Personal Statement

Information sheet

When to use this form

Use this form to apply for Elevate insurance.

We rely on what you tell us

Before we decide to issue a plan, we need to know exactly what the risk is that we are to insure and how likely you would be to make a claim.

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

This Personal statement is dated November 2023
Resolution Life Australasia Limited ABN 84 079 300 379

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 have consented to have if the total combined sum insured with all life insurers for the insurance being applied for is over:

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

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 Moratorium on Genetic Tests. A copy of the moratorium is available in the Life Insurance Code of Practice **cali.org.au/life-code**.

Your privacy

Protecting your personal and sensitive information is important to us. Any information we collect, use, store or disclose about you will be handled in accordance with our Privacy Policy and relevant privacy and data protection legislation.

The information we collect about you is used to provide you with our products and services including to issue, arrange and manage your insurance and membership with us. We will only collect personal and sensitive information from you, from those authorised by you or where required by law.

There may be situations where we will collect sensitive information, such as your health information in order to assess your application for new or additional insurance. We will only use this information for the primary purpose for which it was collected or a related purpose, such as to process a claim.

We will only use and disclose this information where you have provided expressed consent.

We may also disclose your personal information to third parties involved in the above process such as:

- financial advisers
- brokers
- parent or guardian where you are under 18 years of age
- insurers and re-insurers

- claims handlers, investigators
- legal and other professional advisers, regulators and our related companies.

Some of these third parties may be located in other countries such as the UK, India or USA.

Our Privacy Policy details how we collect, use, store and disclose your personal and sensitive information as well as how you can seek access to and correct your personal information or make a complaint. You may not access or correct personal information of others unless you have been authorised by them, or are authorised under law or they are your dependants.

By providing us your personal and sensitive information you consent to us collecting, using, storing and disclosing it in accordance with our Privacy Policy. If you do not provide all of the personal and sensitive information we've requested we may not be able to provide you with our services or products including being able to process your application for insurance.

For more information, see our full Privacy Policy at **resolutionlife.com.au/privacy**.

Personal statement checklist

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38	☐	Superannuation

Where the following symbols have been used:

S	**Superannuation** Please complete this section when you are applying for the Life Insurance Superannuation Plan, TPD Insurance Superannuation Plan or Income Insurance Superannuation Plan issued by Equity Trustees Superannuation Limited (ETSL).
NS	**Non-superannuation** Please complete this section when you are applying for cover that is issued by Resolution Life Limited (Resolution Life) and it is not owned by an SMSF. It should also be completed if you have applied for a FlexiLink plan or PremierLink option (with the exception of the Nomination of beneficiaries section).
SMSF	**Self Managed Superannuation Fund (SMSF)** Please complete this section when you are applying for the Life Insurance SMSF Plan, TPD Insurance SMSF Plan or Income Insurance SMSF Plan. These plans are issued by Resolution Life and are owned by the trustees of an SMSF or Small APRA Super Fund. These are the only Elevate insurance plans that can be owned by an SMSF or Small APRA Super Fund.

If no symbol has been used, the section should be completed for all plans being applied for.

Please retain this information sheet for your records.
Do not return it with your completed form(s).

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Resolution Life

To be completed by the Person to be insured. ☐

Personal Statement

Use this form to apply for Elevate insurance.

Details

'You' refers to the Person to be insured (unless otherwise indicated).

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

Residency and travel details

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

- ☐ No, proceed to question 1b
- ☐ Yes, go to question 2

b. Are you a New Zealand citizen?

- ☐ No, please provide details:
- ☐ Yes, go to question 2

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 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

2. 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

To be completed by the Person to be insured. ☐

Personal details (continued)

Residency and travel details (continued)

3. Do you intend to travel outside Australia or New Zealand for holiday or business purposes? ☐ No ☐ Yes
If yes, please provide details:

Where	When	Duration

Insurance details

4. Other than this application, are you covered by, or are you applying for, life, disability, trauma, income insurance or business expenses insurance with **any company**? **Note:** This includes benefits under superannuation, business or credit insurance or benefits provided by an employer. ☐ No ☐ Yes

If yes, please provide details:

Name of company	Type of cover	Sum insured ($)	Date commenced	To be replaced?
			/ /	☐ No ☐ Yes
			/ /	☐ No ☐ Yes
			/ /	☐ No ☐ Yes

Important notes: If this application for insurance is intended to replace the existing plan(s) listed in the table above or insurance cover held within the Resolution group (if noted on page 7 of the Application form) that is being converted/replaced:

1 When the insurer notifies you that it has accepted your application for insurance, you must cancel such plan(s). If you do not cancel the existing plan(s) listed in the table above, any claim you make to Resolution for the insurance applied for and accepted may not be considered.

2 Under takeover terms, the insurance cover to be replaced must have been fully underwritten and not have been accepted under modified or limited underwriting requirements or on takeover terms previously.

3 If the existing insurance is held with us or another company within the Resolution group of companies, you authorise:
- us to cancel, or to instruct the other insurer to cancel, that insurance effective the date that the new insurance commences, and
- the other insurer (if any) to cancel that insurance at our request on the basis of this authority.

5. Has **any company** ever indicated they would not issue you insurance, or would apply a loading, modify, restrict or exclude your insurance in any way? ☐ No ☐ Yes

If yes, please provide full details including reason, date, company name and type of cover:

6. In the last five years have you, or do you intend in the next 12 months, to claim unemployment benefits? ☐ No ☐ Yes

If yes, please provide details:

Benefit type	Date
	D D M M Y Y Y Y

7. Have you ever, or do you intend to claim benefits under any insurance plan, government scheme, armed forces, pension or allowance, or court proceedings? If yes, please provide details: ☐ No ☐ Yes

Company/benefit type	Reason	Benefit amount ($)	Date
			/ /
			/ /
			/ /

To be completed by the Person to be insured. ☐

Personal details (continued)

Personal habits

8. a. Have you ever been a smoker or used any sort of tobacco products (including e-cigarettes and/or nicotine replacement products)? ☐ No ☐ Yes

If no > go to question 9

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 (please provide details below)

☐ E-cigarettes (please provide details below)

☐ Other **Please specify substance smoked:**

If you have indicated that you use nicotine replacement products, e-cigarettes or any other substance, please answer the following questions.

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

ii. What strength? mgs

b. If you have stopped smoking, using tobacco, nicotine replacement products or other substances, please advise when?

month year

c. Have you ever been advised by a health care professional to reduce your smoking because of a medical condition? If yes, please advise the name of the condition and any treatment received: ☐ No ☐ Yes

Condition Treatment

9. How many standard drinks containing alcohol do you consume per week on average? [standard drink = 1 nip/30ml of spirits, 1 x 100ml glass of wine, 1 x 250 ml glass of beer]

standard glasses per week

10. Have you ever been advised by a health care professional to reduce your alcohol intake or seek alcohol treatment? ☐ No ☐ Yes

If yes, please advise your alcohol intake amount at that time, reason you were advised and details of any treatment:

11. 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.) If yes, please give details, including the type of drug and the date(s) used: ☐ No ☐ Yes

Your health details

Doctor details

12. 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

To be completed by the Person to be insured. ☐

Your health details (continued)

Doctor details (continued)

13. Date of last consultation with any doctor

D D M M Y Y Y Y

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

15. Please advise reason for your last consultation

16. Please advise results/outcome of your last consultation

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

If yes, please provide full details

Personal health history

18. a. What is your: Height Weight

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

If yes, please cross one of the following and provide the amount and the reason: ☐ Gain ☐ Loss

Amount kg Reason

19. At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor)?

a. **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

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

☐ No ☐ Yes

c. Disorder or injury of the muscles, bones or limbs (eg fracture, tendonitis or tenosynovitis) ☐ No ☐ Yes

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

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

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

g. **Stress**, **fatigue, insomnia** or **sleeplessness** ☐ No ☐ Yes

h. Chronic fatigue or chronic pain syndrome ☐ No ☐ Yes

i. Fibromyalgia, fibrositis or myalgia ☐ No ☐ Yes

j. Stroke, Transient Ischaemic Attack (TIA), brain haemorrhage or brain injury ☐ No ☐ Yes

k. Multiple sclerosis, Parkinson's disease, Alzheimer's disease, dementia, paralysis or cerebral palsy ☐ No ☐ Yes

l. Epilepsy, fit or blackout, migraine or recurrent headaches ☐ No ☐ Yes

m. Any neurological complaint or disorder of the nervous system including dizziness, involuntary shaking, memory loss, weakness, loss of feeling, or tingling of limbs or face ☐ No ☐ Yes

n. **High blood pressure or raised cholesterol** (including being advised to take medication or have your levels monitored) ☐ No ☐ Yes

o. Heart condition including irregular heartbeat, heart murmur, heart disease or chest pain ☐ No ☐ Yes

p. Disorder of the blood including anaemia or haemophilia ☐ No ☐ Yes

q. **Asthma** ☐ No ☐ Yes

r. Bronchitis, sleep apnoea, pneumonia or any other lung, respiratory or breathing disorder

Your health details (continued)

Personal health history (continued)

s. Disorder of the thyroid	☐ No	☐ Yes
t. **Diabetes**, sugar in the urine or raised blood sugar levels	☐ No	☐ Yes
u. Disorder of the kidney or bladder including blood or protein in the urine, urinary infections or kidney stones	☐ No	☐ Yes
v. Disorder of the digestive system, gall bladder, stomach, bowel or liver including any changes to your usual bowel habits, hepatitis, haemochromatosis, gastric or duodenal ulcer, indigestion, colitis, Crohn's disease, irritable bowel syndrome or hernia	☐ No	☐ Yes
w. Disorder of the eyes not corrected by glasses or contact lenses (eg iritis, glaucoma, optic neuritis, blurred or double vision)	☐ No	☐ Yes
x. Disorder of the ears or speech including hearing loss or tinnitus	☐ No	☐ Yes
y. Disorder of the skin including psoriasis, eczema or dermatitis	☐ No	☐ Yes
z. Cancer, tumour, leukaemia, Hodgkin's disease, lymphoma, melanoma or **skin cancer** or any malignant condition	☐ No	☐ Yes
aa. **Cyst, skin lesion, growth, lump** (including breast lump), **mole or freckle** that has bled, become painful, changed colour or increased in size	☐ No	☐ Yes
ab. Any sexually transmitted infection or disease	☐ No	☐ Yes

! If you answered **yes** to any of the items in 19, please provide details in the table below, **except** for any condition in bold text above, for which you should complete the relevant Detailed health questionnaire in 28. If you answered **no** to all items, go to 20.

Item no. eg 'f'	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery (%)
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

20. At any time in your life have you ever had, received advice for or experienced symptoms of the following (even if you have not seen a doctor)?

Males only

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

Females only

b. Are you currently pregnant? If yes, please advise expected delivery date D D M M Y Y Y Y	☐ No	☐ Yes
c. Have you ever had any complications with pregnancy or childbirth? If yes, please provide details below, including whether resolved after delivery.	☐ No	☐ Yes
d. Have you ever had an **abnormal cervical screening or pap smear test**, **positive HPV test** biopsy of the cervix or uterus?	☐ No	☐ Yes

! If you answered **yes** to any of the items in 20, please provide details in the table on the next page, **except** for any condition in bold text above, for which you should complete the relevant Detailed health questionnaire in 28.

Your health details (continued)

Personal health history (continued)

Item no. eg 'b'	Date	Details of condition, advice or symptom including nature of treatment and/or results of investigations	Name and address of doctor, hospital or health professional consulted	Time off work	Degree of recovery (%)

Females only

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

f. 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

If yes for **e** or **f**, please provide details in the table below.

Item no.	Date	Reason	Results	Follow up required	Name of doctor	Pending follow up	When
	/ /			☐ No			/ /
				☐ Yes			

21. Other than what you have already told us in this application, have you in the last **five years** (not including colds or flu):

a. Attended any other medical appointment (eg counselling), or had any other test (eg X-ray, blood), including surveillance tests (eg ultrasounds or colonoscopies), surgery either in Australia or overseas, any preventative or prophylactic treatment (eg mastectomy), with any other doctors, medical centres or health care professionals, including chiropractors, physiotherapists, naturopaths, osteopaths, podiatrists or herbalists? **Important:** Please refer to the **genetic test approach** in the **information sheet** when answering this question. ☐ No ☐ Yes

b. Used or are you currently using any medication, prescribed or unprescribed (taken by mouth, injections, inhaled spray, cream, ointment) or had any treatment for any symptoms, sickness, injury or medical condition? ☐ No ☐ Yes

c. Had any sickness, symptom or injury that prevented you from performing any of the duties of your usual occupation for more than 3 consecutive days? ☐ No ☐ Yes

! If you answered **yes** to any of the items in 21, please provide details in the table below.

Item no. eg 'b'	Date	Details of condition, advice or symptom including nature of treatment	Name and address of doctor, hospital or health professional consulted	Date treatment or medication ceased (if applicable)	Time off work	Degree of recovery (%)
	/ /			/ /		
	/ /			/ /		
	/ /			/ /		

Your health details (continued)

Personal health history (continued)

22. Other than what you have already told us in this application:

a. Have you ever been admitted to hospital for any reason? ☐ No ☐ Yes

b. Are you experiencing any symptoms or complaints for which you have not consulted a doctor? ☐ No ☐ Yes

c. Have you contemplated, been advised to seek or are you awaiting any medical advice, investigation or treatment including surgery either in Australia or overseas? ☐ No ☐ Yes

d. Have you, within the last month: ☐ No ☐ Yes
   - 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)?

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

If you answered **yes** to any of the items above please provide details, if 22(d) and/or 22 (e) is answered yes, you should also complete the relevant Detailed COVID-19 health questionnaire in 28.

23. a. Have you or any of your current or previous sexual partners tested positive for HIV/AIDS, or have any sign of HIV infection (eg some signs of HIV/AIDS are: unexplained weight loss, swollen glands or persistent diarrhoea)? ☐ No ☐ Yes

b. In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? ☐ No ☐ Yes

Note: HIV risk situations include but are not limited to:
- sex with or as a sex worker
- sex with an intravenous drug user
- contact with someone else's blood (eg through injection or scratch with a used needle)
- anal intercourse (except in a relationship between you and one other person only and neither of you has had sex with anyone else for at least three years).

(If you answered **yes** to any part of 23 we will send you a confidential questionnaire to complete.)

Family history

24. Has any first-degree blood related family member (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)

To be completed by the Person to be insured. ☐

Your health details (continued)

Family history (continued)

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

Note: You are only required to disclose family information relating to first degree blood related family members — living or deceased (mother, father, sisters, brothers or your children).

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 abnormalities	Doctor consulted
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

b. Are any tests or investigations (excluding genetic test) pending? ☐ No ☐ Yes

If yes, please give details of which tests are pending and when these will be performed.

Sports and pastimes details

26. 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 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, trail bike riding and commuting (please specify below) ☐ 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 items d, e or f, please provide details of each activity in the table below. For any activity in bold text above please complete the relevant section of 27. If you answered no to all items above, go to 28.

Item no. eg 'f'	Activity/Sport and location	Other details (including remuneration received)	No. events/ hours per year	Amateur/ Professional?	Competitive/ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive
				☐ Amateur ☐ Professional	☐ Competitive ☐ Non-competitive

To be completed by the Person to be insured. ☐

Sports and pastimes details (continued)

27. Detailed sports and pastimes questionnaires

! Only complete the relevant sections of this question if you answered **yes** to 26 a, b or c.

a. Aviation questionnaire

1. Do you hold a Department of Transport licence to fly aircraft? ☐ No ☐ Yes
   If yes, please state type of licence and period held:

2. Do you intend to change the scope of your present licence? ☐ No ☐ Yes
   If yes, please provide details:

3. Have you ever had an accident or been charged with violating civil aviation regulations? ☐ No ☐ Yes
   If yes, please provide details:

4. Do you always use recognised Department of Transport airfields? ☐ No ☐ Yes
   If no, please provide details:

5. Please provide details of the type(s) of aviation you are involved in (eg commercial, private, agricultural, aero club, helicopter, ultralight aircraft, aerobatics):

6. Please provide details of the number of hours flown:
   i. in total as a pilot
   ii. in the last 12 months
   iii. expected each year in the future

7. Do you intend to engage in any form of aviation other than the above? (eg ballooning, paragliding) ☐ No ☐ Yes
   If yes, please provide details:

b. Motor racing questionnaire

1. What type(s) of motor sports activities do you participate in (eg circuit racing, drag racing, formula racing, karting, rallies, speedway, stock car racing, time trials)?

2. What type(s) of motor vehicles do you drive or crew? Please state the make, model, year of manufacture, engine size, category, group and class details:

3. Please state the nature of your participation:
   ☐ Recreational ☐ Competitive ☐ Sponsored ☐ Amateur ☐ Professional

4. Number of events you participate in: Last 12 months Next 12 months (expected)

5. Where have you, or do you intend to compete or race? Please provide the name of all organised events:

6. What maximum speeds do you reach?

To be completed by the Person to be insured. ☐

Sports and pastimes details (continued)

27. Detailed sports and pastimes questionnaires (continued)

b. Motor racing questionnaire (continued)

7. Please provide details of your licences/certifications and memberships attained:

Licence/certification or membership details	When attained/ joined
	/ /
	/ /

8. Have you ever had your licence restricted or suspended for any reason? ☐ No ☐ Yes
If yes, please provide details:

c. Underwater diving questionnaire

1. What type of diving activities do you participate in (eg snorkelling, scuba diving, free diving)?
2. What diving certification do you hold?
3. Average depth you dive to metres
4. Maximum depth you dive to metres
5. Number of times you dive per year
6. ☐ Professional ☐ Amateur
7. Do your diving activities include pothole, cave or sink hole diving, wreck exploration or any other hazardous diving? ☐ No ☐ Yes
If yes, please provide details, including how often:
8. Do you ever dive alone? ☐ No ☐ Yes
If yes, please provide details, including where and how often:
9. Have you ever had a diving accident or sickness? ☐ No ☐ Yes
If yes, please provide details:

To be completed by the Person to be insured. ☐

Health questionnaires

28. Detailed health questionnaires

! Only complete the relevant health questionnaires, if you answered **yes** to any items in bold text in 19 and 20.

a. Back or neck disorder questionnaire

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

If no diagnosis, proceed to question 2

2. What part(s) of the back were or are affected? (select all that apply)
   a. ☐ Neck
   b. ☐ Middle
   c. ☐ Lower
3. Have you experienced any of the following (select all that apply): ☐ No ☐ Yes
   a. ☐ Radiation or spread of pain down either the leg or arm (including shooting, stabbing or burning pain)
   b. ☐ Loss of feeling
   c. ☐ Loss of strength
   d. ☐ Pins and needles

   If yes, give details:
4. a. When did you first have symptoms?
   Date D D M M Y Y Y Y
   b. When was the last time you had symptoms?
   Date D D M M Y Y Y Y
   c. How often have you had symptoms (eg once only, monthly, yearly, twice in last 10 years,
   d. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?
5. 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?
6. a. Do you know the cause of your pain? ☐ No ☐ Yes
   If yes > proceed to question b
   If no > proceed to question 7
   b. What do you think was the cause of your pain (select all that apply)?
      i. ☐ Work
      ii. ☐ Sport
      iii. ☐ Other
      iv. ☐ Unknown

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

To be completed by the Person to be insured. ☐

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

a. Back or neck disorder questionnaire (continued)

7. a. 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

b. 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 7a or 7b please complete 7c

c. Please advise which statements apply to you: (select all that apply)

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

i. ☐ My work aggravated my pain
ii. ☐ My work is too heavy for me
iii. ☐ I think my work may cause further injury or pain
iv. ☐ Other

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

8. a. 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:

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

If yes, please provide the details:

9. 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. a. 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
			/ /
			/ /
			/ /

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

a. Back or neck disorder questionnaire (continued)

b. Have you ever received any treatment for this pain/disorder (eg medication, surgery or injections)?If yes, please provide the details in the table below: ☐ No ☐ Yes

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

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

If yes, please provide details:

b. Disorder or injury of the joints questionnaire

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

If no diagnosis, proceed to question 2

2. Please complete one questionnaire for each joint affected

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

☐ 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:

Note: If both left and right joint is affected please complete one questionnaire for each joint

3. Have you experienced any of the following (select all that apply): ☐ No ☐ Yes

a. ☐ Radiation or spread of the pain
b. ☐ Loss of feeling or strength
c. ☐ Loss of range of movement
d. ☐ Pins and needles
e. ☐ Weakness or instability
f. ☐ Swelling or
g. ☐ Other – please advise:

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

4. a. When did you first have symptoms?

Date D D M M Y Y Y Y

b. When was the last time you had symptoms?

Date D D M M Y Y Y Y

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

d. When you have symptoms how long do they last (eg a couple hours, one day, two weeks, ongoing)?

To be completed by the Person to be insured. ☐

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

b. Disorder or injury of the joints questionnaire (continued)

5. 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?

6. a. Do you know the cause of your pain? ☐ No ☐ Yes

   If yes > proceed to question b

   If no > proceed to question 7

   b. What do you think was the cause of your pain (select all that apply)?

   i. ☐ Work
   ii. ☐ Sport
   iii. ☐ Other
   iv. ☐ Unknown

   If you selected any of the above, provide details:

7. a. 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

   b. 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 7a or 7b please complete 7c

   c. Please advise which statements apply to you: (select all that apply)

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

   i. ☐ My work aggravated my pain
   ii. ☐ My work is too heavy for me
   iii. ☐ I think my work may cause further injury or pain
   iv. ☐ Other

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

8. a. 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:

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

   If yes, please provide the details:

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

b. Disorder or injury of the joints questionnaire (continued)

9. 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.

10. a. 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
			/ /
			/ /
			/ /

b. 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
			/ /	/ /
			/ /	/ /
			/ /	/ /

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

If yes, please provide details:

To be completed by the Person to be insured. ☐

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

c. Mental health disorders questionnaire

1. 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.

2. What were the main symptoms of your condition(s)? (For example, did you feel excessive sadness or anger or were you unable to sleep or eat?)

3. When did your symptoms start?

4. How often did you or do you feel these symptoms?

5. When was the last time you experienced any of the symptoms?

6. What, if any, have been the impacts to your work? For example, did you need time off work, reduce or change the number of hours you worked, or stop working? ☐ No ☐ Yes

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

7. What, if any, have been the impacts to your social life? For example has there ever been an impact on your relationships, your ability to socialise with friends or family, or your ability to exercise or play sport? ☐ No ☐ Yes

   If yes, please provide details:

8. Have you consulted a health professional about your condition? For example, your general practitioner, a counsellor, psychologist or psychiatrist? ☐ No ☐ Yes

   If yes, please provide the details in the table below:

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

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

c. Mental health disorders questionnaire (continued)

9. Have any of them ever prescribed or recommended a treatment to you for your condition, including medication, psychotherapy, or talk based therapy? ☐ No ☐ Yes

   If yes, please provide the details in the table below:

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

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

    If no, please advise when you stopped treatment.

11. If you have stopped your treatment, was this decision supported by your health professional? ☐ No ☐ Yes

12. Have you ever been admitted to hospital or clinic because of your condition? ☐ No ☐ Yes

    If yes, please provide details in the table below:

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

13. Have you ever thought of harming yourself or taking your own life? ☐ No ☐ Yes

    If no, please go to question 15

    If yes, please provide the name and address of your doctor that would have the details, if one was consulted:

14. Have you ever acted on these thoughts? ☐ No ☐ Yes

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

15. Has any first degree blood related family member (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).

To be completed by the Person to be insured. ☐

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

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

1. Which of the following do you have or have you had or received treatment or advice for? (Please select all that apply)
   - ☐ Stress
   - ☐ Fatigue
   - ☐ Insomnia and/or sleeplessness
2. Did you see a doctor or other health professional for this condition(s)? ☐ No ☐ Yes
3. Were you diagnosed with anxiety, depression or any other mental health disorder? ☐ No ☐ Yes

   If yes **>** go to the mental health questionnaire on section 29c.

   If no, please continue to complete this questionnaire.
4. Did this condition(s) affect you to the point where you experienced any of the following (select all that apply):
   - ☐ physical symptoms such as headache, dizziness, soreness or irritability
   - ☐ you found it difficult to go to work or were unable to go to work
   - ☐ it had an impact on your relationships
   - ☐ your ability to sleep, eat, or think clearly
   - ☐ problems with concentration, memory or tiredness during the day
   - ☐ 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:
5. What do you think caused your symptoms?
6. When did you first experience symptoms and how long did they last?
7. When was the last time you experienced symptoms?
8. 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.
9. 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:
10. Please advise how often you see or saw your treating health professional for this condition and provide their name(s) and address(es):

To be completed by the Person to be insured. ☐

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

e. High blood pressure or raised cholesterol questionnaire

1. Please indicate which of the following have been raised/high: ☐ Blood pressure ☐ Cholesterol ☐ Both
2. a. When did you first find that your readings/levels were raised or were you advised to have your reading/levels monitored or noted?

   b. What was your reading/level at the time noted in 2a?

   Blood pressure ___ / ___ Cholesterol ___
3. a. What was the last blood pressure/cholesterol reading, and when was this taken?

   Blood pressure ___ / ___ Date D D M M Y Y Y Y

   Cholesterol reading ___ Date D D M M Y Y Y Y

   b. Is the reading above consistent with others when checked? ☐ No ☐ Yes

   If no, what is a typical reading?
4. How often are you required to see your doctor for reviews/check-ups?

   ☐ Monthly ☐ Quarterly ☐ Twice-yearly ☐ Annually ☐ Other—details:
5. When is your next check-up due? D D M M Y Y Y Y
6. Are you currently taking any medication for your blood pressure/cholesterol levels?

   ☐ No, go to question 8 ☐ Yes, please provide the name of any medication you take and the daily dosage

Condition	Medication	Daily dosage
Blood pressure		
Cholesterol		

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

   ☐ No › go to question 9 ☐ Yes, please provide the details below and continue to question 9

When was it changed?	What was changed?	Why was it changed?

8. Have you ever been prescribed medication for blood pressure/cholesterol? ☐ No ☐ Yes

   If no, how has the condition been managed?

   If yes, when and why have you ceased taking this medication?
9. Have you undergone or been referred for any other investigations (eg resting or exercise ECG, 24hr holter monitor, urinalysis, echocardiogram)? ☐ No ☐ Yes

   If yes, please provide details:
10. Has any underlying cause been found for your raised blood pressure/cholesterol? ☐ No ☐ Yes

    If yes, please provide details:

To be completed by the Person to be insured. ☐

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

f. Asthma questionnaire

1. When was your asthma diagnosed? D D M M Y Y Y Y
2. When did you **first** have symptoms? D D M M Y Y Y Y
3. When did you **last** have symptoms? D D M M Y Y Y Y
4. Approximately how many times per year do you or did you get symptoms?
5. Does the environment in which you work or perform your normal daily duties, exacerbate or cause your symptoms of asthma (eg dust, sawdust, pollen, grass)? ☐ No ☐ Yes

   If yes, please provide details:
6. In the last 12 months have you taken time off work or been unable to perform your normal daily activities because of your asthma? ☐ No ☐ Yes

   If yes, please provide details including the number of times and days:
7. Please provide details of the treatment for your asthma, including dosage of drugs taken and frequency (eg aerosol spray, tablets or injections, amounts and number of times per day):
8. Have you ever been treated for your asthma with steroids (eg Prednisone)? ☐ No ☐ Yes

   If yes, please provide details, including dates:
9. Have you ever attended a hospital emergency room or been admitted to hospital because of your asthma? ☐ No ☐ Yes

   If yes, please provide details:
10. In the last three years, have you had or been advised to have a chest X-ray or respiratory function test? ☐ No ☐ Yes

    If yes, please provide dates and results:
11. Have you ever had any complications or other conditions related to your asthma (eg cardiac or respiratory arrest, heart disease, chest deformities)? ☐ No ☐ Yes

    If yes, please provide details:
12. a. Please provide details of the doctor who you consult for your asthma:

    b. When did you **last** consult this doctor for asthma? D D M M Y Y Y Y

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

g. Cyst, mole, skin lesion questionnaire

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

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

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

3. 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):

If surgically removed please also advise the pathology results?

If no, please advise the reason why it has not been removed?

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

If yes, please advise details including frequency

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

Date	Medical provider	Address
/ /		

h. Abnormal cervical screening or pap smear test or positive HPV test questionnaire

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

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

2. 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

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

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

To be completed by the Person to be insured. ☐

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

h. Abnormal cervical screening or pap smear test or positive HPV test questionnaire (continued)

4. 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?

5. 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

6. When is your next screening due?

i. Diabetes questionnaire

1. Which of the following best describes your condition: (select all that apply)
   ☐ Type 2 Diabetes ☐ Glucose Intolerance
   ☐ Type 1 Diabetes ☐ Diabetes Insipidus Insulin
   ☐ Gestational ☐ Resistant
   ☐ Diabetes Not sure

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

3. How is this condition treated? (select all that apply)
   ☐ Diet ☐ Oral medication ☐ Insulin
   ☐ Other:
   Please advise details including name of medication, dosage used per day:

4. 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:

5. 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:

6. When did you last have this condition checked by a medical practitioner?
   (D D M M Y Y Y Y)

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

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

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

Date	Doctor	Address
/ /		
/ /		

Health questionnaires (continued)

28. Detailed health questionnaires (continued)

j. COVID-19 (also known as Coronavirus) questionnaire

1. 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
   - ☐ Been exposed to someone suffering / later diagnosed with COVID-19
2. When did you or the other person return from overseas or when were you exposed?
   Date D D M M Y Y Y Y
3. Have you completed the required 14 days of self-quarantine / isolation? ☐ No ☐ Yes
4. Have you developed any symptoms such as fevers, sore throat, cough, headaches or shortness of breath? ☐ No ☐ Yes
   If yes, please provide details:

5. If you've been tested for COVID-19 what was the result?
   - ☐ Negative
   - ☐ Positive

   If the test was positive, please also advise:
   a. Have you had a subsequent negative COVID-19 test result? ☐ No ☐ Yes
   b. Were you hospitalised? ☐ No ☐ Yes
   If yes, please provide details in the table below:

Name of hospital

Dates of hospitalisation	Treatment received	Did you spend time in Intensive Care?	Date of discharge
/ /		☐ No ☐ Yes If **yes**, number days	/ /

6. 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:

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance or Total and Permanent Disability Insurance. ☐

Occupation details

If you have not applied for plans listed in the top right box, go to the Authorities section.

'You' refers to the Person to be insured (unless otherwise indicated).

29. Please give details of your current and previous occupation or jobs over the last five years. If you have a second occupation, please give details in question 39.

	From	To	Occupation	Employer
Current principal occupation	/ /	Present		
		Cross which is applicable	☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	
Previous occupation	/ /	/ /		
			☐ Employed by own company ☐ Self-employed ☐ Partnership ☐ Employee ☐ Contractor	

If you work in the mining or oil and gas industry, please ensure you complete 42.

30. In the last five years have you ceased or do you intend to cease working for reasons other than holidays (eg unemployment or end of contract)? ☐ No ☐ Yes

If yes, please provide details:

31. How many hours per week do you spend working in your main occupation? hours

32. How many weeks per year do you spend working in your main occupation? weeks per year

33. In your **main** occupation, what percentage of time do you spend performing the following types of duties:

	Describe details of specific duties performed	(%)
Sedentary/Administrative		
Supervising manual work		
Light manual		
Heavy manual		
Home duties (include details of dependants including ages and any other relevant information)		
Other (including hazardous duties, eg handling dangerous substances, working at heights/underground/offshore, refinery)		
Total duties		**100%**

34. a. What qualifications do you hold in relation to your main occupation (eg trade certificate, degree)?

b. When did you qualify/graduate? D D M M Y Y Y Y

c. Please give details of any other qualifications you hold:

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance or Total and Permanent Disability Insurance. ☐

Occupation details (continued)

35. Do you ever work from home? ☐ No ☐ Yes

If yes, provide details of actual work you perform at home, your work set-up (eg separate office) and frequency and type of contact with clients:

36. Do you intend to change your occupation or employment status? ☐ No ☐ Yes

If yes, please provide details below:

37. Have you ever been bankrupt or entered into a personal insolvency arrangement? ☐ No ☐ Yes

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

38. 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.

39. Do you have any other occupations or jobs? ☐ No ☐ Yes

If yes, please provide details below including specific duties:

40. Number of hours per week worked and annual income derived from your other occupations or jobs. hours $

Income details

41. Insurable income

What is Insurable income? This is income earned by your personal exertion (less expenses incurred in earning that income) before tax, which will stop if you are unable to work. It does not include investment or interest income.

Please disclose all income figures that accurately reflect your financial position for the periods indicated below. In the event of a claim, we may call for evidence of your income and business expenses.

Complete this section if you are applying for Total and Permanent Disability Insurance only

a. Please provide details of your total income or salary package for the last two financial years, including any additional benefits, eg pre-tax superannuation contributions, regular bonuses and commissions, fringe benefits:

Last financial year $

Previous financial year $

b. If you are self-employed

i. Has your business had a net operating loss over either of the last two financial years? ☐ No ☐ Yes

ii. So far this financial year, is your business trading profitably? If no, please provide details in the space below: ☐ No ☐ Yes

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance. ☐

Income details (continued)

41. Insurable income (continued)

Complete this section if you are applying for Income Insurances or Business Expenses insurance

! If you are **self-employed, in a partnership or an employee of your own company (or contractor)**, please complete the 'For self-employed' section below.

OR If you are **an employee**, please complete the 'For employees' section on page 31.

For self-employed (sole trader, partnership, employee of own company or trust)

! Only complete this section if you are self-employed. This includes sole traders, partners, contractors or if you are an employee in your own company.

c. Please provide your company's business income details in the table below for the last two financial years for which tax returns, assessment notices and accounts are available. **Do not include any amounts paid to you that are paid from past profits, capital or loans.**

Tax year ending	Gross income for entire business ($)	Less all expenses incurred in earning that income ($)	Equals net business income before tax ($)	Wages/Salary ($)	Drawings/ Director's fees paid to you ($)	Your total income ($)
30 / 06 /						
30 / 06 /						

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

If yes, how much or what percentage?

e. What percentage of the business do you own? % If not 100% owner, please provide percentage ownership and roles/duties of the other owners. Please include details of any income splitting arrangements:

f. How many people do you employ?

g. What proportion of total business income is from your personal exertion? %

h. Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)? ☐ No ☐ Yes
If yes, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax ($)

i. If you were to become disabled, would any of your income (eg investment income and trail/renewal commission) continue? If yes, please provide the following details: ☐ No ☐ Yes

i. What type and amount of income would continue if you were not working and if this is for an investment property, please advise if the property is positively or negatively geared?

ii. Is there an agreement in place (written or otherwise) in relation to this entitlement and when it may cease? ☐ No ☐ Yes
If yes, please provide further details:

j. Has your business had a net operating loss over either of the last two financial years? ☐ No ☐ Yes
If yes, please provide copies of your full company accounts for the last two financial years, including any associated entities.

k. So far this financial year, is your business trading profitably? If no, please provide details in the space below: ☐ No ☐ Yes

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance. ☐

Income details (continued)

41. Insurable income (continued)

If you are **self-employed, in a partnership or an employee of your own company (or contractor)**, please complete the 'For self-employed' section on page 30.

OR

If you are **an employee**, please complete the 'For employees' section below.

For employees

Only complete this section if you are an employee and do not have any ownership in your employer's business.

l. Please indicate your current employment status:

☐ Permanent full-time ☐ Permanent part-time ☐ Casual or non-permanent ☐ Not currently employed

☐ Other, please specify:

m. 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 ($)
Salary			
Bonuses			
Commissions			
Regular overtime			
Superannuation			
Total	**$**	**$**	**$**

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

o. Do you receive or do you expect to receive any income from any other sources (eg rental income, dividends)? ☐ No ☐ Yes

If yes, please advise the source(s) and amount(s) per year:

Source	Net income per year after expenses but before tax ($)

p. If you were to become disabled, would any of your income (including investment income) continue? ☐ No ☐ Yes

If yes, please answer i and ii:

i. What is the income amount that would continue, for how long, and the source (eg salary, sick pay in excess of 100 days, company profits, investments, rental) and if this is for an investment property, please advise if the property is positively or negatively geared?

ii. Is there an agreement in place (written or otherwise) that determines when this entitlement will cease? ☐ No ☐ Yes

If yes, please provide details:

To be completed by the Person to be insured only if applying for: Income Insurances, Business Expenses Insurance or Total and Permanent Disability Insurance. ☐

Income details (continued)

42. Questions to be completed by individuals working in the mining, oil and gas industries:

a. Please advise the type of resource mined/extracted/refined at the mine/plant/platform:

Metal	Coal	Oil	Gas	Other

b. How do you travel to and from your work location?

☐ Commute to your work location daily from home ☐ Fly in fly out to your work location

☐ Other, please provide details:

c. Please complete the table below regarding your salary and any allowances paid for the last two financial years:

	Last financial year ($)	**Year immediately prior to last ($)**
Salary (including super)		
Allowances (eg site allowance, living away from home allowance, travel allowance)		
Bonus		
Other		

To be completed by the Person to be insured only if applying for Business Expenses Insurance. ☐

Business expense details

If you have not applied for plans listed in the box above go to the Authorities section.

43. Business structure

☐ Company ☐ Partnership ☐ Trust ☐ Sole proprietor

Date the business was purchased/started D D M M Y Y Y Y

44. Business details

Business name

Business address | Suburb | State | Postcode

45. Employees

Number of income producing employees: Full-time Part-time

Number of non-income producing employees: Full-time Part-time

46. If a partnership/company, number of partners/directors

47. Percentage of business income derived from your personal exertion %

48. If you were to become totally disabled, what would be the reduction in business income? %

Please provide a brief explanation of what would happen to the business if you were to become disabled:

To be completed by the Person to be insured only if applying for Business Expenses Insurance. ☐

Business expense details (continued)

49. Monthly expenses of the business over the last 12 months:

		Monthly expenses ($)
(i)	Rent or mortgage interest payments	
(ii)	Electricity, gas, water, heating	
(iii)	General insurance premiums	
(iv)	Cleaning	
(v)	Telephone	
(vi)	Leasing of equipment or motor vehicles	
(vii)	Property rates and taxes	
(viii)	Dues to professional bodies	
(ix)	Accountant's fees	
(x)	Salaries and associated costs (eg superannuation contributions) for employees who do not generate revenue	
(xi)	Other fixed expenses (please provide details below)[1]	
(xii)	**Total** monthly expenses (Total of (i) to (xi) above)	**$**
(xiii)	Percentage of expenses in (xii) above that you are responsible for	%

1 Details of other expenses.

For qualified registered medical practitioners or dentists classified as MP or AA only.

50. Net Locum Cost[2] $

2 Net Locum Cost is the estimated cost of engaging a locum to replace you while you are totally disabled and unable to work due to sickness or injury, less any income this person generates. Only complete this question if you estimate locum expense will exceed income generated by the locum.

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To be completed by the Person to be insured ☐ for all applications.

Resolution Life

Authorities

Medical authority S NS SMSF

Please read **'Privacy – collection, use and disclosure of sensitive information'** section of the product disclosure statement.

Authority for Resolution to release medical information to usual doctor

Only complete this section if you authorise Resolution to release medical information to your doctor upon an adverse assessment of your application.

Family name | Given name(s) | Date of birth

I, _____ _____ D D M M Y Y Y Y authorise Resolution Life to advise Doctor _____ of the reason(s) behind any adverse assessment of my application if it was based on health evidence obtained during the assessment of this application. I also authorise Resolution to provide copies of the relevant health evidence to the doctor noted above.

✗ _____ D D M M Y Y Y Y

Financial authority S NS SMSF

Only complete this section if you want your accountant or financial adviser to release information to Resolution.

Family name | Given name(s) | Date of birth

I, _____ _____ D D M M Y Y Y Y authorise my accountant/financial adviser to release to the insurer (Resolution Life Australasia Limited ABN 84 079 300 379 (Resolution Life) and to any other person or company acting on Resolution Life's behalf), all information that the insurer requests for the purpose of assessing my application for insurance. I agree that a photocopy (or similar copy) of this authorisation should be considered as valid as the original.

Signature of person insured | Date signed

✗ _____ D D M M Y Y Y Y

Accountant/financial adviser name | Accountant/financial adviser contact number

_____ _____

Accountant/financial adviser address

_____

Declarations and consent for non-superannuation or SMSF application

To be completed if you are applying for a non-superannuation or SMSF plan, Flexilink plan or PremierLink option, including plans where the insurance will be paid from an investment account. ☐

! Must complete

Non-superannuation or SMSF insurance application and signatures (Declarations and consent) NS SMSF

Plan number

This Personal statement is dated November 2023

! **Before you sign this personal statement, you should:**

- be aware that your financial adviser or Resolution is obliged to have provided you with the product disclosure statement and other information relevant to special offers and/or member discounts for the product(s) you are applying for, and
- **read the product disclosure statement** because it contains important information to help you understand the product and to decide whether it is appropriate to your needs, and
- read and understand the section entitled 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the **product disclosure statement**, 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, and
- read the Declarations and consent section (including the 'Privacy – collection, use and disclosure of sensitive information') in the **product disclosure statement** and understand the terms outlined.

Access to information – I authorise any insurer to disclose to Resolution Life, and for Resolution Life 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.

If you have applied for a Life Insurance SMSF Plan, TPD Insurance SMSF Plan or Income Insurance SMSF

SMSF Plan Are the premiums being paid by your employer? ☐ No ☐ Yes

If yes, has your employer agreed to pay for premium increases due to indexation? ☐ No ☐ Yes

Signature of Person to be insured NS SMSF

If the Person to be insured is the same person as the Plan owner, go to 'Signature of Plan owner(s) – only for individuals'.

Print full name of Person to be insured	Signature	Date signed	Date of birth
	✗	/ /	/ /

Signature of Plan owner(s) – only for individuals (including individual trustees of SMSF) NS SMSF

Print full name of SMSF or Trust (if applicable)

For Plan owner(s) (must be aged 16 years or over)

Print full name of Plan owner/Trustee	Signature	Date signed	Date of birth
	✗	/ /	/ /

Plan owner/Trustee (delete one)

Print full name of Plan owner/Trustee	Signature	Date signed	Date of birth
	✗	/ /	/ /

Plan owner/Trustee (delete one)

– For SMSFs, if there are more than two trustees required as signatories, please cross here ☐ and provide their full name(s) and signature(s) in the adviser notes section.

Declarations and consent for non-superannuation or SMSF application

To be completed if you are applying for a non-superannuation or SMSF plan, Flexilink plan or PremierLink option, including plans where the insurance will be paid from an investment account. ☐

Non-superannuation or SMSF insurance application and signatures (Declarations and consent) NS SMSF (continued)

Signatures of Plan owners – only for companies (including company trustees of an SMSF) NS SMSF

Company seal

Print full name of company

Signature 1 ✗

Signature 2 ✗

Date signed / /

Director/Sole Director and Secretary (delete one)

Director/Secretary (delete one)

Print full name of person signing for and on behalf of the above company

To be signed by:

- For any company, either two directors of the company or a director and company secretary, or
- For a proprietary company, one signature as 'sole director and secretary' where the company has only one director who is also the sole company secretary.

Note: If the company constitution mandates the use of a company seal then it must be provided along with the relevant signatures outlined above.

Declarations and consent for superannuation application

Superannuation insurance application and signatures (Declarations and consent) $

Plan number

This Personal statement is dated November 2023

Before you sign this personal statement, you should:

- be aware that your financial adviser is obliged to have provided you with the product disclosure statement and other information relevant to special offers and/or member discounts for the product(s) you are applying for, and
- **read the product disclosure statement** because it contains important information to help you understand the product and to decide whether it is appropriate to your needs, and
- read and understand the section entitled 'The Duty to Take Reasonable Care Not to Make a Misrepresentation' in the **product disclosure statement**, 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, and
- read the Declarations and consent section (including the 'Privacy – collection, use and disclosure of sensitive information') in the **product disclosure statement** and understand the terms outlined.

Access to information – I authorise any insurer to disclose to Resolution Life, and for Resolution Life 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.

Superannuation membership

Are you applying for insurance through superannuation? This will be through the National Mutual Retirement Fund. ☐ No ☐ Yes

If yes, please complete questions 1 to 3

1. Current employment status
   - ☐ Employee, go to question 2
   - ☐ Self employed (sole trader, partnership)
   - ☐ Employed by own company, go to question 3
2. Does your employer contribute to an existing superannuation fund on your behalf? ☐ No ☐ Yes
3. Have you selected an employer supported plan (ie your employer pays part or all of your premiums)? If yes, please complete employer details below and question 4. ☐ No ☐ Yes

   Company name

   Company address

4. Please confirm that your employer has agreed to pay for premium increases due to indexation. ☐ No ☐ Yes

To be completed by the Person to be insured

Print full name of Person to be insured	Signature	Date signed	Date of birth
	✗	/ /	/ /

All plans, except the Life Insurance Superannuation Plan, TPD Insurance Superannuation Plan and the Income Insurance Superannuation Plan, are issued by Resolution Life Australasia Limited ABN 84 079 300 379 (Resolution Life).

The Life Insurance Superannuation Plan, TPD Insurance Plan and Income Insurance Superannuation Plan are issued by Equity Trustees Superannuation Limited (ETSL)ABN 50 055 641 757, AFSL No. 229757 as trustee of the National Mutual Retirement Fund (NMRF) ABN 76 746 741 299 and Resolution Life. Resolution Life is part of the Resolution Life Group.

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