

3 Income protection cover

Please complete section 3 to apply for, or increase/decrease your existing income protection cover.

This is an application for:

☐

New cover

☐

Increase/decrease of existing income protection cover

Please note: You can have a monthly benefit of up to 75% of your monthly salary plus an optional superannuation contributions benefit up to 10% of your monthly salary not exceeding \$30,000 per month.

Specify cover required (mandatory information)

Income level (% of your salary) ☐ 75% ☐ Other: (up to 75%)

Waiting period (days) ☐ 30 ☐ 60 ☐ 90

Benefit payment period ☐ 2 years ☐ 5 years ☐ to age 65

Superannuation contributions benefit (optional)

Do you want the superannuation contributions benefit? Yes ☐ No ☐

Income level (% of your salary) % (up to 10% of your salary)

See the **Medical & Associated Professions Superannuation Fund insurance guide (MAP.03)** for more information.

4 Personal health statement

1. Have you smoked in the last 12 months?

Yes ☐ No ☐

If you have answered 'Yes', how many cigarettes do you smoke per day?

2. Have you smoked any substance other than tobacco?

Yes ☐ No ☐

If you have answered 'Yes', please specify the type of substance

3. Do you consume alcohol?

Yes ☐ No ☐

If 'Yes', please specify:

a. Quantity of alcohol consumed per day (in standard units)
Standard unit = 1 Nip (30ml) spirits, 1 wine glass (120ml) of wine, 285ml glass of beer

b. Type of alcohol:

4. Height

cm

5. Weight

kg

Occupation details

6. What is the name of your employer?

7. What is your usual occupation?

4 Personal health statement continued

8. What are the principal duties of your usual occupation and the percentage of time performing each (to a total of 100%):

	Percentage of time spent (%)
Clerical/Administration/Managerial	%
Light manual (eg qualified tradespeople, coffee shop owner)	%
Manual (eg carpenter, plumber, plasterer, mechanic or an occupation for which travel is an essential part of the job (eg field surveyor))	%
Heavy manual (eg interstate bus driver, warehouse worker, labourer, bricklayer, house removalist)	%
Other — please specify:	%

Activities

9. Do you currently intend to participate in any of the following activities?

a. Aviation other than as a fare paying passenger on a commercial airline

Yes ☐ No ☐

b. Any activity generally classified as hazardous or extreme in nature

Yes ☐ No ☐

(eg parachuting, hang gliding, motor sports, scuba diving/diving, climbing or caving, boxing, sky diving, etc)

If you have answered 'Yes', please specify the activity and provide details (eg scope and frequency of diving activities, type of motorsport, type of vehicle, location of climbing or caving, any other information including details of injury you have suffered).

Residence and travel

10. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months?

Yes ☐ No ☐

If you have answered 'Yes', please specify the country, departure date, duration of stay and reason for the travel/change of residence.

11. Are you an Australian or New Zealand citizen?

Yes ☐ No ☐

If you have answered 'Yes', please go to 'Previous Insurance' section of the form.

12. Do you hold an Australian Permanent Resident's Visa?

Yes ☐ No ☐

If you have answered 'No', please provide your residency details below:

Previous insurance

13. Have you ever been paid or are you eligible to be paid, are you claiming or have you ever claimed a benefit for any illness or injury from any source including through IOOF or any of its affiliated companies, any superannuation fund, Workers' Compensation, other Government benefits (eg sickness benefit, invalid pension), Veterans' Affairs or any other insurance policy providing terminal illness, total and permanent disablement, income protection cover, including accident or sickness benefits?

Yes ☐ No ☐

14. Have you ever been declined for death, disability, trauma, accident or illness insurance on your life, deferred, or accepted with a loading, exclusion or special terms, or have you ever had an insurance policy cancelled or renewal refused?

Yes ☐ No ☐

15. Do you have, or are you applying for, any other life or disability cover?

Yes ☐ No ☐

4 Personal health statement continued

If you have answered 'Yes' to question 13, 14 or 15 please provide full details below:

Name of insurer	Cover type	Sum insured	Date of application	Accepted/ loaded/ exclusions/ declined	To be replaced? (Yes/No)

Medical

16. Have you ever had, been told you had, received advice, treatment, an operation or are you undergoing or awaiting results for any tests/investigations for any of the following:

If you have answered 'Yes' to any of the following questions, please complete the table on the following page.

- | | | |
|--|------------------------------|-----------------------------|
| a. Chest pain, high blood pressure, raised cholesterol or any heart/circulatory disorder, rheumatic fever? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Stroke, paralysis, neurological disorder, fainting attacks, epilepsy or multiple sclerosis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Impairment of sight, hearing or speech? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Diabetes, pancreatic disorder and/or any disease or disorder of the kidneys, urinary bladder, liver, ovaries, stomach, bowel, intestinal oesophagus, prostate or gall bladder, thyroid problem? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. Leukaemia, hepatitis, haemochromatosis, or any blood problem? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Asthma, bronchitis or other respiratory disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Any injury, complaint, disease or disorder, or degeneration of the back, neck, knee, shoulder or any of the muscles, tendons, bones, discs or joints, including but not limited to gout, arthritis or a repetitive strain injury or tendonitis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. Depression or mental disorder/condition — including but not limited to stress, anxiety, chronic tiredness or, fatigue, panic attacks, post-traumatic stress, behavioural or nervous disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i. Cancer, tumour, melanoma, sun spot, mole or growth of any kind? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j. Drug abuse (prescribed or non-prescribed) or alcohol dependence/abuse? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| k. Psoriasis, eczema or any skin problem? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| l. Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Females only

- | | | |
|--|------------------------------|-----------------------------|
| m. Gynaecological conditions (such as endometriosis, abnormal pap smear, etc)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| n. Complications of pregnancy or childbirth? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| o. Are you currently pregnant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered 'Yes' when is the expected delivery?

- | | | |
|---|------------------------------|-----------------------------|
| p. Breast lump (even if you have not seen a doctor about it)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|---|------------------------------|-----------------------------|

Other medical (both males and females to complete)

- | | | |
|--|------------------------------|-----------------------------|
| q. Excluding the contraceptive pill or inhaled asthma medication, have you been advised to take or been prescribed by a medical practitioner (including but not limited to any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist) medication, drugs, stimulants, sedatives or tranquilisers (includes, but is not limited to medications for blood pressure control, diabetes management, cholesterol lowering agents, oral steroids for asthma or depression/anxiety medication)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|--|------------------------------|-----------------------------|

4 Personal health statement continued

- r. Apart from the questions 'a' to 'q', and excluding the common cold and influenza, have you suffered from, required treatment or operation for, consulted a doctor for, or intend to consult a doctor for, any other condition not mentioned?

Yes ☐ No ☐

Please provide details for all 'Yes' answers in Questions 16a to 16r in the table below.

- Place the question number with the 'Yes' answer at the top of the column (such as 16a) and then respond to the questions (1) to (13) in the table below.
- You may provide details on a separate sheet if required. If the question in the table does not apply to your condition please write 'Not applicable'.

	Please state question number (under Question 16) with a 'Yes' answer (eg Q16A)			
Question no:	Q16	Q16	Q16	Q16
	Please state your specific condition			
(1) Date symptoms first started and description of symptoms?				
(2) What was the condition and which part and side of the body was affected?				
(3) What was the medical diagnosis including results of X-rays and investigations?				
(4) What was the frequency (daily, weekly, etc) of attacks or symptoms?				
(5) What was the severity (mild/moderate/severe) and duration of attacks or symptoms?				
(6) How long were you unable to work or perform your normal duties/activities?				
(7) If a hospital visit was required, please provide date and duration of your stay.				
(8) What advice/treatment did you receive?				
(9) Are you still receiving treatment? If so, please advise nature and frequency of treatment?				
(10) Date treatment/medication ceased.				
(11) When did you last suffer from any symptoms?				
(12) Degree of recovery (%)				
(13) Please supply the name and address of all doctors, hospitals or other practitioners consulted.				

- s. Name and address of your usual doctor

- t. Details of your last medical consultation with your usual doctor (eg reason for your consultation and outcome)

- u. If you have attended that doctor for less than 12 months, please add the name and address of your previous doctor

4 Personal health statement continued

Family history

17. Have any of your immediate family (living or deceased) suffered from: diabetes, heart disease, cancer, kidney disease, high blood pressure, mental disorder or breakdown, haemophilia, Huntington's Chorea, Parkinson's disease, Alzheimer's or dementia, multiple sclerosis or any other hereditary disease before the age of 65?

Yes ☐ No ☐
18. Please provide details of your family history in the table below:

Details of your immediate family member			
Relationship to you (eg mother, father, sister, brother)	Current age	Details of illness or disorder	Age at diagnosis of illness or disorder

Lifestyle

19. To the best of your knowledge, is there any possibility that you have ever been infected with or have you ever tested positive to AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or hepatitis or are you in a high-risk category (for example 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)?
- Yes ☐ No ☐

Work health history

20. Are you, at the date of this application, due to injury accident or illness:
- a. Off work; or restricted from being capable of performing your full and normal duties on a full time basis (for at least 30 hours per week) even though your actual employment may be on a full time, part time or casual basis?

Yes ☐ No ☐

b. Have you been unable to work because of illness or injury (other than a cold or flu) for more than two consecutive weeks in the last 3 years?

Yes ☐ No ☐

5 Your duty of disclosure

Before you answer any questions, you must first understand your duty of disclosure rights and obligations shown in Step 5. If you do not disclose to the Insurer every matter that you know, or could reasonably be expected to know, that would be relevant to its decision to accept the risk, the Insurer may avoid the cover in respect of any insurance provided for you within three years of entering into it. Non-disclosure can impact a future claim so it is important to be as open and honest as possible.

Your duty of disclosure

Before you enter into a life insurance contract, you have a duty to tell the insurer anything that you know, or could reasonably be expected to know, may affect their decision to insure you and on what terms.

You have this duty until the insurer agrees to insure you.

You have the same duty before you extend, vary or reinstate the contract.

You do not need to tell the insurer anything that:

- reduces the risk they insure you for
- is common knowledge
- they know or should know as an insurer
- they have waived your duty to tell them about.

If you do not tell the insurer something

In exercising the following rights, the insurer may consider whether different types of cover can constitute separate contracts of life insurance. If they do, they may apply the following rights separately to each type of cover.

If you do not tell the insurer anything you are required to, and they would not have insured you if you had told them, they may void the contract within three years of entering into it.

If the insurer chooses not to void the contract, they may, at any time, reduce the amount you have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told them everything you should have. However, if the contract has a surrender value, or provides cover on death, the insurer may only exercise this right within three years of entering into the contract.

If the insurer chooses not to void the contract or reduce the amount you have been insured for, they may, at any time vary the contract in a way that places them in the same position they would have been in if you had told them everything you should have. However, this right does not apply if the contract has a surrender value or provides cover on death.

If your failure to tell the insurer is fraudulent, they may refuse to pay a claim and treat the contract as if it never existed.

Non-disclosure

If you have not disclosed all relevant matters to us and the insurer, and the insurer would not have entered into all or part of the cover on the same terms had they known about those matters, the insurer may avoid the contract within three years of the commencement date. If your non-disclosure or misrepresentation is fraudulent and the insurer would not have provided the cover on the same terms had they known about these matters, the insurer may avoid all or part of the cover at any time. This means that the insurer can treat the cover as if it never existed and would not be liable to pay any claims.

Alternatively, instead of avoiding all or part of the cover the insurer may decide:

- a. to reduce the benefits for all or part of the cover 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, although any reduction to benefits payable in respect of your death can only occur within three years of the commencement date; or
- b. for any benefits provided under the cover other than benefits payable in respect of your death, to vary the cover in such a way as to place you in the position you would have been in if you had disclosed all relevant matters to the insurer.

If you have applied for cover via a financial adviser it is also your responsibility to ensure that the information provided to your adviser is accurate and complete and that the correct information is entered into the Application Form.

6 Privacy statement

The way in which IOOF and the Insurer, TAL Life Limited, ABN 70 050 109 450 (TAL) collect, use, disclose and handle your information is set out in the IOOF Investment Management Limited ABN 53 006 695 021 (IIML) and TAL privacy policies available at www.ioof.com.au/privacy (IIML) and www.tal.com.au/Privacy (TAL) or on request.

These privacy policies include information about how you may access and seek correction of your personal information as well as how you can make a complaint about a breach of your privacy. Further information about privacy is available from the Office of the Australian Information Commissioner at www.oaic.gov.au.

IIML and TAL may collect and use your personal information (including sensitive health and financial information) to assess, verify and process any application or claim for insurance.

To provide products and services IIML and TAL may collect, use and disclose information about you from financial advisers, employers, superannuation trustees and their administrators, medical practitioners, health professionals, hospitals, government departments, claims assessors, accountants, lawyers, regulators, reinsurers or other third party service providers. If information to assess your application or claim is not provided, IIML and TAL may not be able to process your form.

If you would like to obtain more information regarding your privacy please contact IIML on 1800 062 963 or TAL:

Telephone 1300 209 088
Fax 02 9448 9100
Postal address TAL Services, GPO Box 5380, Sydney NSW 2001

7 Member declaration and signature

- I, the member, acknowledge that I have read the notice explaining my duty of disclosure in section 5 and understand that this duty also applies until formal notification of acceptance by TAL. 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 authorise and direct any medical or other practitioner to divulge at any time to IIML and TAL 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 effective and valid as the original. To this extent, all professional confidence and privilege is waived.
- I acknowledge that I have received, read and understood the PDS in relation to this insurance.
- I have read the privacy statement in section 6 above, and consent to my personal information (including sensitive health information) being collected, used and disclosed by IIML and TAL or their 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 or any claim I may make. This consent applies to any health and sensitive information IIML and TAL collect on this form or future forms in relation to this insurance.
- If I provided IIML and/or TAL with information about another person, I undertake to advise them that:
 - their personal information will be collected, held and used for the purpose set out in IIML's and TAL's privacy policies
 - their personal information may be disclosed to a third party; or
 - they may access or correct any personal information held about them.
- I understand that if this application is accepted, my cover will be subject to the terms and conditions of IOOF's insurance policy with TAL.

Insurance opt-in

☐ I elect to have any existing or future insurances retained, even if my account does not receive a contribution for a continuous period of 16 months. I acknowledge I can request to cancel my insurance at any time.

Member signature

Date

 / /

Please forward all correspondence to

Applications & forms

Post Medical & Associated Professions Superannuation Fund
 Reply Paid 264, Melbourne VIC 8060
Email newbusinessteam@ioof.com.au
Fax (03) 6215 5800

Enquiries

Telephone enquiries 1800 009 921
Email enquiries employersuper@ioof.com.au