



Personal Statement/ Member's Statement

Group Life including Salary Continuance



Policy Ref No. **MP9926**

Member ID:

Employer Name:

Disclosure Notice

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, 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 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 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 contribution that would have been payable if you had disclosed all relevant matters to the insurer.

Life Insured *(please provide your current details)*

Member Number	<input type="text"/>	Title	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	<input type="checkbox"/> Other	<input type="text"/>
Surname	<input type="text"/>	Given Name(s)	<input type="text"/>			Gender	<input type="checkbox"/> F	<input type="checkbox"/> M
Date of Birth	<input type="text" value="DD / MM / YYYY"/>	Age Next Birthday	<input type="text"/>	Phone (home)	<input type="text"/>			
Phone (business/mobile)	<input type="text"/>	Email address	<input type="text"/>					
Address	<input type="text"/>							
		State	<input type="text"/>	Postcode	<input type="text"/>	Country	<input type="text"/>	
Occupation	<input type="text"/>	Industry	<input type="text"/>					
Daily Duties (Including % time spent performing each duty, i.e. manual duties)								
<input type="text"/>								
Do you work full or part time?	<input type="text"/>	How many hours per week do you work?	<input type="text"/>					

Type of Insurance

(Please tick one)

- New
 Increase

(Please tick one or more)

- Death Only
 Death and TPD
 Salary Continuance

Number of Units	<input type="text"/>
Number of Units	<input type="text"/>
Annual Salary	\$ <input type="text"/>

... continued

Medical History (continued)

SECTION D – Personal Doctor's Details (please provide current details)

If no personal doctor, please state name/address of last clinic or medical centre attended.

Name	<input type="text"/>	Date of last consultation	<input type="text" value="DD / MM / YY"/>	How long have you been a patient?	<input type="text"/>	yrs/mths
Address	<input type="text"/>			State	<input type="text"/>	
Telephone	<input type="text"/>	Facsimile	<input type="text"/>			
Email (if known)	<input type="text"/>			ABN (if known)	<input type="text"/>	

Please state the reasons and results of your last consultation.

SECTION E – Other Details

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1) Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, what type of alcohol? <input type="text"/> How much (daily intake)? <input type="text"/> | | |
| 2) Do you have existing life, disability or trauma cover on your life (including any current applications held with any insurer)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, please provide the policy details in the schedule below. | | |

Commencement Date	Insurer	Type of Cover	Amount of Cover	*To be Replaced 'Y' or 'N'

*For policies to be replaced, please attach a copy of the policy document or other proof of existing insurances and terms of acceptance.

SECTION F – Family History

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1) Have any of your parents, brothers or sisters (living or deceased) had Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease or any other hereditary disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, please provide details in the schedule below. | | |

Relation	Condition/Illness	Age at Onset (approximately)	Age at Death (if applicable)

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 2) Have any of your parents, brothers or sisters (living or deceased) been diagnosed prior to age 65 with any of the following conditions: Diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, please provide details in the schedule below. | | |

Relation	Condition/Illness For Cancer – Specify Type	Age at Onset (approximately)	Age at Death (if applicable)

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Further Income Details (Complete only if Salary Continuance is required)

1) a) Please state your monthly income from your current occupation (net of business expenses but before tax)?
DO NOT INCLUDE INVESTMENTS AND SUPERANNUATION.

• **SELF EMPLOYED**

If you are self-employed, a working director or partner in a partnership, your income is the income generated by the business or practice due to your personal exertion or activities, less your share of necessarily incurred business expenses. Note the benefit may be averaged in some circumstances based on the last 2 years' incomes.

• **EMPLOYED**

Your income is the total value or remuneration paid by your employer including salary, fees, regular commission, regular bonuses, regular overtime and fringe benefits but excluding mandated superannuation contributions.

Principal Occupation: Current Year \$ [] per month Previous Year \$ [] per month

b) How long have you been at your current occupation? [] years [] months

c) How much of the above income will continue if you are disabled? \$ []

i) For how long? [] years/months

ii) State source of income (e.g. sick leave, directors fees, income protection insurance, profit share from the business)

[]

2) If you become disabled, would you receive income from **other** sources? Yes No

If YES:

a) How much? \$ [] per month

b) For how long? [] years/months

c) State source of income []

3) Do you also perform another occupation? Yes No

If YES, describe the daily duties of this occupation (including manual work)

[]

4) Do you receive any unearned income Yes No If YES, how much? \$ [] per month
(e.g. from investments such as rental property or dividends)?

5) What was your previous occupation? []

6) Are you self-employed or employed by your own company? Yes No

If YES:

a) Date your business started [DD / MM / YY]

b) How long have you been self-employed? [] years/months

c) What percentage of your work is: i) Freelance? [] % ii) Contract? [] %

d) How many people do you employ? []

7) Has your business or practice had a net operating loss in the last 2 years? Yes No

If YES, please provide copies of Profit & Loss Statements for the last 2 years.

8) Have you or any business with which you were associated ever been made bankrupt or placed in receivership, involuntary liquidation or under administration? Yes No

If YES, when [DD / MM / YY] Date of discharge [DD / MM / YY]

9) Do you work at home? Yes No If YES, state percentage of the time [] %

10) Do you earn commission or bonuses? Yes No If YES, state percentage of total income [] %

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AIDS Declaration

I hereby declare that:

- I am not suffering from Acquired Immune Deficiency Syndrome (AIDS) and I am not infected with the HIV virus and I am not carrying antibodies to the HIV virus;
- Since 1980, I have not used intravenous drugs, I have not engaged in male to male anal sexual activity and I have not worked as or had sexual intercourse with a prostitute; and
- I have not had sexual intercourse with someone I know or suspect to be HIV positive.

I am ABLE to declare that ALL the above statements are true.

I am UNABLE to declare that ALL the above statements are true.*
*If unable, a Confidential Supplementary Personal Statement is required.

Before signing, one of the above boxes must be ticked.

Signature of Life Insured

X

Date

DD / MM / YY

Declaration

I declare that the above statements are true and correct (whether written in my hand or not) and that no information material to the insurance has been withheld.

I agree that any personal statements made together with other relevant documents shall form the basis of the proposed contract of insurance with AIA Australia Limited.

I declare that I have read the Privacy Statement set out in this application and I consent to the collection, use and disclosure of my personal and sensitive information in the manner described in that Privacy Statement.

I consent to AIA Australia collecting sensitive information, that is, health information about me for the purposes of the performance of this contract.

I agree that cover will not commence until the premium is paid and the proposal is accepted by AIA Australia.

I have read the Duty of Disclosure notice and understand what is meant by that notice.

I also understand that my duty to disclose continues after I have completed this application until AIA Australia has accepted the risk.

I understand that AIA Australia does not currently send any Direct Marketing materials.

Signature of Life Insured

X

Date

DD / MM / YY

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Privacy Statement

AIA Australia Limited (AIA Australia) ABN 79 004 837 861 AFSL 230043 is required under the National Privacy Principles of the Privacy Amendment (Private Sector) Act 2000 to provide you with the following information.

Purpose of Collection

AIA Australia collects personal information about you to:

- a) process your application(s);
- b) administer and manage your policy including claims;
- c) facilitate AIA Australia's business operations; and
- d) market AIA Australia promotional material. (Please refer to 'Your acknowledgment and consent' below.)

If you do not wish to provide us with all or part of the personal information we request to from you, we may not be able to provide you with insurance cover.

Access to Your Information

You are entitled at any time to request access to your personal information held by AIA Australia. All requests to access your personal information should be made in writing to the Policy Services Manager, AIA Australia, PO Box 6111, St Kilda Road Central, Vic. 8008.

You can ask us to update your personal information at any time if it is inaccurate, incomplete or out of date.

In some circumstances, AIA Australia may not permit access to your personal information. Circumstances where access may be denied include where access would be unlawful or denying access is authorised by law.

In these cases, AIA Australia will provide you with written reasons for denial of access or a refusal to correct personal information.

Disclosure of Information

AIA Australia may disclose your personal information to:

- a) another member of the AIA group of companies (whether in Australia or overseas);
- b) your adviser;
- c) AIA Australia contractors and third party service providers, eg. medical practitioners and reinsurers;
- d) your employer (for employee superannuation products);
- e) financial institutions you nominate;
- f) mail houses (only for the purposes of sending AIA Australia mail) and archive companies.

We will only disclose your personal information to these parties for the primary purpose for which it was collected. In some circumstances AIA Australia is entitled to disclose your personal information to third parties without your authorisation, such as law enforcement agencies or government authorities to protect our interests or to report illegal activities.

Any Questions or Concerns

If you have any questions or concerns about your personal information please write to the Complaints Officer, AIA Australia, PO Box 6111, St Kilda Road Central, Vic. 8008

AIA Australia has established an internal dispute resolution process for handling customer complaints about AIA Australia's compliance with the National Privacy Principles. This dispute resolution mechanism is designed to be fair and timely to all parties and is free of charge.

If you have a complaint about AIA Australia's compliance with the National Privacy Principles, you should submit it in writing to the Complaints Officer. You will receive a letter from AIA Australia within 5 working days, which documents AIA Australia's complaints handling process. Your complaint will be referred to AIA Australia's Internal Dispute Resolution Committee who shall endeavour to resolve your complaint within 45 days of receipt.

Should your complaint not be resolved to your satisfaction by AIA Australia's internal dispute resolution process, you may take your complaint to the Privacy Commissioner. The Privacy Commissioner's contact details are: Office of the Federal Privacy Commissioner, GPO Box 5218, Sydney NSW 2001 or call the Privacy Hotline on 1300 363 992.

Your acknowledgment and consent

Your signature below indicates your consent to such use and disclosures of your personal information as outlined above.

Your signature below indicates that you understand that AIA Australia does not currently send any Direct Marketing materials.

Signature of Life Insured

X

Date

DD / MM / YY

Print name:

Given name

Family name

Medical Authority

I,

authorise any Doctor/Hospital/Clinic to disclose to AIA Australia full details of my health and medical history.

Signature of Life Insured

X

Date

DD / MM / YY



AIA Australia Limited (ABN 79 004 837 861 AFSL 230043)
PO Box 6111, St Kilda Road Central, VIC 8008
Freecall: 1800 333 613 Freefax: 1800 832 266

