from anywhere that is not a registered airfield? ☐ No ☐ Yes

If 'Yes', please provide details:

h. Have you ever been involved in flying accidents, been grounded or had your licence revoked? ☐ No ☐ Yes

If 'Yes', please provide details:

4. Other activities

a. Please indicate the activity(ies) you take part in:

b. On what basis do you participate in this activity? ☐ Amateur ☐ Semi-professional ☐ Professional

c. Frequency of participation? ____ per annum Duration of participation? ____ years

d. Details of any licences or qualifications:

e. Name of any club or organisation that you are a member of:

f. Location(s) where you undertake or participate in this activity:

1 Type of flying as defined by the aviation authorities: eg aerobatics; agricultural (including crop dusting and inspecting); airline operations; air racing; aircraft record attempts; ballooning; charter flying; commuter operations; competition flying; experimental flying; gliding; hang-gliding; microlighting/powered hang-gliders; paragliding and parascending; private flying or business commuting; record attempts; stunt flying; test flying; training/instructing; other (specify).

4. Other activities (continued)

g. Maximum altitude/depth or speed etc:

h. Do you participate in competition? ☐ No ☐ Yes

If 'Yes', please provide details:

i. Details of any injury(ies) as a result of participating in this activity:

j. Details of any definite plans to change from what you stated above:

k. Details of any other relevant features of your involvement in this activity:

Office/Adviser use only

Financial adviser number

Plan number

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905192_RL 07/22