

# Insurance Application & Personal Health Statement

Please complete this form using **BLOCK LETTERS** and a **BLACK** or **BLUE** pen. Write **X** in the appropriate boxes.

## 1 LIFE INSURED DETAILS

Member Number (if existing member)

M A P

Title Surname

Given Name(s)

Address

City/Suburb State Postcode

Date of Birth (DD-MM-YYYY) Place of Birth Telephone

Employer's Industry Occupation Gross Salary \$

What is the nature of your duties?

## 2 INSURANCE COVER

If you are increasing your level of cover, the amount shown should represent the total cover you wish to have, NOT the amount of the increase.

	Sum Insured	OR	Nominated Premium Per Week
<input type="checkbox"/>	Death Only		
<input type="checkbox"/>	Death & TPD		

**Note:** If you nominate your level of cover, the sum insured remains fixed and premiums will generally increase with age. If you nominate a fixed premium, (eg \$2.00 per week), the sum insured will generally reduce with age.

	Waiting period	Benefit period
<input type="checkbox"/>	Income Replacement	30 days 60 days 90 days 2 years 5 years to age 65

Nominate the amount of cover you require per month (maximum 75% of gross salary)

**Note:** Insurance cover is not in force until acceptance terms are issued in writing by the insurer and accepted by you where applicable. Details regarding maximum levels of cover are provided in the Product Disclosure Statement, available from our website or MAP Customer Service.

## 3 HEALTH AND MEDICAL HISTORY

a. Height Weight

cm OR  feet  inches  kg OR  stone  pounds

If you answer 'Yes' to any of the following, please circle the appropriate condition and provide details in the space provided on the following page.

- b. Have you EVER had high blood pressure, heart or vascular disease, chest pain, rheumatic fever, stroke, diabetes, kidney, liver, bladder or bowel disease, asthma or any lung disease, blood disorder, epilepsy or fits, tumour, cancer or cyst of any kind? Yes  No
- c. Have you EVER had any disease of or injury to the spine, including the neck or back, such as back strain, disc disorder or sciatica, or suffered a serious personal injury or had any injury, deformity or disease (eg arthritis, gout) involving any joint or limb or tendonitis or muscle overuse syndrome? Yes  No
- d. Have you EVER had any mental disorder, depression, stress, anxiety, chronic fatigue, or any eye, ear or skin disorder? Yes  No
- e. Have you EVER had any other operation, disability, illness or injury and/or have you been advised, or do you intend, to seek medical advice or treatment in the near future? Yes  No
- f. During the past five (5) years, have you ever consulted a doctor or other health professional for medical or surgical advice or treatment of any kind (not including colds or influenza)? Yes  No

# Insurance Application & Personal Health Statement continued

## 3 HEALTH AND MEDICAL HISTORY continued

If you have answered 'Yes' to any of questions 3b) to 3f) inclusive, please provide further details below:

Question	Name of injury, illness or test	Date commenced (DD-MM-YY)	Time off work	Details of treatment including date of last symptom and degree of recovery %	Name and address of doctor or hospital (if any)
<input type="checkbox"/>		<input type="text"/>	<input type="text"/>		
<input type="checkbox"/>		<input type="text"/>	<input type="text"/>		

g. Have you EVER tested positive for HIV/AIDS or have you ever been in a high risk category for contracting HIV? (eg had a blood transfusion, injected drugs other than prescribed by a medical practitioner, shared needles or engaged in male-to-male anal sexual intercourse?) Yes  No

h. In the past 12 months, have you taken any drugs not prescribed by a medical practitioner? Yes  No

If you answered 'Yes' to questions 3g) or 3h), please provide further details below:

Question	Details
<input type="checkbox"/>	
<input type="checkbox"/>	

## 4 ALCOHOL CONSUMPTION & SMOKING HABITS

I have never drunk alcohol  I currently drink alcohol  I do not currently drink alcohol but I used to

Type of alcohol   
 No.  eg glasses/stubbies/bottles etc.  
 Quantity  Daily  Weekly

In the last 12 months have you smoked tobacco or any other substances, including marijuana? Yes  No

If yes, type of substance  Average Daily Quantity

## 5 DOCTORS DETAILS

a. Please provide the name and address of your usual medical practitioner or the last doctor attended, if you do not have a regular doctor.

Name

Address

City/Suburb  State  Postcode

b. When did you last consult this doctor and for what reason?

c. Results of consultation (including any medication prescribed and duration of treatment)

## 6 OVERSEAS TRAVEL

Do you intend to travel/reside overseas in the future? Yes  No

Destination  When  For how long   
 Reason

# Insurance Application & Personal Health Statement continued

- 7 Have you EVER had an application for life, income protection, total & permanent disablement or trauma insurance declined, postponed, premium increased or modified or had a current policy cancelled or renewal refused? Yes  No
- 8 Have you EVER claimed for benefits under any accident, sickness, trauma insurance or such benefits as Worker's Compensation or Motor Vehicle Third Party Schemes? Yes  No
- 9 Have you EVER engaged in, or intend to engage in, any hazardous occupation or recreational activities (eg football, parachuting, rock climbing, motor racing or scuba diving) or intend to engage in aviation other than as a fare-paying passenger on a registered commercial airline? Yes  No
- 10 Have any near relatives suffered from diabetes, heart disease, mental disorder or breakdown, haemophilia, Huntingtons' chorea, kidney disease, high blood pressure, cancer or any hereditary disease? Yes  No

For all 'Yes' answers to Questions 7 to 10 inclusive, please provide further details below:

Question	Details

I do not wish to be contacted directly by TOWER Australia Limited for clarification on any of the above questions.

## 11 YOUR DUTY OF DISCLOSURE

Before you enter into a contract of insurance with the 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 life insurance. Your duty, however, does not require disclosure of a matter

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

## 12 NON-DISCLOSURE

If you fail to comply with the 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 3 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 3 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.

## 13 MEMBER DECLARATION

I acknowledge that I have read the notice explaining my duty of disclosure above 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 that relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I authorise and direct any medical or other practitioner to divulge at any time to TOWER Australia 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 acknowledge that I have read and understood the Product Disclosure Statement in relation to the benefits proposed. I acknowledge that no cover commences until this application has been accepted by TOWER Australia Limited.

I have read the Privacy Declaration in the Product Disclosure Statement and consent to my personal information (including health and sensitive information) being collected, used or disclosed by TOWER Australia Limited or its external service providers/contractors as provided by 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 TOWER Australia Limited collects on this form or future forms in relation to this insurance.

**Before signing, please check that you answered ALL questions.**

Member Signature

Date (DD-MM-YYYY)

**Please forward all correspondence and queries to**

Medical & Associated Professions Superannuation Fund, GPO Box 529, Hobart TAS 7001  
 MAP Customer Service 1800 009 921 Facsimile (03) 6215 5933 Website [www.mapsuper.com.au](http://www.mapsuper.com.au)