Personal Statement

Do you know you can apply for additional insurance online?

It's as easy as logging in to your account through *MemberAccess* at **clubplussuper.com.au** and going to the *'Insurance Details'* tab, where you'll find the online forms to complete.

When to use this form

Please complete this form if you wish to:

- **apply for, or increase your Death only, Death and Total and Permanent Disablement (TPD) or Income Protection (IP) cover with Club Plus Super;**
- **reduce the waiting period that applies to your Short Term Income Protection cover with Club Plus Super; and/or**
- **apply for Long Term Income Protection cover (in addition to any Short Term Income Protection cover) with Club Plus Super.**

If you are an Industry division member and wish to apply for, or increase your Death only or Death and Total and Permanent Disablement (TPD) up to a maximum of $500,000 (including any existing cover), you may be eligible to apply for your cover using the *Short Personal Statement* instead of this form. *The Short Personal Statement* is available at **clubplussuper.com.au/tools-forms**

Return your signed and completed form to: Club Plus Super, Locked Bag 5007, Parramatta NSW 2124.

Binding Death Nomination

To ensure your Death Benefit is paid to the people you want and as soon as possible after your death, you should advise the Trustee of your wishes. You can make your wishes clear by completing a *Binding Death Benefit Nomination form* available at **clubplussuper.com.au/tools-forms.**

About the insurer

Insurance cover is provided by OnePath Life Limited ABN 33 009 657 176 AFSL 238 341 (**the Insurer**) and subject to the terms and conditions of the insurance policy issued to Club Plus Super by OnePath Life Limited (**the Policy**). You should read Club Plus Super's PDS and Insurance Booklet applicable to your membership category (ie either Industry Division or Personal Division) for a summary of the terms and conditions of the Policy. You can download the applicable PDS and Insurance Booklet from **clubplussuper.com.au/pds** or contact Club Plus Super on **1800 680 627** if you would like a copy of the Policy.

Your application will be assessed by the Insurer and Club Plus Super will notify you of the outcome in writing.

The Insurer requires this form, and may require other health information, to determine your application for cover. This form is confidential. Please refer to the OnePath Life's Privacy Statement at Section F for more information about confidentiality.

Duty of disclosure

The Trustee, who enters into a life insurance contract in respect of your life, has a duty, before entering into the contract, to tell the Insurer anything that it knows, or could reasonably be expected to know, may affect the Insurer's decision to provide the insurance and on what terms.

The Trustee has this duty until the Insurer agrees to provide the insurance.

The Trustee has the same duty before it extends, varies or reinstates the contract.

The Trustee does not need to tell the Insurer anything that:

- reduces the risk the Insurer insures you for; or
- is of common knowledge; or
- the Insurer knows or should know as an insurer, or
- the Insurer waives your duty to tell the Insurer about.

Personal Statement (cont.)

Duty of disclosure (cont.)

You must disclose relevant information

You **must** tell the Insurer anything you know, or could reasonably be expected to know, may affect the Insurer's decision to provide the insurance and on what terms. If you do not do so, this may be treated as a failure by the Trustee to tell the Insurer something that the Trustee must tell the Insurer.

If you provide relevant information to the Trustee rather than the Insurer, The Trustee will provide the information you give the Trustee to the Insurer. The Trustee will do this so that you comply with your obligation to provide relevant information to the Insurer.

If you do not tell the Insurer something

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

If the Trustee does not tell the Insurer anything the Trustee is required to, and the Insurer would not have provided the insurance or entered into the same contract with the Trustee if the Trustee had told the Insurer, the Insurer may avoid the contract within 3 years of entering into it.

If the Insurer chooses not to avoid the contract, the Insurer may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if the Trustee had told the Insurer everything it should have. However, if the contract provides cover on death, the Insurer may only exercise this right within 3 years of entering into the contract.

If the Insurer chooses not to avoid the contract or reduce the amount of insurance provided, the Insurer may, at any time vary the contract in a way that places the Insurer in the same position it would have been in if the Trustee had told the Insurer everything it should have. However this right does not apply if the contract provides cover on death.

If the failure to tell the Insurer is fraudulent, the Insurer may refuse to pay a claim and treat the contract as if it never existed.

Section A: Your details

Member number:

Title: Mr/Mrs/Ms/Miss/Other

Male ◯ Female ◯

Surname:

Given name(s):

Address: (this cannot be a PO Box)

Suburb

State

Postcode

Home number: ( )

Work number: ( )

Mobile number: ( )

Email:

Date of birth (DD/MM/YY):

May one of our underwriting staff or OnePath authorised service providers contact you by phone if we require more information?

Yes ☐ **No** ☐

If **yes**, when is the most convenient day(s) and time and on which phone number?

Days:

Time: From to

Phone: H W M

Personal Statement (cont.)

Section B: Details of insurance cover you are applying for

Select the insurance you wish to apply for by inserting a ✓ in the relevant box.

Death and TPD cover

I wish to apply for / increase my cover to the following:

Unitised cover

Please refer to the PDS applicable to your membership division for the insurance amount of one unit of cover for all ages.

☐ Death number of units and ☐ TPD* number of units **or**

☐ Death only number of units

Fixed cover**

☐ Death $,000 and ☐ TPD* $,000 **or**

☐ Death only $,000

**The amount of TPD cover cannot exceed the amount of Death cover. You cannot hold TPD only cover.*

***Fixed cover must be in multiples of $1,000.*

Income protection cover

To be eligible to hold income protection cover, you must currently be working. In addition, if you are an Industry division member, your employer must be paying SG contributions to your account for you to hold Short Term Income Protection cover.

Short Term Income Protection cover

a) I wish to apply for/increase my cover to the following:

☐ Short Term Income Protection $ per month (this should be 80% of your current income)

b) Please select one from the following waiting period options*:

☐ 30 days (default) ☐ 45 days ☐ 90 days

**If you are applying to reduce your waiting period, increased premiums may apply.*

Long Term Income Protection cover

a) I wish to apply for/increase my cover to the following:

☐ Long Term Income Protection $ per month (this should be 75% of your current income)

Personal Statement (cont.)

Section C: Questionnaire

1. RESIDENCE AND TRAVEL DETAILS

1. Are you currently residing in Australia? ☐ Yes ☐ No
   If **no**, please advise where you are currently residing and how long you intend to reside there?

2. Are you an Australian citizen or do you hold a visa that entitles you to reside permanently in Australia? ☐ Yes ☐ No
   If **yes**, please proceed to question 3.
   If **no**, please advise what type of visa you hold.

3. Do you have any intention of travelling outside Australia within the next two years? ☐ Yes ☐ No
   If **yes**, please complete the following:

Date of departure (dd/mm/yy): ☐☐ ☐☐ ☐☐ Duration of stay: Destination(s) (country/cities):

Purpose of stay: ☐ Holiday ☐ Business ☐ Residing ☐ Other Please specify if **other**

2. INSURANCE DETAILS

1. Are you covered by, or are you applying for, any other life, TPD, trauma, income protection, salary continuance or living expense cover with any company, including OnePath Life (other than this application), including benefits under superannuation or insurance benefits by your employer? ☐ Yes ☐ No

If you have answered **yes**, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	Type of cover	Amount insured	Date commenced (dd/mm/yy)	Will this policy be discontinued/ replaced?	Date last fully underwritten (replacement policies only) (dd/mm/yy)
		$	/ /	☐ Yes ☐ No	/ /
		$	/ /	☐ Yes ☐ No	/ /

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? ☐ Yes ☐ No
   If **yes**, please provide name of company, alteration, date and reason (if known).

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? ☐ Yes ☐ No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

Personal Statement (cont.)

Section C: Questionnaire (cont.)

3. OCCUPATION DETAILS

1. What is your usual occupation?

_____

2. Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed
Sedentary/administration (e.g. filing, computer work, answering telephone, reception duties, etc.)		
Manual work – light (e.g. driving, warehousing, surveying, lifting under 5kgs, etc.)		
Manual work – heavy (e.g. bricklaying, lifting over 5kgs, painting, carpentry, mechanic, etc.)		

3. How many hours (on average) do you work per week? ☐☐

4. What is your current annual income earned through personal exertion, before tax, and including superannuation contributions, but after deduction of business expenses? $ ☐☐☐,☐☐☐

5. Do you have more than one occupation? ☐ Yes ☐ No

If **yes**, please specify the occupation, your normal duties and the average hours you work per week in each of your other occupation(s):

_____

6. Are you familiar with all applicable safe-work procedures relating to your occupation? ☐ Yes ☐ No

If **no**, please indicate the reason you gave this response:

_____

If **yes**, do you practice these at all times when performing your work? ☐ Yes ☐ No

If **no**, please provide details of when safe-work procedures are not practiced in your occupation:

_____

4. PASTIMES

Do you engage in any hazardous pastimes or pursuits such as, but not limited to, football (other than touch or Oztag), motorised sports, parachuting, hang-gliding, abseiling, mountaineering activities, aviation (other than a fare paying passenger), scuba diving or any sport(s) in a professional capacity? ☐ Yes ☐ No

If you answered **yes** to the above, provide details of the activity and the frequency with which you participate in this activity, including maximum speed/height/depth:

_____

_____

How often do you participate in this activity? ☐☐ times per year

Personal Statement (cont.)

Section C: Questionnaire (cont.)

5. PERSONAL STATEMENT

1. What is your current height and weight? Height (cm) ☐☐☐ Weight (kg) ☐☐☐

2. Has your weight varied by more than 10kg during the last 12 months (excluding pregnancy)? ☐ Yes ☐ No
   If **yes**, please provide details.

---

3. During the last 12 months have you smoked tobacco, E-cigarettes (vaping), or any other substance? ☐ Yes ☐ No
   If **yes**, please state **type** and **quantity** per day.

---

4. During the last three months, have you used nicotine replacement therapy (e.g. nicotine gum, patches, etc.)or anti-smoking medication (e.g. Zyban, Chantix, etc.)? ☐ Yes ☐ No
   If **yes**, please state **type(s)** used and **length of time** you have been using this.

---

5. Non-smokers – have you ever smoked regularly in the past? ☐ Yes ☐ No
   If **yes**, please state **type**, **quantity** per day and date ceased.

---

6. Do you consume alcohol? ☐ Yes ☐ No
   If **yes**, please state how many standard drinks you consume **per** day (a standard drink is 125ml wine, 250ml beer or 30ml spirits).

---

7. Have you ever been advised to stop or reduce your alcohol intake due to a medical condition? ☐ Yes ☐ No
   If **yes**, please provide full details.

---

6. FAMILY HISTORY

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, diabetes mellitus, breast cancer, bowel cancer, ovarian cancer, multiple sclerosis, motor neurone disease, familial adenomatous polyposis of the bowel, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) been diagnosed before the age of 60 with any of the following conditions: heart disease, stroke, mental illness, haemochromatosis, cervical cancer, prostate cancer, melanoma or any other cancer (please specify type)? ☐ Yes ☐ No

If you answered **yes** to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed

Note: You are only required to disclose family history information pertaining to first degree blood related family members – living or deceased (mother, father, brothers, sisters).

Personal Statement (cont.)

Section C: Questionnaire (cont.)

7. MEDICAL HISTORY

To the best of your knowledge, have you ever had any of the following:
Please tick the appropriate box and circle the specific conditions that are applicable.

1.	Asthma?	☐ Yes	☐ No
2.	High blood pressure?	☐ Yes	☐ No
3.	High cholesterol?	☐ Yes	☐ No
4.	Diabetes?	☐ Yes	☐ No
5.	Stress, anxiety, depression or any other mental health condition?	☐ Yes	☐ No
6.	Back or neck pain, sciatica or any disorder of the spine or neck?	☐ Yes	☐ No
7.	Arthritis, shoulder or knee pain or any other disorder of the joints?	☐ Yes	☐ No
8.	Cyst, mole or skin lesion?	☐ Yes	☐ No

If you answered **yes** to any of the conditions in bold above, please complete the relevant questionnaire on pages **15** to **23**.

9.	Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition?	☐ Yes	☐ No
10.	Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder?	☐ Yes	☐ No
11.	Thyroid or glandular trouble?	☐ Yes	☐ No
12.	Ulcers, bowel trouble or recurring indigestion?	☐ Yes	☐ No
13.	Epilepsy, fits or dizziness, fainting of any kind or persistent headaches?	☐ Yes	☐ No
14.	Alzheimer's disease or dementia?	☐ Yes	☐ No
15	Kidney, liver, prostate or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis?	☐ Yes	☐ No
16.	Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs?	☐ Yes	☐ No
17.	Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)?	☐ Yes	☐ No
18.	Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)?	☐ Yes	☐ No
19.	Varicose veins, hernia, scleroderma, systemic sclerosis or skin disorders?	☐ Yes	☐ No
20.	Any abnormality affecting eyesight, hearing or speech?	☐ Yes	☐ No
21.	Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis or any diagnosed intellectual disability or cognitive impairment?)	☐ Yes	☐ No
22.	Anaemia, haemophilia or any other disease of the blood?	☐ Yes	☐ No
23.	Bowel, liver or gall bladder disease or hepatitis?	☐ Yes	☐ No
24.	Coughing of blood or passing of blood from the bowel or in the urine?	☐ Yes	☐ No

Personal Statement (cont.)

Section C: Questionnaire (cont.)

7. MEDICAL HISTORY (CONT.)

25.	Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason?	☐ Yes	☐ No
26.	Due to injury or illness have you ever been off work for more than seven consecutive days (if not already mentioned)?	☐ Yes	☐ No
27.	Do you now have any symptoms of ill health or disability?	☐ Yes	☐ No
28.	Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation or other medical investigation or test in the future? (e.g. x-ray, ECG, blood test, etc)	☐ Yes	☐ No
29.	Do you take, or have you **ever** taken drugs or any medications on a regular or ongoing basis?	☐ Yes	☐ No
30.	Have you **ever** used or injected any drugs not prescribed for you by a medical attendant or have you ever received advice, counselling or treatment for drug dependence?	☐ Yes	☐ No
31.A	Is the combined total of your existing insurance(s) detailed in section 2 Question 1, and any new insurance you are applying for with OnePath Life, more than any one of the following; $500,000 Death; $500,000 TPD; $200,000 Trauma; $4,000 per month in total of any combination of Income Protection/Business expense/Living expense/salary continuance cover?	☐ Yes	☐ No
	If you answered Yes to question 31(A) please proceed to 31(B), otherwise continue to question 32		
31.B	Have you ever had, or have you scheduled an appointment to have a genetic test where you received (or are currently awaiting) an individual result? (please do not include any test conducted solely for the purpose of medical research study where the result of the test has not been or will not be, provided to you).	☐ Yes	☐ No
32.	**Females only**		
	a. Have you ever had any complications with pregnancy or childbirth?	☐ Yes	☐ No
	b. Are you now pregnant? If **yes**, please advise due date (dd/mm/yy) ☐☐☐☐☐☐	☐ Yes	☐ No
	c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram?	☐ Yes	☐ No
	d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium?	☐ Yes	☐ No
33.	Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands?	☐ Yes	☐ No
34.	Have you ever tested positive for HIV (Human Immunodeficiency Virus), which causes AIDS (Acquired Immune Deficiency Syndrome), or are you suffering from AIDS or any AIDS related condition?	☐ Yes	☐ No
35.	Have you received or are you expected to receive treatment, or undergo a medical consultation for a sexually transmitted disease including but not limited to HIV (AIDS), gonorrhoea or syphilis?	☐ Yes	☐ No

Personal Statement (cont.)

Section C: Questionnaire (cont.)

7. MEDICAL HISTORY (CONT.)

If you answered **yes** to any questions from 9–35, please complete the following table. If there is not enough space here, please provide details on page 24.

If you answered **no** to all questions from 9–35, please complete Part 8 of Section C and Sections D and E on pages **11** to **13**.

Question number	
Disability, illness, injury or condition	
Investigation type(s) and result(s)	
Date of first symptoms (dd/mm/yy)	Frequency of symptoms
Type of treatment	
Date treatment provided and ceased (dd/mm/yy):	From to
Has further treatment, referral or investigation(s) been recommended?	Yes No
Time off work	
Have you completely recovered?	Yes No Date of last symptoms (dd/mm/yy)
Name and address of medical facility and attending doctor	

Question number	
Disability, illness, injury or condition	
Investigation type(s) and result(s)	
Date of first symptoms (dd/mm/yy)	Frequency of symptoms
Type of treatment	
Date treatment provided and ceased (dd/mm/yy):	From to
Has further treatment, referral or investigation(s) been recommended?	Yes No
Time off work	
Have you completely recovered?	Yes No Date of last symptoms (dd/mm/yy)
Name and address of medical facility and attending doctor	

Personal Statement (cont.)

Section C: Questionnaire (cont.)

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yy) Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yy): From to

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yy)

Name and address of medical facility and attending doctor

Question number

Disability, illness, injury or condition

Investigation type(s) and result(s)

Date of first symptoms (dd/mm/yy) Frequency of symptoms

Type of treatment

Date treatment provided and ceased (dd/mm/yy): From to

Has further treatment, referral or investigation(s) been recommended? Yes No

Time off work

Have you completely recovered? Yes No Date of last symptoms (dd/mm/yy)

Name and address of medical facility and attending doctor

Personal Statement (cont.)

Section C: Questionnaire (cont.)

8. USUAL DOCTOR OR MEDICAL CENTRE DETAILS

1. Full name and address of usual doctor/medical centre.

Doctor/Medical centre:

Phone:

Fax:

Address:

Suburb/Town

State

Postcode

2. How many years have you been attending this doctor/medical centre?

Years

Months

a. When was your last visit to this doctor/medical centre?	b. Reason for check up or consultation?	c. Outcome including medication, treatment etc.	d. Degree of recovery?
			%

3. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? ☐ Yes ☐ No

If **yes**, please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted (dd/mm/yy)	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	/ /		
	/ /		
	/ /		
	/ /		

Section D: Consent for accessing Health Information

NOTES ON RELEASING INFORMATION ABOUT YOUR HEALTH

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, OnePath Life, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the *Insurance Contracts Act 1984* (Cth).

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Personal Statement (cont.)

Section D: Consent for accessing Health Information (cont.)

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Title: Mr/Mrs/Ms/Miss/Other

Date of birth (DD/MM/YY):

Surname:

Given name(s):

Policy/Claim number:

Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to OnePath Life, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form OnePath Life asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- OnePath Life can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while OnePath Life is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature

X

Date (DD/MM/YY)

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to OnePath Life, or to third parties they engage, only if OnePath Life has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- OnePath Life can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while OnePath Life is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name:

Signature

X

Date (DD/MM/YY)

Personal Statement (cont.)

Section E: Declaration

- I have obtained, read and understood the insurance information in the current Club Plus Super PDS and Insurance Booklet applicable to my membership category (ie either Industry Division or Personal Division).
- I have read and understood the questions in this Personal Statement.
- The answers I have provided to the questions in this Personal Statement (including all questions in this form that appear after this Declaration) signed by me are true and correct.
- I have read the Privacy Statement at Section G of this form (The Insurer's Privacy Policy details how the Insurer manages personal information. It is available free of charge by calling 133 667 or may be downloaded from onepath.com.au/insurance/privacy-policy.)
- I consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in the Privacy Statements on this form (see Sections F and G).
- I understand my duty of disclosure and the remedies available to the Insurer if I fail to comply with my duty of disclosure under the Insurance Contracts Act 1984. I understand that my duty of disclosure continues after I have completed this application until I am notified in writing that my application for insurance has been accepted.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to the Insurer in relation to insurance issued under the Policy.
- I understand that the Insurer may require additional information or medical tests to enable assessment of my application. I understand that if I fail to attend any required medical appointments, my application may not be accepted by the Insurer.
- I understand that if my application is accepted by the Insurer:
  - the cover I have applied for will replace any cover I may already hold within Club Plus Super;
  - the cover I have applied for will not commence until my application is accepted by the Insurer in writing;
  - any existing cover will not be affected should my application be declined by the Insurer; and
  - insurance cover will be provided to me on the terms contained in the Policy as changed from time to time.
- I acknowledge that if I do not complete this form correctly or I do not sign and date this Declaration, my application will not be considered by the Insurer.

Member's signature

X

Date (DD/MM/YY)

Section F: Privacy Statement - Club Plus Super

The personal information provided on this form is collected by and held for Club Plus Super by the fund administrator Australian Administration Services (AAS) in accordance with the Australian Privacy Principles of the *Privacy Act 1988 (Cth),* for the purpose of administering accounts and providing services associated with your membership of the Fund.

You should read the *Privacy Policy* at **clubplussuper.com.au/privacy-policy** before completing the form. Call us on **1800 680 627** for a hard copy of the Policy. The Policy contains information about how personal information is collected, used and disclosed, how you can correct your personal information, make a complaint about a privacy breach and other important information about safeguards in place to protect your personal information.

By providing your information, you acknowledge that you have read and understood the *Privacy Policy.*

Personal Statement (cont.)

Section G: Privacy Statement - OnePath Life Limited

In this section 'we', 'us' and 'our' refers to OnePath Life Limited. 'You' and 'your' refers to policy owners and life insureds.

Any reference to your personal information includes any health or other sensitive information we may hold about you. We collect your personal information from you in order to manage and administer our products and services. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

We are committed to ensuring the confidentiality and security of your personal information. Our Privacy Policy details how we manage your personal information and is available on request or may be downloaded from onepath.com.au/insurance/privacy-policy.

We may disclose your personal information to certain third parties as outlined below. Unless you consent to such disclosure we will not be able to consider the information you have provided.

Providing your information to others

The parties to whom we may routinely disclose your personal information include:

- an organisation that assists us to detect and protect against consumer fraud
- organisations performing administration and/or compliance functions in relation to the products and services we provide
- organisations providing medical or other services for the purpose of the assessment of any insurance claim you make with us (such as reinsurers)
- our solicitors or legal representatives
- organisations maintaining our information technology systems
- organisations providing mailing and printing services
- persons who act on your behalf (such as your agent or financial adviser)
- the policy owner (or parties acting on behalf of the policy owner)
- regulatory bodies, government agencies, law enforcement bodies and courts
- our related companies (members of Zurich Insurance Group Ltd group), including for carrying out any group business functions
- organisations, including those in an alliance with us or our related companies, to distribute, manage and administer our products and services, carry our business functions, enhance customer service and undertake analytics activities.

We will also disclose your personal information in circumstances where we are required by law to do so.

Examples of such laws are:

- the *Family Law Act 1975* (Cth) enables certain persons to request information about your interest in a superannuation fund;
- there are disclosure obligations to third parties under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006.*

Information required by law

We may be required by relevant laws to collect certain information from you. Details of these laws and why they require us to collect this information are contained in our Privacy Policy at onepath.com.au/insurance/privacy-policy

Privacy consent

Where you wish to authorise any other parties to act on your behalf, to receive information and/or undertake transactions, please notify us in writing.

If you give us personal information about someone else, you must show them a copy of this document or our Privacy Policy available at **onepath.com.au/insurance/privacy-policy** so that they may understand the manner in which their personal information may be used or disclosed by us in connection with your dealings with us.

Privacy Policy

Our Privacy Policy contains information about:

- when we may collect information from a third party
- how you may access and seek correction of the personal information we hold about you and
- how you can raise concerns that we have breached the Privacy Act or an applicable code and how we will deal with those matters.

You can contact us about your information or any other privacy matter as follows:

In writing: GPO Box 75
Sydney NSW 2001
Email: insuranceprivacy@onepath.com.au

We may charge you a reasonable fee for this.

If any of your personal information is incorrect or has changed, please let us know by contacting Customer Services on 13 36 67.

More information can be found in our Privacy Policy at onepath.com.au/insurance/privacy-policy

Overseas recipients

We may disclose your personal information to recipients (including service providers and related companies) which are (1) located outside Australia and/or (2) not established in or do not carry on business in Australia.

You can find details about the location of these recipients in OnePath Life's Privacy Policy at onepath.com.au/insurance/privacy-policy

Personal Statement (cont.)

⚠ **This page and the following pages are only required to be completed if you answered yes to any of questions 1 to 8 in section 7 of Section C (see page 7). If you answered No to all of these questions, your application is complete.**

Section H: Supplementary questionnaires

ASTHMA QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 1 in Section 7.

1. When did you have your first episode of asthma? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

2. When was your most recent episode of asthma? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

3. Approximately how many episodes have occurred in the last 12 months? ☐

4. Have you ever suffered from nocturnal asthma attacks? ☐ Yes ☐ No
If **yes**, please provide the frequency of these attacks and approximate date of last attack.

5. Have you had any time off work due to this condition? ☐ Yes ☐ No
If **yes**, please provide the dates and duration.

6. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? ☐ Yes ☐ No
If **yes**, please provide details.

7. Have you sought medical treatment or advice for asthma? ☐ Yes ☐ No
If **yes**, please provide details.

Name of doctor/health professional:

Address:

Suburb/Town State Postcode

Date of last consultation: (dd/mm/yy) ☐☐ ☐☐ ☐☐

8. How has your doctor described your asthma? ☐ Mild ☐ Moderate ☐ Severe

9. Have you ever used any medication, including steroids? ☐ Yes ☐ No
If **yes**, please provide details.

Type	Date commenced (dd/mm/yy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	

10. Have you ever been hospitalised due to asthma? ☐ Yes ☐ No
If **yes**, please provide details.

Date from (dd/mm/yy) ☐☐ ☐☐ ☐☐ Date to (dd/mm/yy) ☐☐ ☐☐ ☐☐

Name and address of hospital.

11. Have you ever had lung function tests performed? ☐ Yes ☐ No
If **yes**, please provide details.

Date (dd/mm/yy)	Test results
/ /	
/ /	

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

BLOOD PRESSURE QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 2 in Section 7.

1. When was your high blood pressure first diagnosed? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

2. What was your blood pressure reading at that time? Systolic ☐☐☐ Diastolic ☐☐☐

3. Have you ever been treated by medication? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4. Did you undergo any tests or investigations? ☐ Yes ☐ No

If **yes**, please provide details.

Tests performed	Date commenced (dd/mm/yy)	Results
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name:

Address:

Suburb/Town State Postcode

Date of last consultation (dd/mm/yy): ☐☐ ☐☐ ☐☐

6. What was the date of your last blood pressure check? (dd/mm/yy) ☐☐ ☐☐ ☐☐

7. What was your blood pressure reading at that time? Systolic ☐☐☐ Diastolic ☐☐☐

8. How has your doctor described your blood pressure control? ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

---

9. When was your high blood pressure first diagnosed? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

CHOLESTEROL QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 3 in Section 7.

1. When was your high cholesterol first diagnosed? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

2. What were your cholesterol readings at that time? Cholesterol ☐ Triglycerides ☐

HDL Cholesterol ☐ LDL Cholesterol ☐

3. Did you undergo any tests or investigations? ☐ Yes ☐ No

If **yes**, please provide details.

Tests performed	Date (dd/mm/yyyy)	Results
	/ /	
	/ /	

4a. Have you ever used any medication? ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced (dd/mm/yy)	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable) (dd/mm/yy)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? ☐ Yes ☐ No

If **yes**, please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name:

Address:

Suburb/Town State Postcode

Date of last consultation (dd/mm/yy): ☐☐ ☐☐ ☐☐

6. What was the date of your last cholesterol check? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

7. What were your cholesterol readings at that time? Cholesterol ☐ Triglycerides ☐

HDL Cholesterol ☐ LDL Cholesterol ☐

8. How has your doctor described your blood pressure control? ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

9. What is the date of your next cholesterol check-up? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

DIABETES QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 4 in Section 7.

1. What type of diabetes were you diagnosed with?

2. When was your diabetes first diagnosed? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

3. How is your diabetes controlled?

☐ Insulin – go to question 3

☐ Diet only – go to question 4

☐ Oral – list medications below and then go to question 4

4. How many times a day do you administer insulin?

☐ I'm on an insulin pump ☐ One or two times daily ☐ Three or more times daily

5. How often do you monitor your sugar levels? ☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details.

6. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

If **yes**, please provide details.

Condition	Date (dd/mm/yy)	Treatment
	/ /	
	/ /	
	/ /	

7. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details.

Date (dd/mm/yy)	Test results
/ /	
/ /	
/ /	

8. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name:

Address:

Suburb/Town State Postcode

Date of last consultation (dd/mm/yy): ☐☐ ☐☐ ☐☐

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

MENTAL HEALTH QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 5 in section 7.

1. Please tick the conditions you have had (or currently have), or received treatment for:

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including anorexia nervosa or bulimia
- ☐ Depression including major depression or dysthymia
- ☐ Manic depressive illness or bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness or chronic tiredness
- ☐ Other

If **other**, please describe.

2. Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed (dd/mm/yy)	Date condition ceased (if applicable) (dd/mm/yy)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No
If **yes**, please provide details including dates.

4. Are you currently symptom free? ☐ Yes ☐ No
If **yes**, please provide date(s) of last symptoms.

5. Have you ever attempted suicide or self harm? ☐ Yes ☐ No
If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

6. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No
If **yes**, please provide details.

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

MENTAL HEALTH QUESTIONNAIRE (CONT.)

7. Have you ever had any time off work due to your condition(s)?
If **yes**, please provide the dates and duration.

☐ Yes ☐ No

8. Are you currently or have you ever been on treatment, including medication?

If **yes**, please provide details.

☐ Yes ☐ No

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc.)	Date commenced (dd/mm/yy)	Date ceased (if applicable) (dd/mm/yy)	Reason ceased
	/ /	/ /	
	/ /	/ /	

9. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life?

☐ Yes ☐ No

If **yes**, please provide details.

10. Have you been referred for consultation with a psychiatrist or psychologist?

☐ Yes ☐ No

If **yes**, please provide details.

Name of consultant:

Address:

Suburb/Town

State

Postcode

Date of last consultation (dd/mm/yy): ☐☐ ☐☐ ☐☐

11. Have you been admitted to hospital or any other care facility?

☐ Yes ☐ No

If **yes**, please provide details.

Name of consultant:

Address:

Suburb/Town

State

Postcode

Date of last consultation (dd/mm/yy): ☐☐ ☐☐ ☐☐

Doctor(s) consulted:

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

BACK/NECK QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 6 in section 7.

1. When did your back/neck condition first occur? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed? ☐ Yes ☐ No

If **yes**, please provide details.

Tests performed	Date commenced (dd/mm/yy)	Results
	/ /	
	/ /	

6. Have you had recurrent or multiple episodes of the back/neck condition? ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

7. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted (dd/mm/yy)	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	

8. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your back/neck condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

ARTHRITIS/JOINT QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 7 in Section 7.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	Left	Right		Left	Right
Ankle	☐	☐	Wrist	☐	☐
Elbow	☐	☐	Hip	☐	☐
Shoulder	☐	☐	Other	☐	☐
Knee	☐	☐	If **other**, state which joint		

2. When did this condition first occur? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known.

5. Have you had recurrent or multiple episodes of the condition? ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

6. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	**Type** (e.g. doctor, chiropractor, physiotherapist)	**Date last consulted** (dd/mm/yy)	**Treatment prescribed** (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		/ /	
		/ /	

7. Have you had any time off work due to this condition? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

8. Do you have any residual pain, limitation of movement or restriction of any kind? ☐ Yes ☐ No

If **yes**, please provide details.

9. Are your work duties or activities limited/affected by the condition? ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment? ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your back/neck condition is: ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? Date (dd/mm/yy) ☐☐ ☐☐ ☐☐

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

CYST/MOLE/SKIN LESION QUESTIONNAIRE

Only complete this questionnaire if you answered **yes** to question 8 in Section 7.

1. Please provide details in the table below.

Site (e.g. back, left leg)	**Date diagnosed** (dd/mm/yy)	**Type** (e.g. basal cell carcinoma, melanoma, cyst, mole)	**Pathology results** (e.g. malignant, benign, unknown)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes**, please provide details for each

Date of removal (dd/mm/yy) ☐☐ ☐☐ ☐☐

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable.

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? ☐ Yes ☐ No

If **yes**, please provide details and advise how often follow up is required.

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No

If **yes**, please provide details.

Tests/Treatments/Investigations	**Date** (dd/mm/yy)	**Results**
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details for each

Name:

Address:

Suburb/Town

State

Postcode

Date of last consultation (dd/mm/yy): ☐☐ ☐☐ ☐☐

Personal Statement (cont.)

Section H: Supplementary questionnaires (cont.)

ADDITIONAL INFORMATION/COMMENTS