

Personal Statement

If you are applying for top-up death and TPD cover or income protection cover, or changing your existing income protection benefit period and/or waiting period, please also complete this Personal Statement.

Office Use

Policy number

Member number

Plan administrator

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, that's 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 us before you extend, vary or reinstate a contract of life insurance. Your duty however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of his business, ought to know
- disclosure of which is waived by the insurer.

The duty of disclosure applies even after this Application is completed until TAL advises acceptance 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 life 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 premium that would have been payable if you had disclosed all relevant matters to the insurer.

All questions on this Personal Statement are relevant as to whether or not TAL 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.

A

Personal details

Please print answers clearly

Name of plan

Policy number

Title Mr Mrs Miss Ms Other

Surname

Member Number

Given name(s)

Date of birth

Residential address (PO Box not acceptable)

Suburb

State

Postcode

Mobile

Home phone no.

Business phone no.

Email address

* To save unnecessary delays, Telstra Super or TAL may contact you by telephone to clarify any answers you have provided.

B

Occupation details

1. Self employed Employee full-time OR Employee part-time hours p/week weeks p/a

2. Occupation

Industry

3. Duties performed

4. Annual salary (includes packaged items but excludes bonuses/commission) \$

C**Insurance Application**Death sum insured TPD sum insured Monthly income benefit Benefit period Waiting period

1. Is this an increase? Yes No
2. Have you ever held or applied for any life, disability, accident & sickness or trauma insurance, that was declined, postponed, premium increased or modified, or had a current policy cancelled or renewal refused? Yes No
3. Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party? Yes No
4. Do you have, or are you applying for, any other life or disability cover? Yes No

Please provide full details below for any Yes answers to questions 2–4.

Name of company	Cover type	Sum insured	Date of application	Accepted	Loaded	Exclusion	Declined	To be replaced?	
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

D**Habits and activities**

1. Do you drink alcohol? Yes No
If Yes, state type and daily quantity.
2. Have you smoked in the past 12 months? Yes No
If Yes, state form and daily quantity.
3. Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? Yes No
If Yes, please provide full details.
4. 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 travelling over recognised routes), motor racing, diving, football, parachuting, hang-gliding or any other extreme sport? Yes No
If Yes, please complete a sports and pastimes statement.
5. Do you intend travelling outside Australia within the next two years? Yes No
If Yes, please provide details below (where, when, duration and reason).
6. Are you an Australian or New Zealand citizen? Yes No
7. Do you hold an Australian Permanent Resident's Visa? Yes No

If No to 6 and 7, please provide details.

Personal Statement

1. Have you ever had, been advised that you had, or received advice or treatment for any of the following.

- A. High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder? Yes No

- B. Bowel, stomach or intestinal problem, gall bladder or liver disease? Yes No

- C. Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks? Yes No

- D. Depression, anxiety, panic attacks, stress, chronic fatigue or any mental or nervous condition? Yes No

- E. Diabetes, sugar in urine, pancreatic or thyroid problem? Yes No

- F. Cancer, tumour, melanoma, sunspots, mole or growth of any kind? Yes No

- G. Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis? Yes No

- H. Impairment of sight, hearing or speech? Yes No

- I. Asthma, bronchitis, any lung complaint? Yes No

- J. Leukaemia, haemochromatosis, any blood problems? Yes No

- K. Kidney, bladder problems? Yes No

- L. Psoriasis, eczema, any skin problem? Yes No

- M. Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury? Yes No

- N. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? Yes No

- O. Have you ever engaged in any activity/ies reasonable accepted to having an increased risk of exposure to the HIV/AIDS virus? Yes No

Females only

- P. Have you ever had any gynaecological conditions (e.g. endometriosis, abnormal pap smear, etc.)? Yes No

- Q. Have you ever had any complications of pregnancy or childbirth? Yes No

- R. Are you currently pregnant? Yes No

- If 'Yes' what is the expected delivery date?

- S. Have you ever had a breast lump (even if you have not seen a doctor about it)? Yes No

2. Family History

Have any of your immediate family (living or deceased) suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental problems or breakdown, haemophilia, Huntington's Chorea or any hereditary disease? Yes No

If Yes, please provide full details

3. Please give details of your family medical history

Relative	Living Relatives		Deceased Relatives	
	Current Age	Specify current state of health	Age at death	Specify cause of death
Mother				
Father				
Sisters				
Brothers				

G

General Medical Questionnaire

Please provide details for all Yes answers in section F, A to S. Please complete on a separate sheet if required

Question No.	Q	Q	Q	Q
Specific Condition				
A. Date symptoms first started and description of symptoms?				
B. What was the condition and which part and side 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. Date treatment/ medication ceased.				
K. When did you last suffer from any symptoms?				
L. Degree of recovery (%)	%	%	%	%
M. Please supply the name and address of all doctors, hospitals or other practitioners consulted.				

H**Privacy Disclosure**

Privacy laws protect your privacy. The way in which we collect, use, disclose and handle your information is described in the TAL Privacy Statement. Please be aware that the Duty of Disclosure explained on page 1 applies to the information you have submitted.

If you fail to comply with this duty you may be in breach of it. The consequences of this are explained on page 1.

We may collect and use or disclose information relating to you or your Application to or from a range of providers including reinsurers, superannuation trustees, past or present medical practitioners, health professionals, hospitals, government department(s) which retain health records or as part of our regulatory requirements, personal accountants or current or former employers or lawyers. You have a right of access to any personal information held about you unless we are legally entitled to deny access. If you want to know more about our approach to privacy please telephone (02) 9448 9416.

I**Member's Declaration**

I acknowledge that I have read the notice of my Duty of Disclosure on page 1 and understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting and to the best of my knowledge and belief all the answers to the questions in this application and any supplementary application or personal statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Member, authorise and direct any medical or other practitioner to divulge at any time to TAL Life Limited, or to any lawfully constituted tribunal, any and all information concerning my state of health and medical history, acquired in the course of professional attendance or consultation.

A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by TAL Life Limited to its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information TAL collected on this form or future forms in relation to this insurance.

Full name of member

Signature of member

X

Date

J**Medical Authority**

I agree that any Medical Practitioner or any other person who has been or may hereafter be consulted by me, whether named by me, or not, will hereby be authorised and directed by me to divulge to TAL Life Limited or any legal

tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full name of member

Signature of member

X

Date