

## MEMBER'S PERSONAL STATEMENT

Policy Number	<input type="text"/>	OFFICE USE ONLY
Member Number	<input type="text"/>	
Plan Administrator	<input type="text"/>	

Please address correspondence to:  
**Telstra Super Insured Benefits Group**  
 PO Box 14309 Melbourne VIC 8001

### Your Duty of Disclosure

Before TOWER Australia Limited (TOWER) advises acceptance of cover on your life, you have a duty under the Insurance Contracts Act 1984 to inform TOWER of every matter that you know, or could reasonably be expected to know, which may affect TOWER's decision to insure you or the terms of that insurance cover. You have the same duty to inform TOWER before cover is varied, extended or reinstated. This duty of disclosure does not apply to anything that reduces TOWER's risk, that is common knowledge that TOWER should know in the ordinary course of business or that TOWER does not require you to disclose. Your duty of disclosure applies even after this Personal Statement is completed until TOWER advises acceptance of the cover.

If you do not disclose relevant matters and TOWER would not have granted cover at all, TOWER may cancel cover within three years of granting it. If your non-disclosure was fraudulent, TOWER may cancel cover at any time. If TOWER is entitled to cancel the insurance cover or increase in insurance cover, it may within the first three years adjust the sum insured based on the premium charged, to the amount that would have applied had full disclosure been made.

All questions on this Personal Statement are relevant as to whether or not TOWER accepts the risk and, if so, on what terms. Consequently, all questions must be answered correctly and completely. Block letters should be used. A dot or dash is not acceptable.

### 1. MEMBER - PERSONAL DETAILS & INSURANCE HISTORY

a) Name of Plan	<input type="text"/>	Telstra Super Member Number	<input type="text"/>
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	Surname	Given Names	Sex	Date of Birth
b) Member Details	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

c) Self-Employed  OR Employee  Full-Time  OR Part-Time   hours p/w  weeks p/a

d) Occupation  Industry

e) Duties Performed

f) Salary for Insurance purposes (Total annual remuneration package including allowances as applicable, but excluding overtime, bonuses and commission). \$

g) Has Life, Disability, Accident & Sickness or Superannuation cover on your life **ever** been declined, deferred by or withdrawn from **any** Insurance Company or accepted with a loading, exclusion or other than as applied? No  Yes   
 If YES please provide full details (including dates, name of company and reason for deferral, loading etc)

  


h) Have you ever made a claim for disability benefits under an Insurance, Superannuation or Workers' Compensation policy, Veteran's Affairs or under Social Security (including CTP and public liability)? No  Yes   
 If YES please provide details (including dates, cause of claim, type of benefit and amount paid)

i) Other than this application, do you have or are you applying for, any life, TPD, crisis or disability insurance with TOWER or any other company? No  Yes

Company	Type of Insurance	Benefit Amount \$	Owner	To be Replaced
				N <input type="checkbox"/> Y <input type="checkbox"/>
				N <input type="checkbox"/> Y <input type="checkbox"/>
				N <input type="checkbox"/> Y <input type="checkbox"/>

If a plan is to replace all or part of existing insurance, cover under that plan will not start until the existing insurance has been cancelled.

## 2. HABITS AND ACTIVITIES

a) Do you drink alcohol? No  Yes  If YES state type and daily quantity

b) Have you smoked in the past 12 months? No  Yes  If YES state form and daily quantity

c) Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger on a recognised airline), motor racing of any kind, diving, football, parachuting, hangliding etc? No  Yes

If YES please give full details

d) Are you an Australian or New Zealand Citizen or do you have an Australian Permanent Resident's Visa? No  Yes   
If 'No' please provide details below

e) Do you intend travelling overseas in the immediate future (ie next 2 years)? No  Yes   
If 'Yes' please provide details below (where, when, duration and reason)

  


## 3. MEDICAL STATEMENT

a) Name and Address of your Doctor  Phone Number   
( )

b) Details of last medical consultation, including doctors, physiotherapists, chiropractors or ANY other health professional.  
Date  /  /  Reason

c) Outcome/Result

If you consult or have consulted more than one doctor or other health professional (eg chiropractor, etc) please advise name and address and reason(s) for consultations.

Name	Address	Reason for Consultation	Date of Consultation

d) Please state your: Height  cm Weight  kg

e) Within the LAST THREE YEARS have you, other than advised above: (tick  appropriate box) No Yes

1. Consulted, been examined or treated by, or received advice from any doctor, psychologist, psychiatrist counsellors, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation?

2. Either occasionally or regularly taken any drugs, stimulants, sedatives, tranquillisers, medications by mouth, by inhalation or by injection?

f) Have you EVER had an ECG, X-ray, transfusion, mammogram, surgery or any other investigation?

g) Have you EVER had any blood tests which revealed an abnormality eg. raised blood sugar, liver function or renal function results, or anaemia etc?

h) Do you contemplate seeking any medical examination, advice, treatment or surgery, in the future?

Please provide full details for all YES answers above.

Dates From To	Name/Address of Doctor or Hospital, Clinic etc	Condition, Medications, Treatment & Time Off Work	Recovery %

- i) Have you EVER received any advice or treatment for: (tick  appropriate box)
- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| 1. High blood pressure, raised cholesterol, stroke or circulatory disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chest pain, shortness of breath, palpitations, any heart complaint or rheumatic fever?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Asthma, bronchitis or other lung complaint?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Diabetes?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Indigestion, hernia, gastric or duodenal ulcer, colitis or any other intestinal disorder?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Hepatitis or any other liver or gall bladder disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Back, neck or knee complaint or any disorder of the joints, bones or muscles (eg gout, arthritis)?              | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Kidney or bladder disease, renal colic, stones or blood in the urine?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Depression, anxiety, stress, mental or nervous condition, or chronic fatigue?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Cancer, tumour, melanoma, sunspots, mole or growth of any kind?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Eczema, dermatitis, psoriasis or any other skin condition?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Tinnitus, hearing loss or any defect in hearing, sight or speech?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Anaemia, leukaemia, haemophilia or any other blood disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Thyroid or prostate disorder, any disorder of the reproductive organs, or sexually transmitted disease?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Persistent diarrhoea, unexplained weight loss, enlarged lymph glands, recurrent fever or night sweats?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Epilepsy, fits of any kind, recurrent headaches, dizzy spells or fainting attacks?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Any other physical impairment, congenital abnormality, deformity or symptoms of ill health, illness or injury? | <input type="checkbox"/> | <input type="checkbox"/> |

**FEMALES ONLY**

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| 18. Have you ever had any gynaecological conditions (eg endometriosis, abnormal pap smear, etc.)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had any complications of pregnancy or childbirth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are you currently pregnant? If 'Yes' what is expected delivery date <span style="border: 1px solid black; padding: 2px 10px;">  /  /  </span> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever had a breast lump (even if you have not seen a doctor about it)?  | <input type="checkbox"/> | <input type="checkbox"/> |

For each 'Yes' answer in section 'i', please complete details within the following schedule.

Question No.	Q. -	Q. -	Q. -
<b>Specific Condition</b>			
A. Date symptoms first started and description of symptoms?			
B. What was the condition and which part of the body was affected?			
C. What was the medical diagnosis including results of x-rays and investigations?			
D. What was the frequency (daily, weekly, etc) of attacks or symptoms?			

E. What was the severity (mild/moderate/severe) and duration of attacks or symptoms?			
F. How long were you unable to work or perform your normal duties/activities?			
G. If a hospital visit was required, please provide date and duration of your stay.			
H. What advice/treatment did you receive?			
I. Are you still receiving treatment? If so, please advise nature and frequency of treatment?			
J. When did you last suffer from any symptoms?			
K. Degree of recovery (%).			
L. Please supply the name and address of all doctors or hospitals or other consultations.			

#### 4. FAMILY HISTORY

a) Have any of your parents, brothers or sisters suffered from heart disease, diabetes, kidney disease, mental illness, cancer, Huntington's Disease or any other hereditary disease? No  Yes   
 If YES please provide details including date of diagnosis and death (if applicable).

#### 5. QUESTIONS IN RELATION TO AIDS

a) Have you EVER been infected by the virus which causes AIDS (the Human Immunodeficiency Virus), had an AIDS related condition or are you carrying antibodies for that virus? No  Yes

b) Have you EVER sought or are expecting to receive treatment for AIDS or an AIDS related condition or have you ever had a positive test for HIV? No  Yes

c) Have you EVER shared a needle or syringe for the injection of any drug, engaged in anal activity or worked as or engaged in sexual activity with a prostitute or someone you know or suspect to be HIV positive? No  Yes

If questions a), b) or c) answered 'Yes', we will send you a separate questionnaire.

#### 6. FINANCIAL DETAILS - ONLY TO BE COMPLETED WHERE DEATH OR TOTAL & PERMANENT DISABLEMENT COVER EXCEEDS \$2 MILLION OR FOR GROUP SALARY CONTINUANCE COVER WHERE YOUR SALARY EXCEEDS \$240,000 PER ANNUM. ALSO COMPLETE WHERE VOLUNTARY TOP UP AMOUNTS OF COVER ARE REQUIRED

a) If disabled, would all or part of your income continue? If 'Yes', please advise income that would continue, for how long and source (eg sick pay, pension, company profits, investment, rental, etc). No  Yes

b) In respect of your principal occupation, what has been the total value of remuneration paid by your employer over the last two years. This should be determined by calculating the amount you could be expected to receive if your total remuneration was received as a salary or wage (before income tax is deducted):

Current Year  \$

Last Tax Year  \$

Commission/Bonus/Overtime component of this amount is: \$

Commission/Bonus/Overtime component of this amount is: \$

## 7. PRIVACY

Personal information is collected from or in respect of you to enable TOWER to provide or arrange for the provision of the product or service requested. Further personal information may be requested from you at a later time, such as if you want to make alterations to the policy or at claim time. If you do not supply the required information, we may not be able to provide the product or service requested or pay the claim.

In processing and administering your insurance (including health information) we may disclose your personal information (excluding health information) to a number of parties or such organisations to whom we outsource our mailing and information technology, the Insurance Reference Service, Government regulatory bodies, and other companies within the TOWER group and accounts (if applicable).

We may also disclose your personal information (including health information) to other bodies such as the reinsurers; your adviser; health professionals; investigators; the administrator; the trustee of any superannuation fund through which the policy is effected, external complaints resolution bodies and as required by law.

By signing the application form you are agreeing to our collection, use and disclosure of your personal information.

We should also like to provide you with information about our other products and services that we or other companies within the TOWER group offer. To do so we need to disclose personal information (excluding health information) to companies within the TOWER group, authorized TOWER advisers or financial planners and the distributors and suppliers who are commissioned by us to perform certain tasks such as market research.

If you do not want to be informed of other products or services, please notify our Customer Service Centre on 1800 101 014.

You may also be entitled to gain access to personal information we may have on file in respect of you. If you wish to obtain access please make a request to our Customer Service Centre on 1800 101 014.

## 8. MEMBER'S DECLARATION

I agree that this Personal Statement and any other medical evidence obtained shall be the basis on which TOWER grants cover on my life under the relevant Group Insurance contract. I understand that all questions asked on this Personal Statement are relevant to TOWER's decision whether to accept the risk and, if so, on what terms. I also understand that I must advise TOWER of any change in my health between now and when TOWER actually accepts the cover being sought.

I hereby declare that I have read and understood the general nature and effect of a member's Duty of Disclosure, shown on the front page of this form.

I further declare that all the answers shown on this Personal Statement are true and that I have not withheld any information which might be material to TOWER accepting cover on my life. To the extent that any answers are not in my own handwriting, they have been checked by me and I certify that they are correct.

I/We have read and understood the Privacy Disclosure Statement in the Personal Statement which sets out important details of how TOWER may use my information.

I request and/or consent to the Policyowner effecting the insurance on my life to which this statement relates.

I understand that cover to which this Personal Statement relates will not commence until TOWER accepts in writing my application for insurance on standard terms or I accept in writing any non-standard terms offered to me and TOWER receives a sufficient contribution to meet the required premium.

Signature of Member

X

Date

## 9. ADDITIONAL INFORMATION (TO ASSIST WITH CLARIFICATION OF ANY ISSUE)


## 10. MEDICAL AUTHORITY

I have applied to Tower Australia Limited (TOWER) for insurance and a medical report from your practice is required. I hereby authorize you to release details of my personal medical history, including referrals to or treatment by other Practitioners, to TOWER. The purpose is to allow TOWER to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. I have been advised of the ways this information may be used and to whom it may be disclosed, and approve these purposes.

Under Privacy legislation I may request access to a copy of your report from TOWER.

A photocopy or facsimile of this authority shall be considered as valid as the original. I would be grateful if you could attend to this matter as soon as possible.

Full Name of Member

Signature of Member

Date

## 11. MEDICAL AUTHORITY

I have applied to Tower Australia Limited (TOWER) for insurance and a medical report from your practice is required. I hereby authorize you to release details of my personal medical history, including referrals to or treatment by other Practitioners, to TOWER. The purpose is to allow TOWER to assess my application for new/additional/reinstated insurance (as applicable) and assess any claim that might arise. I have been advised of the ways this information may be used and to whom it may be disclosed, and approve these purposes.

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Full Name of Member

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PO Box 14309 Melbourne VIC 8001

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