Personal Statement/ Member's Statement

Group Life including Income Protection

Policy Ref No. **MP9926**

Member ID:

Employer Name:

Disclosure Notice

Your duty of disclosure – Before you enter into a contract of life insurance with an insurer, you have a duty under the *Insurance Contracts Act 1984* to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate a contract of insurance.

Non-disclosure – If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time. An insurer who is entitled to avoid a contract of insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the contribution that would have been payable if you had disclosed all relevant matters to the insurer.

Life Insured *(please provide your current details)*

Member Number

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname

Given Name(s)

Gender ☐ F ☐ M

Date of Birth DD / MM / YYYY

Age Next Birthday

Phone (home)

Phone (business/mobile)

Email address

Address

State

Postcode

Country

Occupation

Industry

Daily Duties (Including % time spent performing each duty, i.e. manual duties)

Do you work full or part time?

How many hours per week do you work?

Type of Insurance

(Please tick one)

☐ New

☐ Increase

(Please tick one or more)

☐ Death Only — Number of Units

☐ Death and TPD — Number of Units

☐ Income Protection — Annual Salary $

Income Protection Waiting Period ☐ 90 days ☐ 30 days

☐ 75% of Income ☐ 50% of Income

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AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, Melbourne VIC 3004 Phone: 1800 333 613 Fax: 1800 832 266

Personal History

		Yes	No
1)	Please state your: Height? ______ cm and Weight? ______ kg		
2)	Are you a permanent resident of Australia?		
3)	Have you smoked any tobacco or any other substance in the last 12 months? If YES, please state forms and quantities		
4)	Do you intend to work, live or travel overseas? If YES, please state the destination, duration, frequency and purpose of travel		
5)	Have you ever engaged or are you ever likely to engage in aviation (other than as a fare paying passenger) or in any hazardous occupation, recreation, pastime, pursuit or sport (e.g. motor racing, football, martial arts, scuba diving)? If YES, please provide details		

At the date of this application:

		Yes	No
6)	Are you absent from work or unable to carry out all of the duties of your current or usual occupation on a full time basis?		
7)	Have you ever had back or neck pain for 7 or more consecutive days, or have you ever had mental/nervous/stress disorders, cancer, blindness or deafness?		
8)	In the last 3 years, have you had any medical advice or treatment, taken prescribed (excluding for colds or flu) or illicit drugs or been hospitalised for any injury or illness?		
9)	Are you under any treatment by diet, medication, sedative, drugs?		
10)	Has any company ever declined, deferred, applied special or modified conditions or cancelled any proposal to insure you for life or disablement policy?		

If you answered YES to any of the above questions (6–10), please give full details.

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Medical History

SECTION A – Medical Details

Yes No

1) Have you ever had or received treatment for or had symptoms of:

a) High blood pressure or blood disorder e.g. leukaemia, anaemia or haemophilia?

b) Heart, vein or circulatory disorder, including chest pain, heart attack, stroke, heart murmur, raised cholesterol or rheumatic fever?

c) Mental or nervous disorder (e.g. stress, depression, insomnia), fainting, epilepsy, fits of any kind, paralysis, multiple sclerosis, migraines, brain disorder, psychiatric treatment/counselling or neurological disorder?

d) Gout, arthritis, rheumatism, skeletal injury, spine/neck disorder, cartilage or ligament injury, bone fracture or hernia?

e) Back or neck pain, whiplash, sciatica or any muscle or joint disorder?

f) Asthma, bronchitis, tuberculosis, pleurisy or other respiratory disorder?

g) Stomach, intestinal or rectal disorder, ulcer, bleeding from bowel, gall bladder?

h) Diabetes, thyroid or prostate disorder?

i) Cancer, tumour or any form of breast lump (even if you have not seen a doctor)?

j) Impairment/disorder of hearing or sight (other than short or long sightedness fully correctable by glasses) or loss of any limb?

k) Hepatitis B or C or have you ever been told you are a Hepatitis B or C carrier?

l) Dermatitis, psoriasis or any skin disorder?

m) Liver, kidney or bladder disease, including renal colic or stone, blood in urine or reproductive organ disorder?

n) Sexually transmitted diseases?

o) Drug or alcohol dependence?

p) Any other medical condition not mentioned above?

q) **Females only** i) Female organ disorder (including abnormal:- pap smear, breast ultrasound or mammogram)?

ii) Are you currently pregnant?

If YES, date of expected delivery DD / MM / YY

SECTION B – Further Medical Background

Yes No

1) Are you considering consulting a doctor, seeking a medical examination, advice, treatment, tests or an operation?

2) During the last five (5) years have you:

a) Had any examination, advice or treatment by a medical practitioner, chiropractor or other health professional?

b) Been in hospital, clinic or nursing home?

c) Been advised to have an operation?

d) Had any tests, including blood tests, ECG, x-rays or genetic tests?

e) Occasionally or regularly taken any medication, drugs, stimulants, sedatives or tranquilisers?

If you answered YES to ANY of the questions in Sections A or B, please complete all Sections below.
Otherwise, complete Section D onwards.

SECTION C – Answers in Detail

1) If you answered YES to ANY question in sections A or B, please provide details in the schedule below. If there is insufficient space, please provide a signed and dated supplementary statement.

Question Reference (Section A or B)	Tests, or nature of condition or complaint	Commencement Date	Duration	Time off work	Degree of Recovery (%)	Full details of treatment and results (include type of operations)	Full name and address of doctor or hospital (if any)

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Medical History (continued)

SECTION D – Personal Doctor's Details (please provide current details)

If no personal doctor, please state name/address of last clinic or medical centre attended.

Name | Date of last consultation DD / MM / YY | How long have you been a patient? yrs/mths

Address | State | Postcode

Telephone | Facsimile

Email (if known) | ABN (if known)

Please state the reasons and results of your last consultation.

SECTION E – Other Details

Yes No

1) Do you drink alcohol?

If YES, what type of alcohol? How much (daily intake)?

2) Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer)?
If YES, please provide the policy details in the schedule below.

Commencement Date	Insurer	Type of Cover	Amount of Cover	*To be Replaced 'Y' or 'N'

*For policies to be replaced, please attach a copy of the policy document or other proof of existing insurances and terms of acceptance.

SECTION F – Family History

Yes No

1) Have any of your parents, brothers or sisters (living or deceased) had Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary disorder?
If YES, please provide details in the schedule below.

Relation	Condition/Illness	Age at Onset (approximately)	Age at Death (if applicable)

Yes No

2) Have any of your parents, brothers or sisters (living or deceased) been diagnosed prior to age 65 with any of the following conditions: Diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease?
If YES, please provide details in the schedule below.

Relation	Condition/Illness For Cancer – Specify Type	Age at Onset (approximately)	Age at Death (if applicable)

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Further Income Details (Complete only if Income Protection is required)

) a) Please state your monthly income from your current occupation (net of business expenses but before tax)?
DO NOT INCLUDE INVESTMENTS AND SUPERANNUATION.

- **SELF EMPLOYED**
If you are self-employed, a working director or partner in a partnership, your income is the income generated by the business or practice due to your personal exertion or activities, less your share of necessarily incurred business expenses. Note the benefit may be averaged in some circumstances based on the last 2 years' incomes.
- **EMPLOYED**
Your income is the total value or remuneration paid by your employer including salary, fees, regular commission, regular bonuses, regular overtime and fringe benefits but excluding mandated superannuation contributions.

Principal Occupation: Current Year $ per month Previous Year $ per month

b) How long have you been at your current occupation? years months

c) How much of the above income will continue if you are disabled? $

i) For how long? years/months

ii) State source of income (e.g. sick leave, directors fees, income protection insurance, profit share from the business)

2) If you become disabled, would you receive income from **other** sources? Yes No
If YES:
a) How much? $ per month
b) For how long? years/months
c) State source of income

3) Do you also perform another occupation? Yes No
If YES, describe the daily duties of this occupation (including manual work)

4) Do you receive any unearned income (e.g. from investments such as rental property or dividends)? Yes No If YES, how much? $ per month

5) What was your previous occupation?

6) Are you self-employed or employed by your own company? Yes No
If YES:
a) Date your business started DD / MM / YY
b) How long have you been self-employed? years/months
c) What percentage of your work is: i) Freelance? % ii) Contract? %
d) How many people do you employ?

7) Has your business or practice had a net operating loss in the last 2 years? Yes No
If YES, please provide copies of Profit & Loss Statements for the last 2 years.

8) Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? Yes No
If YES, when DD / MM / YY Date of discharge DD / MM / YY

9) Do you work at home? Yes No If YES, state percentage of the time %

10) Do you earn commission or bonuses? Yes No If YES, state percentage of total income %

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AIDS Declaration

I hereby declare that:

- I am not suffering from Acquired Immune Deficiency Syndrome (AIDS) and I am not infected with the HIV virus and I am not carrying antibodies to the HIV virus;
- Since 1980, I have not used intravenous drugs, I have not engaged in male to male anal sexual activity and I have not worked as or had sexual intercourse with a prostitute; and
- I have not had sexual intercourse with someone I know or suspect to be HIV positive.

☐ I am ABLE to declare that ALL the above statements are true.

☐ I am UNABLE to declare that ALL the above statements are true.*
*If unable, a Confidential Supplementary Personal Statement is required.

Before signing, one of the above boxes must be ticked.

Signature of Life Insured ✗ Date DD / MM / YY

Declaration

I declare that the above statements are true and correct (whether written in my hand or not) and that no information material to the insurance has been withheld.

I agree that any personal statements made together with other relevant documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.

I have read and consent to the handling, collection, use and disclosure of my personal and sensitive information in the manner described in the Privacy section of this form and the AIA Australia Privacy Policy available at www.aia.com.au as updated from time to time, including the exchange with third parties located in Australia and overseas. I agree that any personal and sensitive information AIA Australia holds will be governed by the most current Privacy Policy on AIA Australia's website.

I consent to AIA Australia collecting sensitive information, that is, health information about me for the purposes of the performance of this contract.

I agree that cover will not commence until the premium is paid and the proposal is accepted by AIA Australia.

I have read the Duty of Disclosure notice and understand what is meant by that notice.

I also understand that my duty to disclose continues after I have completed this application until AIA Australia has accepted the risk.

I understand that AIA Australia does not currently send any Direct Marketing materials.

Signature of Life Insured ✗ Date DD / MM / YY

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Privacy

Your privacy is important to us. The AIA Australia Privacy Policy sets out how your personal information (including sensitive information) is collected, used, handled and disclosed by us, and other important information. AIA Australia's current Privacy Policy is available at www.aia.com.au or by calling 1800 333 613. In summary, for the purposes set out in AIA Australia's Privacy Policy (including for the purposes of administering, assessing or processing your insurance or any claim) AIA Australia may:

- collect personal and sensitive information from you, including from application forms or other information submitted in respect of your insurance, or when interacting with you (including online);
- collect your personal and sensitive information from, and provide to, third parties in Australia and overseas, such as your financial adviser, employers, health professionals, reinsurers, government agencies, service providers and affiliates;
- be required or authorised to collect your personal and sensitive information under various laws including insurance, taxation, financial services and other laws set out in the AIA Australia Privacy Policy; and
- disclose personal and sensitive information to third parties which may be located in Australia, South Africa, the US, Europe, Asia and other countries including those set out in our Privacy Policy and you acknowledge that by providing your consent as set out in this form, Australian Privacy Principle 8.1 (which relates to cross-border disclosures) will not apply to the disclosure, we will not be accountable for those overseas parties under the Privacy Act and you may not be able to seek redress under the Privacy Act for breaches of the Privacy Act by those overseas parties.

If you do not provide the required personal and sensitive information, AIA Australia may not be able to provide insurance or other services to you. Information about how to access or correct your personal information held by AIA Australia or lodge a privacy-related complaint is set out in AIA Australia's privacy policy.

Signature of Life Insured ✗ Date DD / MM / YY

Print name: Given name Family name

Medical Authority

I, Full Name of Life Insured

authorise any Doctor/Hospital/Clinic to disclose to AIA Australia full details of my health and medical history.

Signature of Life Insured ✗ Date DD / MM / YY

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, Melbourne VIC 3004
Phone: 1800 333 613 Fax: 1800 832 266