

Full Personal Statement

This form can be used to obtain or change your insurance cover.

Your Duty of Disclosure

When you apply for a life insurance policy, you have a duty to tell us anything that you know, or could reasonably be expected to know, that may affect our decision to insure you and on what terms.

You have this duty until we agree to insure you.

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

You do not need to tell us anything that:

- reduces the risk we insure you for; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive your duty to tell us about.

If someone other than you will be the life insured under the policy, any failure by that person to comply with the above duty will be treated as failure by you.

If you request life insurance inside super, the Trustee obtains this insurance from us in relation to you. In this circumstance, we rely on the disclosures that you or the Trustee makes to us.

If you do not tell us something

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

If you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the policy within 3 years of entering into it.

If we choose not to avoid the policy, we 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 us everything you should have. However, if the policy provides cover on death, we may only exercise this right within 3 years of entering into the policy.

If we choose not to avoid the policy or reduce the amount you have been insured for, we may, at any time vary the policy in a way that places us in the same position we would have been in if you had told us everything you should have. However, this right does not apply if the policy provides cover on death.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the policy as if it never existed.

Information about genetic tests

If you have had a genetic test, you only need to disclose this to us if your total insurance cover (including cover under superannuation or held with other life insurers as well as cover applied for) will be more than any one of the following:

- \$500,000 life cover, or
- \$500,000 Total and permanent disability cover (TPD), or
- \$200,000 critical illness (trauma) cover, or
- \$4,000 income protection cover, salary continuance cover or business expenses cover.

Your cover may have been arranged through a financial adviser or directly with a life insurance company or cover is held under a group arrangement.

If you have had a favourable (negative) genetic test result you can provide this information regardless of the amount of cover applied for.

SECTION A – INSURANCE DETAILS

Policy name

Maritime Super

Member number

Please specify the type of insurance cover being applied for:

<input type="checkbox"/> New	<input type="checkbox"/> Death Only	Number of Units	<input type="text"/>
<input type="checkbox"/> Increase	<input type="checkbox"/> Death and TPD	Number of Units	<input type="text"/>
	<input type="checkbox"/> Income Protection	Annual Salary	<input type="text"/>
	Income Protection Waiting Period	<input type="checkbox"/> 90	<input type="checkbox"/> 30 days
	<input type="checkbox"/> 75% of Income	<input type="checkbox"/> 50% of Income	

SECTION B – ADVISER DETAILS (IF APPLICABLE)

Adviser Name

Adviser Phone Number

Adviser Email

I agree to the Insurer or any one of their authorised representatives contacting the client directly if required to collect further information to assist with the completion of this application.

I am lawfully authorised to advise on, and deal in, MLC Group Insurance policies under an Australian Financial Services Licence. I do not provide these services on behalf of MLC Limited (ABN 90 000 000 402) (AFSL 230694).

Signature of the financial adviser listed above

	Date (DD/MM/YYYY)
	<input type="text"/>

SECTION C – PERSONAL DETAILS

1 Person whose life is to be insured

Title Surname (Family name)

Given names

Male Female Date of birth / /

Marital status

2 Contact address for notices

	Postcode

Home telephone

Work telephone

Mobile phone number

Facsimile

Email address (Please provide your email so notices relating to your application can be sent to you)

SECTION D – EMPLOYMENT DETAILS

3 Current employer's name

4 What is your current occupation?

5 What professional or trade qualification do you have?

6 On what basis are you employed?

Full-time
 Part-time
 Casual
 Contractor
 Fixed-term employment

Date you started with your CURRENT employer.

7 What is your annual salary?

SECTION E – ADDITIONAL DETAILS

8 Are you in receipt of or have you ever made a claim for any type of accident or sickness (including lump sum total and permanent disablement, workers' compensation or third party insurance benefit) or have you ever applied for unemployment, sickness or accident benefits or other Centrelink or Veterans' Affairs Benefits?

No

Yes Give details

9 Have you ever had an application for insurance on your life declined, postponed, cancelled, accepted with an exclusion or a higher than standard premium, or modified in any way?

No

Yes Give details

10 Are you covered by, or are you applying for other life, disability, critical illness, or income protection insurance with any company including the Insurer (other than this application) – including benefits under superannuation?

No

Yes Give details for each.

If there is not enough space here, please list at Question 29, page 5.

Type of Insurance		Commencement Date	
<input type="text"/>		<input type="text" value="/ /"/>	
Company		Policy Number	
<input type="text"/>		<input type="text"/>	
Sum Insured or Monthly Benefit	If income protection Waiting Period	Benefit Period	Is this application replacing this insurance?
<input type="text"/>	<input type="text"/>	<input type="text"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>

If you answered "Yes" to this question please ensure you cancel your insurance with the Insurer or another provider once this application has been accepted.

11 Do you now engage or do you intend to engage in any of the following activities?

	No	Yes
a Flying as a pilot or crew in an aircraft	<input type="checkbox"/>	<input type="checkbox"/>
b Motor car, motor cycle or motor boat racing	<input type="checkbox"/>	<input type="checkbox"/>
c Underwater diving	<input type="checkbox"/>	<input type="checkbox"/>
d Football, parachuting, hang-gliding	<input type="checkbox"/>	<input type="checkbox"/>
e Other hazardous pursuits, activities or sports (eg polo, competitive judo, mountain climbing, mountain biking, downhill mountain biking)	<input type="checkbox"/>	<input type="checkbox"/>

If you answered 'Yes' to any of these, give full details of each below. If there is not enough space here, please list at Question 29, page 5

Activity
<input type="text"/>
Location
<input type="text"/>
Amateur <input type="checkbox"/> Professional <input type="checkbox"/> Events/Hours per year <input type="text"/>
Other details
<input type="text"/>

SECTION F – HEALTH AND MEDICAL HISTORY

12 What is the name and address of your usual doctor or medical centre? (If no usual doctor, then the doctor you last visited)

If you have known this doctor for less than 12 months, please also advise your previous doctor's details at question 29 on page 5.

This question must be completed.

Doctor's name or medical centre

Address

Postcode

Business Number ()

How long have you been attending this practice?
 years months

Please provide details of your last check-up or consultation.
 Date of last consultation Reason for last check-up or consultation
 / /

Result

Medication prescribed, referral given or tests ordered

13 Are you carrying the Human Immunodeficiency Virus (HIV) which causes AIDS, antibodies to that virus, or are you suffering from AIDS or any AIDS related condition?

No Yes

14 In the past three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed? Note – HIV risk situations are situations in which you have been potentially exposed to HIV infection. These situations include but are not limited to, intercourse with someone you know or suspect to be HIV positive, intravenous drug use, or unprotected anal intercourse, (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years)

No

Yes A confidential questionnaire will be sent out to you to complete and return to the Insurer's Chief Underwriter.

15 Have you ever had any of the following conditions?

Yes' to any item in this question please give details at Question 27.

	No	Yes
a Asthma	<input type="checkbox"/>	<input type="checkbox"/>
b any cyst, mole or skin lesion requiring medical advice or treatment	<input type="checkbox"/>	<input type="checkbox"/>
c a strained back, sciatica, whiplash, spondylitis or any other back, neck or spinal problem	<input type="checkbox"/>	<input type="checkbox"/>
d any disorder of the bones, joints or muscles, arthritis, gout or repetitive strain injury	<input type="checkbox"/>	<input type="checkbox"/>
e treatment or counselling for depression, or any nervous, anxiety, stress or mental disorder	<input type="checkbox"/>	<input type="checkbox"/>
f high blood pressure or high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

16 Further medical requirements may be necessary to assess your application (eg. Blood tests, Medical exam). Do you wish the Insurer to arrange these?

No You will be advised what requirements to organise.

Yes The Insurer's provider will contact you directly.

17 Do you drink alcohol?

No

Yes Number of standard drinks:
 per day or per week
 Note: 1 standard drink = 1 glass of beer/wine/nip of spirit

18 Have you smoked tobacco or any other substance or used any nicotine-containing product in the last 12 months?

No

Yes What type? eg cigarettes, gum, patch Daily quantity

19 What is your height/weight? cm kg

20 Do you currently have or have you ever had any of the following?

If you answered 'Yes' to any item in this question please give details at Question 27.

	No	Yes
Heart complaint a	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or any neurological disorder b	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or vascular disorder c	<input type="checkbox"/>	<input type="checkbox"/>
Lung complaint d	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, bowel, kidney or bladder disorder e	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug dependence f	<input type="checkbox"/>	<input type="checkbox"/>
Professional advice to reduce alcohol consumption g	<input type="checkbox"/>	<input type="checkbox"/>
Migraine, persistent headache or chronic fatigue h	<input type="checkbox"/>	<input type="checkbox"/>
Disorder of the reproductive system (eg prostate, ovary), or sexually transmitted disease i	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or leukaemia j	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilia or blood disorder k	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder l	<input type="checkbox"/>	<input type="checkbox"/>
Liver disorder, hepatitis or test indicating past or present hepatitis infection m	<input type="checkbox"/>	<input type="checkbox"/>
Any allergies, skin disorder, or disorder of the eyes, ears, nose or throat n	<input type="checkbox"/>	<input type="checkbox"/>
Any other operation, disability, illness or injury, medical investigation or test* (eg biopsy, mammogram, ultrasound, ECG) not already mentioned o	<input type="checkbox"/>	<input type="checkbox"/>

*Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing

21 Other than already stated, have you in the last 5 years:

No **Yes**

Taken any prescribed medication on a regular or ongoing basis? (Other than for colds or flu) **a**

Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist? **b**

If you answered 'Yes' to any item in this question please give details at Question 27.

22 Do you currently have any other disability, illness, injury or symptoms not already mentioned?

No Yes

If you answered 'Yes' to this question please give details at Question 27.

23 Are you contemplating seeking any medical advice, test*, investigation or treatment?
**Before you answer this question, please refer to page 1 of this form which relates to information about genetic testing*

No Yes

If you answered 'Yes' to this question please give details at Question 27.

Males: Go to Question 27.

Females Only

24 Have you had any complications of pregnancy or childbirth?

No

Yes **Give details at Question 27.**

25 Are you currently pregnant?

No

Yes Date due

26 Have you ever had an abnormal pap smear?

No

Yes When

Treatment

Date and result of most recent pap smear

27 Did you answer 'Yes' to any item in Questions 15, 20, 21, 22, 23 and 24?

No **Go to next question**

Yes **Give full and accurate details below of each instance. If there is not enough space here, please list at question 29.**

Question number in Section F	Illness, injury, condition or test	Test results	When did it start?	When did it cease?	Type of treatment and when treatment ceased	How long off work?	Have you completely recovered?	Name and address of institution and attending person

SECTION G – DECLARATION

Read this section carefully before signing.

My decision to apply for insurance under MLC Group Insurance is based on the Product Disclosure Statement and/or Policy Document for the relevant product that I have received and my understanding of the information it contains.

I understand and agree that:

- (a) I have read the Duty of Disclosure set out on page 1. I understand that, until the Insurer accepts this application, I have a duty to disclose every matter which I know, or could reasonably be expected to know, is relevant to the Insurer's acceptance of this application and that if I fail to comply with my duty of disclosure the Insurer's may (as permitted by law) decline to pay, or reduce our liability to pay, the benefits under this policy;
- (b) The answers to the questions in this application and any other relevant personal statement(s) and questionnaires are true and complete, and the answers given form the basis of the contract;
- (c) If any answers to the application questions are not in my own handwriting, I certify that I have checked them and they are correct;
- (d) I consent to notices relating to my application to be sent to the email address or the mobile number provided by me and I acknowledge that my personal and sensitive information may be sent to that email address.
- (e) Where this application is for insurance cover under a superannuation fund, I will provide the Insurer or the Trustee or any appointed adviser, intermediary or administrator with any information which relates to my membership of that fund which they may request;
- (f) This insurance application is not effective until the Insurer accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;
- (g) I was actively at work performing the normal duties of my occupation when I applied for this insurance;
- (h) All statements and declarations given by me on this form are true and correct; and
- (i) The information contained in this application may be released to the trustee which has arranged this group insurance, or to an adviser, intermediary or administrator appointed by the trustee for the purposes of administering this insurance or the superannuation fund under which it is provided.

I authorise the Insurer to:

- (a) Collect further medical information from any doctor, medical centre, hospital or any other health service provider identified by me in this application for the purpose of assessing my application for insurance; and
- (b) Provide my personal, financial and medical information (whether provided in this application or otherwise subsequently collected by the Insurer with my consent) to any medical professional, medical facility, reinsurer, assessor, adviser or any other confidential service provider, now or at any time in the future, for the purpose of issuing or administering this insurance, and assessing any claim made in respect of this insurance; and
- (c) Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undertaken in connection with this application to my usual doctor or medical centre as nominated at Question 12 of Section E, Health and Medical History; and
- (d) Provide a copy of the HIV Antibodies test to my usual doctor or medical centre as nominated at Question 12 of Section E, Health and Medical History unless I have nominated an alternative doctor to receive the results, in which case I authorise the results to be provided to the alternative doctor specified.

I also authorise the Insurer and any third party referred to in paragraphs (a), (b), (c) and (d) of this authority, to transfer any such information outside the State, Territory or jurisdiction in which the information was collected in order to give effect to this authority.

Privacy

I acknowledge that I have access to the Insurer's privacy policy and agree that the Insurer may collect, use, disclose and handle my personal information in a manner set out in the Insurer's privacy policy available on mlc.com.au

I acknowledge that where my Employer (or former Employer) or the trustee of my superannuation fund has appointed an adviser, intermediary or administrator to arrange and/or administer the group insurance policy on their behalf, my personal information, including my pastime activities, occupation and financial status will be provided to the Insurer for the purpose of expediting the assessment of this application for insurance.

Consent

I consent that where my application is declined, loaded and/or an exclusion is applied, the Insurer may disclose any personal medical information or finding that resulted in my application being declined, loaded and/or having an exclusion applied, to the adviser, intermediary or administrator providing services in relation to this group insurance.

I understand that I can withdraw this consent at any time by contacting the Insurer on **(02) 8908 6111** or email enquiries.group@mlcinsurance.com.au

Where, in the Insurer's opinion, your medical information or our findings are of a personal or sensitive nature, the Insurer reserves the right to withhold disclosure of this information to the appointed adviser, intermediary or administrator.

I acknowledge that MLC Group Insurance does not represent a deposit with or liability of NAB Limited or any other member of the National Group of companies. Neither NAB Limited, nor any other company in the National Group of Companies guarantees or accepts liability in respect of MLC Group Insurance.

Signature of Life to be Insured

X

Date

/ /

YOU MUST SIGN THE MEDICAL AUTHORITY ON PAGE 7.

SEND TO:

Mail:

Maritime Super
Locked Bag 2001
QVB Post Office NSW 1230

Phone:

(02) 9261 3683

Email:

info@maritimesuper.com.au

Website:

maritimesuper.com.au

(DO NOT DETACH)

Medical Authority

LIFE INSURANCE



Please sign and date

Authority to obtain a report from a medical practitioner or hospital.

I request and authorise any doctor/hospital/clinic to supply the Insurer and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer such information to another State, Territory or jurisdiction. **A photocopy of this authorisation shall be as valid as the original.**

Print Name

If married, what is your maiden name?

Signature of Life to be Insured

	Date / /
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MLC Limited ABN 90 000 000 402 AFSL 230694 (the Insurer) uses the MLC brand under licence. MLC Limited is part of the Nippon Life Insurance Group and not a part of the NAB Group of Companies. Any references to 'we', 'us' and 'our' means MLC Limited.