

PART B: SHORT PERSONAL STATEMENT

SECTION B1. MEDICAL DETAILS



If you answer 'YES' to any of the questions below, please **DO NOT** continue completing this Part B – instead continue straight to Parts C and D.

1. Will the combined amount of total cover that you are requesting (including any existing cover) exceed \$1,000,000 for Death-only or Death and TPD cover, or \$8,000 per month for Salary Continuance cover? No Yes
2. Do you engage in any hazardous pastimes, pursuits or occupational duties, such as but not limited to motorised sports, parachuting, hang-gliding, scuba diving below 40 metres or flying? No Yes
3. Do you intend to travel or reside overseas for more than six months in the next two years? No Yes
4. Have you received any medical advice, or undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any illness or injury that would affect your long-term health and require ongoing medical supervision? This includes, but is not limited to:
 - cancer or diabetes
 - high blood pressure, cholesterol or any heart complaint
 - alcohol or drug abuse
 - stroke, paralysis, neurological disorder or multiple sclerosis No Yes
5. Have you received any medical advice or undergone any medical treatment, investigation or an operation, suffered from or are you contemplating surgery for any of the following:
 - any injury or complaint of the back, neck, knee or shoulder requiring time off work in the last 12 months AND/OR any disease, disorder or degeneration to the muscles, tendons, bones, discs or joints? No Yes No Yes
 - loss of the sight of an eye or the total and permanent loss of the use of a limb (where 'limb' includes a whole hand or whole foot)? No Yes
 - depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post traumatic stress, behavioural or nervous disorder)? No Yes
 - chest pain, asthma, bronchitis or any other lung complaint requiring hospitalisation within the last five years? No Yes
 - disorders of the kidney, bladder, prostate, ovaries, gall bladder, bowel or liver? No Yes
 - epilepsy? No Yes
6. Has an application for life, disability, trauma, accident or sickness insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms? No Yes
7. Are you claiming, or have you ever claimed any type of disability benefit from any source, eg TPD benefit from any superannuation fund, Workers' Compensation, Disability Pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits? No Yes
8. Are you at the date of this application, due to injury, accident or illness:
 - off work? No Yes
 - restricted from being capable of performing your full and normal duties on a full-time basis (for at least 35 hours per week), even though your actual employment can be on a full-time, part-time or casual basis? No Yes
9. Excluding the contraceptive pill and inhaled asthma medication, have you been advised to take or been given prescribed medication by a medical practitioner that was intended to be used for three months or longer within the last year (including but not limited to blood pressure, diabetes or depression medication, or oral steroids for asthma)? No Yes
10. Have you been unable to work because of sickness or injury for more than two consecutive weeks in the last three years? No Yes
11. Have you been infected with, or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or hepatitis B or C? No Yes



If you answered 'NO' to all questions above, go to PART D on page 13.

If you answer 'YES' to any of the questions below, continue completing PARTS C and D of this form on the following pages.

PART C: FULL PERSONAL STATEMENT

SECTION C1. INSURANCE HISTORY DETAILS

1. Other than this application, do you have or have you recently applied for life, total and permanent disability, trauma, or salary continuance insurance on your life with the OSF, CommInsure or any other insurance company?

No Yes – provide details below:

Insurance company name	Type of cover	Insurance benefit	To be replaced?	Policy number	Policy commenced
		\$	No / Yes		/ /
		\$	No / Yes		/ /

2. Has an application for life, total and permanent disability, trauma, or salary continuance insurance on your life ever been declined, deferred or accepted with a loading, exclusion or special terms?

No Yes – provide details below:

Insurance company name	Date	Terms offered and reason
	/ /	
	/ /	

3. Are you claiming or have you ever claimed a benefit from any source, eg. a TPD benefit from any superannuation fund, Workers' Compensation, Disability Pension, Veterans' Affairs or any other insurance policy providing accident or sickness benefits?

No Yes – provide details below:

Benefit type/source/reason for claim	Claim date	Claim amount	Date claim finalised
	/ /	\$	/ /
	/ /	\$	/ /

SECTION C2. INSURED MEDICAL DETAILS

Have you ever had or sought advice or treatment, experienced symptoms or suffered from any of the following:

1. Cysts, moles, sunspots or skin lesions? No Yes
2. Back, neck, shoulder, knee, elbow complaints, sciatica, disc or spine complaints, or injury of the joints, bones or muscles (joint/musculoskeletal conditions)? No Yes
3. High blood pressure or raised cholesterol? No Yes
4. Stress, anxiety, depression or any other mental health condition? No Yes



Please note: If you answered 'YES' to any of questions 1 to 4 above, you will need to complete the specific questionnaire below related to the condition. Otherwise go to question 5 on page 8.

1. Cysts, moles, sunspots or skin lesions questionnaire

- (a) Please provide type (eg. cyst, mole, melanoma)

- (b) Location of growth(s) (eg. face, back, right arm)

- (c) When was this?

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C2. INSURED MEDICAL DETAILS (continued...)

1. Cysts, moles, sunspots or skin lesions questionnaire (continued...)

(d) Was the growth(s) removed?

 No Yes – provide date of removal: / /Number of growth(s) removed? Method of removal: Frozen/Burnt off Surgical/Cut out

(e) Were any further special tests, investigations, treatments or follow-up required?

 No Yes – provide dates and details of further tests, investigations, treatments or follow-up below:
(f) Was the growth(s) reported to be cancerous (malignant)? No Yes(g) Was the doctor you consulted different from your usual doctor? No Yes – provide details below:

Name of doctor

Doctor's address

 State PostcodePhone number () Fax number ()

2. Joint/Musculoskeletal questionnaire

If you are applying for Death-only cover, please complete questions (a) and (b) only; otherwise, please complete all questions.

(a) Nature of complaint (doctor's diagnosis), eg. sciatica, back pain, broken bone

(b) Location of complaint, eg. lower back, right knee, sciatic nerve

(c) When did symptoms first begin? / /

(d) Cause of condition, eg. lifting, car accident, fall in workplace, unknown

(e) Was an x-ray or scan taken? No Yes – provide date of tests taken / /

Details of results of tests taken

(f) Is the nature of the condition degenerative or a disc problem? No Yes

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C2. INSURED MEDICAL DETAILS (continued...)

2. Joint/Musculoskeletal questionnaire (continued...)

(g) Are you still undergoing treatment or experiencing symptoms?

No – complete date details below Yes

Date symptoms ceased / / Date treatment ceased / /

(h) Have you ever been off work as a result of this complaint or been unable to perform your normal day-to-day activities?

No Yes – provide period(s) off work:

Date(s) from	Date(s) to
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

(i) Do you have any residual, ongoing effects or restrictions as a result of this condition?

No Yes – provide dates and details below:

(j) Is your treating doctor different from your usual doctor?

No Yes – provide details below

Name of doctor

Doctor's address

State

Postcode

Phone number ()

Fax number ()

3. High blood pressure/Raised cholesterol questionnaire

(a) What condition do you have? (indicate one or both as applicable):

High blood pressure

Raised cholesterol

(b) When were you first diagnosed with this condition?

Within the last 12 months

More than 12 months ago

(c) Do you have any problems or complications resulting from this condition (eg. heart disease, kidney disorder)? No Yes

(d) Are you taking regular medication for this condition? No Yes

(e) When was your last reading?

Within the last 12 months

More than 12 months ago

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C2. INSURED MEDICAL DETAILS (continued...)

3. High blood pressure/Raised cholesterol questionnaire (continued...)

(f) Is your treating doctor different from your usual doctor?

 No Yes – provide details below:

Name of doctor

Doctor's address

State

Postcode

Phone number ()

Fax number ()

Additional questions – complete question (g) for **raised cholesterol**; complete question (h) for **high blood pressure**:

(g) What was the result of your last cholesterol reading?

 2.0 to 5.9 mmol 6.0 to 6.9 mmol 7.0 or above mmol Don't know

(h) What was the result of your last blood pressure reading?

 /

4. Mental health questionnaire

(a) Provide details of the condition (ie. doctor's diagnosis)

(b) Indicate the reason or cause:

- Bereavement/Family illness
- Marital problems
- Post-natal
- Work-related
- Other

(c) Date symptoms first commenced / / (d) Date symptoms ceased / / or ongoing (e) Have you taken or are you taking medication? No Yes – provide details of the type and dosage of medication below:(f) Are you currently on medication? No Yes

(g) Have you ever been hospitalised?

 No Yes – provide period(s) below:

Date(s) from

 / / / /

Date(s) to

 / / / /

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C2. INSURED MEDICAL DETAILS (continued...)

4. Mental health questionnaire (continued...)

(h) Were there any suicide attempts, thoughts or ideations?

 No Yes – provide dates and details below

(i) Did the condition ever cause you to lose time off work?

 No Yes – provide details below:Total time off work: Days Months Years

(j) Has your ability to work or perform daily activities been restricted in any way?

 No Yes – provide dates and details below:

(k) Were any of the doctors you consulted different from your usual doctor?

 No Yes – provide details below:

Name of doctor

Doctor's address

State

Postcode

Phone number ()

Fax number ()

**Please continue to complete the following questions 5 to 28(c).**

Have you ever had or sought advice or treatment, experienced symptoms or suffered from any of the following:

- | | | |
|---|-----------------------------|------------------------------|
| 5. Asthma (other than childhood) chronic bronchitis, emphysema or any other lung complaint? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Diabetes or abnormal blood sugar? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Chest pains, heart complaint, heart murmur, palpitations or rheumatic fever? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Stroke, paralysis, neurological disorder, multiple sclerosis or blood vessel disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Cancer, tumour or melanoma? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 10. Thyroid, glandular or pancreatic disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. Gastric or duodenal ulcer, persistent indigestion, irritable bowel or other bowel disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 12. Any disorder of the gall bladder or liver (including hepatitis B or C, or raised liver function)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 13. Varicose veins, haemorrhoids or hernia? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 14. Disorder of the kidney, bladder or prostate, blood in urine or kidney stones? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 15. Epilepsy, fits of any kind, fainting episodes or recurring headaches or migraines? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 16. Chronic fatigue syndrome, lethargy, sleep apnoea or any sleeping disorder? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C2. INSURED MEDICAL DETAILS (continued...)

17. Arthritis, gout, osteoporosis, fibromyalgia, Repetitive Strain Injury (RSI) or any chronic pain syndrome? No Yes
18. Eczema, dermatitis, psoriasis or any other skin disorder? No Yes
19. Anaemia, leukaemia, haemophilia, haemochromatosis or any other blood disorder? No Yes
20. Any impairment of sight (other than corrected by glasses or lenses) or blurred vision? No Yes
21. Any impairment of hearing or speech including tinnitus? No Yes
22. Any sexually transmitted diseases? No Yes
23. Any other illness, injury, disease or disorder not mentioned above? No Yes
24. Are you taking any prescribed medication (excluding contraceptives)? No Yes
25. Within the last 3 years, have you had:
- (i) any blood tests which revealed an abnormality? No Yes
- (ii) any tests such as an electrocardiogram (ECG), X-ray (excluding broken bones or joint strains), genetic test or ultrasound (other than for pregnancy)? No Yes
26. Are you considering seeking medical advice, treatment, tests or surgery in the future? No Yes
27. Have you ever had a genetic test? No Yes

FEMALES ONLY

28. a) Are you currently pregnant? No Yes

If 'Yes', provide due date for birth of baby:

- (b) Have you ever had an abnormal result for a pap smear, breast ultrasound or mammogram? No Yes

If 'Yes', provide details including dates and results of treatments

- (c) Have you ever had a breast lump or breast cyst (even if you have not consulted a doctor)? No Yes

If 'Yes', provide details including dates and results of treatments

! If you answered 'Yes' to any of questions 5 to 27 above or on the previous page, please provide full details in the detailed medical questionnaire on pages 10 and 11. Otherwise, please continue to section C3 on page 11.

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C2. INSURED MEDICAL DETAILS (continued...)

Detailed medical questionnaire – required only if you answered ‘Yes’ to any of questions 5 to 27 on pages 8 and 9.

Write the question number (from 5 to 27) where you answered ‘Yes’ at the top of the column and provide additional details relating to your answer.

	QUESTION ()	QUESTION ()	QUESTION ()
1. Name of condition			
2. Date symptoms first started	/ /	/ /	/ /
3. Date symptoms ceased <i>(if symptoms are ongoing, circle ‘Yes’ below)</i>	/ /	/ /	/ /
Ongoing <i>(circle answer)</i>	No / Yes	No / Yes	No / Yes
4. How often do/did you have symptoms? Choose one of the following: daily, weekly, monthly, quarterly, half-yearly, yearly, one-off, other (please specify)			
5. How severe is the condition? Choose one of the following: mild, moderate, severe, never had symptoms, symptoms ceased			
6. Did you take medication or have any other treatment (eg. physiotherapy, operation) for this condition? If ‘Yes’, name the treatment/condition	No / Yes	No / Yes	No / Yes
	Details	Details	Details
7. Are you still on treatment, including medication?	No / Yes	No / Yes	No / Yes
8. Have you ever been off work as a result of this condition?	No / Yes	No / Yes	No / Yes
	Details	Details	Details
If ‘Yes’, state the total time off work in days, months and years	Days	Days	Days
	Months	Months	Months
	Years	Years	Years
9. Have you had any residual, ongoing effects or restrictions as a result of this condition?	No / Yes	No / Yes	No / Yes
If ‘Yes’, provide details and dates	Details	Details	Details

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C2. INSURED MEDICAL DETAILS (continued...)

Detailed medical questionnaire (continued...)

	QUESTION ()	QUESTION ()	QUESTION ()
10. Have you ever had an x-ray, scan or blood test for this condition? If 'Yes', provide details and dates	No / Yes	No / Yes	No / Yes
	Details	Details	Details
11. Is your treating doctor different from your usual doctor? If 'Yes', provide the doctor's name and contact details	No / Yes	No / Yes	No / Yes
	Details	Details	Details

! Please continue to complete sections C3 to C7 below and on the following pages.

SECTION C3. DOCTOR DETAILS

1. What is the name and address of the last/your usual doctor or medical centre you visited?

Name of doctor

Doctor's address
 State Postcode

Phone number () Fax number ()

2. When did you last consult a doctor?

Within the last month
 1 to 3 months ago
 3 to 6 months ago
 6 to 12 months ago
 12 months to 2 years ago
 Over 2 years ago

3. Reason for last consultation

4. What was the result/outcome from your last consultation?

Referral to specialist/health professional
 Tests conducted – results pending
 Not fully recovered yet
 Ongoing treatment (eg. Ventolin inhaler)
 Routine tests conducted – results all clear/normal
 All clear/normal/full recovery – no tests or prescribed treatment required (other than contraceptive and cold/flu medication)

5. Is the doctor/medical centre mentioned above your usual doctor/medical centre? No Yes

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C3. DOCTOR DETAILS (continued...)

6. How long have you been a patient of this doctor or medical centre? years months

If less than 12 months, please provide details of your previous doctor/medical centre:

Full name of doctor
 Address State Postcode
 Phone number () Fax number ()

SECTION C4. FAMILY HISTORY DETAILS

Have any of your immediate family (ie. parents, brothers, sisters) suffered from or been diagnosed with any of the following: heart problems, stroke, high blood pressure, diabetes, cancer (breast, ovarian, cervical, bowel or other), hereditary disorders such as Huntington's disease, muscular dystrophy, polycystic kidney, familial polyposis, or any other inherited or hereditary disease?

No Yes Unknown

If you answered 'Yes' to this question, provide details below:

Family member	Condition	Approximate age of onset	Age at death (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION C5. HABITS & PASTIME DETAILS

1. Have you smoked tobacco or any other substance at any time during the last 12 months? No Yes

If 'Yes', indicate type (eg. cigarettes, cigars, tobacco, etc) and average amount smoked below:

Substance smoked	Per day	Per week	Per year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Do you drink alcohol? No Yes

If 'Yes', provide the average number of drinks consumed: Per day Per week Per year

3. Do you currently engage in or intend to engage in any of the following sports or hazardous activities:

- (a) Flying (other than as a fare paying passenger on a commercial airline) No Yes
- (b) Underwater diving: Maximum depth metres No Yes
- (c) Motor sports of any kind, eg. rally driving, trail bike riding, ocean racing No Yes
- (d) Football of any code (including touch football or oz tag) No Yes
- (e) Any other sport or hazardous activities, eg. parachuting, hang gliding, body contact sports, paragliding, competitive water sports or recreations involving heights No Yes

If you answered 'Yes' to any of the options in question 3 above, provide further details below.

What activity(ies) you engage in?

At what level do you participate?

Recreational only (non-competition) Recreational with competition Semi-professional/Professional

Number of times you participate in the activity(ies) each year (eg. hours flown, number of dives, events, etc)

Do you receive any income from participating in the activity(ies)? No Yes

PART C: FULL PERSONAL STATEMENT (continued...)

SECTION C6. TRAVEL DETAILS

Do you plan to travel, live or work in another country within the next two years? No Yes – *provide details below:*

(a) Please provide the date(s) and countries/cities you intend to travel to

(b) Duration of your trip(s)?

(c) Reasons for travel? Holiday Business Residing/Migrating

SECTION C7. LIFESTYLE DETAILS

To the best of your knowledge, is there any possibility that you have ever been infected with, or have you ever tested positive for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or Hepatitis, or are you in a high-risk category (eg. injected drugs other than as prescribed by a medical practitioner, shared needles, engaged in unprotected male to male sexual intercourse, worked as or engaged the services of a prostitute)?

No Yes – *provide details below*

Please note: If you answered 'Yes' to the declaration above, you will also need to complete the lifestyle questionnaire available from our website osfsuper.com.au or by calling 1800 023 928. Alternatively, one will be sent to you once your application has been initially assessed.

PART D: DUTY OF DISCLOSURE & DECLARATION

YOUR DUTY OF DISCLOSURE

Before you enter into or become insured under 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 the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you renew, extend, vary or reinstate 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 its business ought to know, or
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have covered you on any terms if the failure had not occurred, the insurer may void the cover within three years of issuing it. If your non-disclosure is fraudulent, the insurer may void your cover at any time.

An insurer who is entitled to void your cover may, within three years of issuing it, elect not to void it but to reduce the sum for which you have been insured 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. **Incomplete answers may delay the assessment of this application.**

