Accelerated Protection

Data Capture Form

(This form is not to be submitted for new applications)

SAVE PRINT

This form applies to insurance cover structured:

- outside of superannuation, and
- through superannuation (where the policy is owned by the trustee of the fund).

Reference number
(Please ensure the correct quote illustration is attached to this Application Form.)

Life to be insured name

IMPORTANT INFORMATION

Product Disclosure Statement (PDS)

Before you apply for new insurance cover, you should read the Accelerated Protection Combined Product Disclosure Statement and Policy Document (PDS) and, if your cover is to be structured through TAL Super, the Accelerated Protection through TAL Super Product Disclosure Statement (TAL Super PDS), dated 24 September 2021, which TAL or a financial adviser must have provided you with prior to you submitting your application.

Target Market Determination of the product (where applicable) is available on our website. Alternatively you may contact your financial adviser or call us on 1300 209 088 to obtain a copy.

Completing this form

Please complete all relevant sections. If you do not provide the required information, we may not be able to process your application.

Your financial adviser must submit an electronic application to TAL.

Please complete in black ink, using BLOCK letters. Use X in boxes.

PRIVACY

In this section, the words 'we' and 'our' refer to both TAL and the Trustee.

The way in which we collect, secure, hold, use and disclose personal and sensitive information (your information) is explained in the 'Your Privacy' section of the PDS and in our privacy policies. These policies can be obtained online at www.tal.com.au/privacy-policy (all policies) and www.mercer.com.au/privacy.html (TAL Super policies only) or by contacting us.

If you have any questions about the way in which your information is managed, or would like a paper copy of our privacy policies, please contact us by phone on 1300 209 088 or by email to customerservice@tal.com.au.

TAL Life Limited ABN 70 050 109 450 | AFSL 237848
TAL Super – a plan within the Retail Division in the Mercer Super Trust
ABN 19 905 422 981
Trustee: Mercer Superannuation (Australia) Limited
ABN 79 004 717 533 | AFSL 235906

DUTY TO TAKE REASONABLE CARE NOT TO MAKE A MISREPRESENTATION

About this application

When you apply for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover you, and if so on what terms and for what premium.

We will ask questions we need to know the answers to. These will be about your personal circumstances, such as your health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information you give us in response to our questions is vital to our decision.

If your application is for a new policy and your application is accepted, the policy will be a consumer insurance contract.

The duty to take reasonable care

When applying for insurance, there is a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty also applies when extending or making changes to existing insurance, and reinstating insurance.

If the duty is not met

If the duty is not met, this can have serious impacts on your insurance. Your cover could be avoided (treated as if it never existed), or its terms may be changed. This may also result in a claim being declined or a benefit being reduced.

Please note that there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Guidance for answering our questions

You are responsible for the information provided to us when applying for insurance. When answering our questions, please:

- Think carefully about each question before you answer. If you are unsure of the meaning of any question, please ask us before you respond.
- Answer every question.
- Answer truthfully, accurately and completely. If you are unsure about whether you should include information, please include it.
- Review your application carefully before it is submitted. If someone else helped prepare your application (for example, your adviser), please check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before your cover starts

Before your cover starts, we may ask you whether the answers to the questions that you have given when applying for insurance remain accurate or whether there has been a change to any of your circumstances. As any changes might require further assessment or investigation, it could save time if you let us know about any changes when they happen.

If you need help

It's important that you understand this information and the questions we ask. Ask us or your adviser for help if you have difficulty understanding the process of applying for life insurance or answering our questions.

If you're having difficulty due to a disability, language, or for any other reason, please let us know - we're here to help and can provide additional support.

1. PERSONAL DETAILS

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

First name

Middle name

Last name

Previous last name

Date of birth DD / MM / YYYY

Gender ☐ Male ☐ Female

Tax file number

Only provide this if you are applying for cover through TAL Super.

Important Please refer to Section PROVIDING YOUR TAX FILE NUMBER for further information.

If the life to be insured has been pre-assessed for this application and a Pre-assessment Reference Number was provided, please enter below. Do not include phone call pre-assessments.

Pre-assessment Reference Number 1

Pre-assessment Reference Number 2

1. PERSONAL DETAILS (continued)

Residential address

Do not enter a PO Box in this field. If your mailing address is different to your residential address, please complete your residential address details and then provide your mailing address in Section 2.

Street address

Suburb State Postcode

Country

2. CONTACT DETAILS

Email

Preferred email

We will use email for some of the information we need to send you about your policy, rather than sending paper copies. However, if you'd prefer to receive information by post, please indicate by writing X in the box on the right. ☐

Phone

Preferred contact number 1 Home ☐ Business ☐ Mobile ☐

Preferred contact number 2 Home ☐ Business ☐ Mobile ☐

Mailing address

If your mailing address is different to the residential address provided in Section 1, please provide details.

Address

Suburb State Postcode

Country

3. EMPLOYMENT DETAILS

To be completed for:
- **TPD (except Home Duties)**
- **Income Protection benefits**
- **Life cover that exceeds $6 million.**

Questions 1 to 3 must be completed when:
- **Critical Illness cover exceeds $1 million and**
- **Life cover is between $2,500,001 and $6 million.**

1. Are you self-employed?

☐ No → Go to Question 12. ☐ Yes → Go to Question 2.

You must select self-employed if you directly or indirectly own all or part of the business in which your work is performed (i.e. you are a sole trader, shareholder, partner, beneficiary, trustee or unit holder of a trust). This includes where the business operates under a company structure (ignoring shares in publicly listed companies).

2. What is your share of the business? %

3. How many other owners/shareholders are there in the business?

Questions 4 to 11 are required for Income Protection applications only.
For other benefits go to Question 12.

4. If there is only one other business owner, is this your spouse?

☐ Yes → Go to Question 5. ☐ No → Go to Question 9.

5. Does your spouse work in the business?

☐ Yes → Go to Question 6. ☐ No → Go to Question 9.

6. Does your spouse perform administration tasks only for the business?

☐ Yes → Go to Question 7. ☐ No → Go to Question 9.

3. EMPLOYMENT DETAILS (continued)

7. Is your spouse being paid a wage consistent with the hours and work they perform (that is, a market rate)?

☐ Yes → Go to Question 8. ☐ No → Go to Question 9.

8. Please tell us about your spouse's role in the business, their duties, wage, working hours and whether they are applying for insurance cover.

9. How many employees do you have? Please include any contractors or sub-contractors.

10. What percentage of your work is done from home? %

11. If more than 50% of work is done from home, what percentage of this time involves face to face meetings with clients (coming to your residence or you visiting theirs)? %

12. How long have you been working in your current occupation? years months

If less than two years, please go to Question 13. If self-employed, go to Question 14. Otherwise, go to Question 17.

13. In the last two years, have you had any period of unemployment longer than two months?

☐ No ☐ Yes → Please provide an employment history for the last three years.

PREVIOUS OCCUPATION	PREVIOUS EMPLOYER	DATE FROM	DATE TO
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

14. If **self-employed**, did you establish your business within the last 12 months? ☐ Yes ☐ No

a) **If yes,** are you contracting back to your previous employer? ☐ Yes ☐ No

b) **If no,** Please advise the date you started working in your current occupation, became self-employed or established in this business, if you are contracting back to your previous employer, whether you have purchased an existing business or franchise, how you source business, the terms and conditions of any contracts in place and any other information that will assist us in underwriting this application.

15. If not self-employed, how long have you been working for your current employer?

years months

16. Are you doing the same type of work, in the same industry as your previous occupation?

☐ Yes → Go to Question 17. ☐ No → Please provide your employment history for the last three years.

PREVIOUS OCCUPATION	PREVIOUS EMPLOYER	DATE FROM	DATE TO
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY
		DD / MM / YYYY	DD / MM / YYYY

17. In the next 12 months, do you have plans to change your occupation or work duties, work hours, take a redundancy, become self-employed, take extended leave (eg parental or study leave) or make other changes (including leaving your current employer) to your work circumstances?

☐ No → Go to next question. ☐ Yes → Please provide details including dates.

4. INCOME DETAILS

You will need to complete the questions relevant to your application and employment status.

Your application	Employed	Self employed
Life, TPD or CI cover	Questions 1, 2 and 3	Questions 1, 2 and 3
More than $2.5m Life or $2m TPD	Questions 1, 2, 3, 4 and 5	Questions 1, 3, 4, 5, 9, 10 and 11
Income Protection with a monthly benefit under $20,000	Questions 2, 3, 6, 7 and 8	Questions 3, 9, 10 and 11
Income Protection with a monthly benefit of $20,000 or more	Questions 2, 3, 6, 7, 8 and 12	Questions 3, 9, 10, 11 and 12

1. If applying for Life, TPD or Critical Illness insurance, what is the purpose of the cover being applied for?

☐ Key person ☐ Partnership/Share purchase ☐ Loan cover ☐ Personal ☐ Combination

2. What is your current annual income before tax? $
   'Current annual income' means your gross income including superannuation (less any business expenses if you are self-employed) before tax is deducted, earned for the current tax year. It does not include investment income.

3. In the last five years, have you been either declared bankrupt or put under any form of personal insolvency administration or if you've been a business owner, has your business ever been insolvent or placed into any form of insolvency or external administration (such as liquidation, receivership or administration)?

☐ No ☐ Yes → Please answer a), b) and c).

   a) Has your bankruptcy been discharged or company liquidation, receivership or administration been finalised?

   ☐ No ☐ Yes
   If yes, how long ago did the discharge or finalisation occur? years ☐ months ☐

   b) Have any of the above events occurred more than once? ☐ Yes ☐ No

   c) Please advise the circumstances, the date(s) when this commenced and the date(s) of discharge.

4. Assets and liabilities

Please provide full and complete information about the assets and liabilities that you own or have control of directly or otherwise, including the value of any shares in private (Pty Ltd) or public (Limited) companies. Please attach a separate sheet if insufficient space below.

Assets		**Liabilities**	
Description	**Value**	**Description**	**Value**
Personal residence and furniture etc	$	Mortgage	$
Motor vehicles, boats etc	$	Motor vehicles, boats etc – loan(s)	$
Investment properties	$	Investment properties – mortgage(s)	$
Investment shares	$	Investment shares – loan(s)	$
Business	$	Business loan(s)	$
Other (please specify)		Other (please specify)	
1.	$	1.	$
2.	$	2.	$
Total	**$**	**Total**	**$**

5. Do you have any dependants?

☐ No ☐ Yes → Please provide the age of each dependant and their relationship to you.

4. INCOME DETAILS (continued)

Questions for Employees (arms-length)

6. Employer superannuation contribution percentage? %

7. Income excluding employer superannuation contribution percentage? $

8. Does your remuneration include a bonus or commission component?

☐ No ☐ Yes → Complete the following.

a) What percentage is this of your total remuneration package? %

b) Is this percentage likely to be paid at this level or higher in the next tax year? ☐ Yes ☐ No

If bonus is more than 30% of total remuneration package, please complete the table below:

	CURRENT TAX YEAR	LAST TAX YEAR	PREVIOUS TAX YEAR
SALARY/WAGE EXCLUDING SUPER	$	$	$
BONUS	$	$	$
OTHER BENEFITS EXCLUDING SUPER	$	$	$
TOTAL	$	$	$

Questions for Self-Employed

9. How many entities do you have an ownership interest in or are entitled to profit share from either directly or indirectly?

10. Please complete income details here if you are a business owner, sole trader, an employee of a company you have a shareholding in either directly or indirectly, a beneficiary or trustee or unit holder of a trust, or are in a partnership. If newly self-employed refer to the Adviser Guide for instructions to assist completing this section.

	Last tax year	**Previous tax year**
A. Gross business income (turnover) This is the total revenue figure for your business excluding any passive income (eg interest, rent, dividends).	$	$
B. Business expenses This is the total expenses figure for your business, including all add back and non-add back items.	$	$
C. Total net business income before tax (net profit) This figure is derived by deducting business expenses from gross business income.	$	$
D. Share of net business income? This figure is derived by multiplying net business income by your share of the business as stated in the Occupation Details section.	$	$

Please enter the following income items that were paid to you (as shown in your Profit and Loss account):

Add back items	**Last tax year**	**Previous tax year**
E. Salary/Wages	$	$
F. Superannuation	$	$
G. Other benefits	$	$
Total income (D+E+F+G)	$	$

11. If a figure is entered at Question 8G (Other benefits), please advise what has been included.

Do not add back drawings, dividends or any salary/wage paid from the business if you are a sole trader or in partnership.

4. INCOME DETAILS (continued)

To be completed for Income Protection only, If the monthly benefit exceeds $20,000 in total.

12. Do you have net assets (excluding the personal residence/family home and superannuation) exceeding $5 million and/or net investment or unearned annual income exceeding $250,000?

    This includes assets and investments you have either an ownership interest in or control over (directly or indirectly) including those held in your spouse's name, in trusts or other entities owned by trusts or any other entity that you have control over.

☐ No ☐ Yes → Please provide details here. If you answer yes to this question, cover may be restricted.

5. OCCUPATION DETAILS

To be completed for all cover.

1. What is your occupation?

2. What industry do you work in?

3. Please select the statement that describes your occupation.

	Occupation description	Occupation category
	Professional | Medical | Legal | Administration | White Collar	
☐	• I am a university qualified professional, and • I am registered and working with my qualification in a role that requires membership of a professional or government body, and • I spend less than 10% of my time performing manual duties and less than 20% of my time in the field or remote work site environment. OR • I am working in an office-based management role that I have held for 2 years or more, and • I earn $120,000 or more per annum, and • I spend less than 10% of my time performing manual duties and less than 20% of my time in the field or remote work site environment.	AAA
☐	I am a university qualified medical practitioner, registered and practising in my field of qualification.	AA+
☐	• I am working in an office-based management or clerical role, and • I spend less than 10% of my time performing manual duties and less than 20% of my time in the field or remote work site environment. OR • I am a qualified health professional providing medical advice and/or light physical therapy. OR • I am a classroom teacher, not teaching manual arts or physical education.	AA
	Supervisory | Trades | Light Manual | Heavy Manual | Driving	
☐	I work in an occupation that requires me to undertake some light physical work, supervise manual work or work in an environment that is not office-based.	A
☐	• I spend more than 10% of my time performing or supervising manual work in an occupation for which I hold trade certification. OR • I spend more than 10% of my time performing or supervising manual work in a skilled occupation that is not office-based.	BBB
☐	I perform moderate to heavy manual work including using machinery, driving or lifting. I do not undertake work at heights over 10 metres.	BB
☐	I perform heavy manual work including using machinery, driving or lifting. I do not undertake work at heights over 20 metres.	B

5. OCCUPATION DETAILS (continued)

	Occupation description	Occupation category
☐	I perform heavy manual work including using machinery, driving or lifting.	SRA
	House Person | Unemployed	
☐	My occupation is Home Duties.	Home Duties
☐	I am not working in paid employment – I am a retiree, a pensioner, a student or unemployed.	Not working
☐	**Other**	

To be completed when applying for:

- **TPD (except for Home Duties)**
- **Income Protection benefits**
- **Life cover that exceeds $6 million.**

4. Please select the term that best describes your occupation status.

☐ Permanent full-time ☐ Permanent part-time ☐ Casual ☐ Contractor

- Permanent full-time means you are employed on a permanent basis and work a minimum of 30 hours and five days per week.
- Permanent part-time means you are employed on a permanent basis and work less than 30 hours and/or five days per week.
- Casual means you are not employed on a permanent basis and do not have an employment contract.
- Contractor means you have a contractual agreement to provide services for a specific period of time or task.

5. How many hours do you work per week? hours

6. How many days do you work per week? days

7. How many weeks do you work per year? weeks

8. Do you have any professional or trade qualifications?

☐ No → Go to Question 10. ☐ Yes → Complete Questions 9 and 10.

9. What type of qualification do you have? If more than one, please select the highest level achieved.

☐ Certificate I – II
☐ Certificate III – IV (Trade Certificate)
☐ Diploma, Advanced Diploma or Associate Degree
☐ Bachelor Degree or Honours Degree
☐ Graduate Certificate or Graduate Diploma
☐ Master's Degree
☐ Doctoral Degree or Higher Doctoral Degree

10. Did you become registered or licensed within the last 3 years? ☐ Yes ☐ No

11. Are you applying for the New Professionals Offer? (See Flyer on the TAL Adviser Centre for details). ☐ Yes ☐ No

12. What is your current employer's or your business name and street address?

Employer/Business name

Street address

Suburb State Postcode

Contact number Contact type ☐ Business ☐ Mobile

Email

13. Do you have any other occupation?

☐ No → Go to Question 15 or 18 whichever is applicable. ☐ Yes → Go to next question.

5. OCCUPATION DETAILS (continued)

14. Do you work in the same occupation and industry as your main occupation?

☐ Yes ☐ No → Please provide details.

a) What is your other occupation?

b) Name of your employer.

c) How many hours per week do you work in this other occupation? hours

d) How long have you been doing this other occupation? years months

e) What is your annual income from this other occupation? $

COVID-19 Self-Employed Questionnaire

To be completed if applying for Income Protection or Total & Permanent Disability

15. Has your business received a Government wage subsidy (e.g. JobKeeper)?

☐ No ☐ Yes → Please provide details including the number of eligible employees.

16. As a result of Government restrictions for COVID-19 have you had:

a) Your occupational duties changed? ☐ No ☐ Yes

b) A change to the products or services offered by your business? ☐ No ☐ Yes

c) A decrease in your working hours? ☐ No ☐ Yes

d) A decrease in turnover or net income? ☐ No ☐ Yes

e) A change to the number of employees you have? ☐ No ☐ Yes

If Yes to any of the above, provide more information including; What the circumstances were prior to COVID? What changed? Did you cease work completely? What is your current trading capacity (in percentage)? Are circumstances likely to change again, when and to what?

17. Have you received any COVID-19 related financial assistance payments?

a) Cash flow boost ☐ No ☐ Yes

b) Rental reduction or waiver ☐ No ☐ Yes

c) Other ☐ No ☐ Yes

Please provide details including the type of subsidy, amount received and the date of the last payment for each subsidy

5. OCCUPATION DETAILS (continued)

COVID-19 Employee Questionnaire

To be completed if applying for Income Protection or Total & Permanent Disability

18. Have you received or are you receiving a Government wage subsidy via your employer? (You don't need to tell us about Job Keeper 1) ☐ No ☐ Yes

19. As a result of Government restrictions for COVID-19 have you had:

    a) A change in your occupational duties? ☐ No ☐ Yes

    b) A decrease in your working hours? ☐ No ☐ Yes

    c) A decrease in your income (salary or wages)? ☐ No ☐ Yes

If Yes to any of the above, provide further information including; What the circumstances were prior to COVID? What changed? Did you cease work completely? Are circumstances likely to change again, when and to what? When did wage subsidy cease?

6. OTHER INSURANCE DETAILS

To be completed for Life, TPD and Critical Illness insurance applications.

1. Apart from this application, do you have or are you applying for any other Life, TPD or Critical Illness insurance (including cover held under superannuation)?

☐ No → Go to Question 3. ☐ Yes → Complete Question 2.

2. Is this other insurance being completely replaced by this application?

☐ Yes ☐ No → What will be the total amount of cover in force on your life (including this application)?

Note Please include any TPD benefits under Critical Illness type contracts. Financial evidence may be required if total combined cover exceeds our financial underwriting limits.

Life $ TPD $ Critical Illness $

To be completed for Income Protection applications.

3. Apart from this application, do you have or are you applying for any other Income Protection insurance (including cover held under superannuation)?

☐ No → Go to Section 7. ☐ Yes → Complete Question 4.

4. Is this cover held with TAL or an associated company? ☐ Yes ☐ No

If yes, complete Question 5. **If no,** complete Question 6.

5. Please tell us what action should be taken with the existing cover.

6. Is this other insurance being completely replaced by this application? ☐ Yes ☐ No

If no, Complete Question 7

7. Would you like an offset to apply to this policy because you are retaining your other insurance?

☐ Yes ☐ No →Please provide details of existing IP insurance including Monthly Benefit amount, Waiting Period and Benefit Period, plus name of company cover is held with.

7. HEALTH AND LIFESTYLE DETAILS

1. Height and weight

Height ☐ cm or ☐ feet ☐ inches

Weight ☐ kg or ☐ stone ☐ pounds

2. Have you lost weight in the last 12 months?

☐ No → Go to next question. ☐ Yes → Complete the following:

a) How many kilograms have you lost? kg ☐

b) Have you undergone surgery to reduce your weight?

☐ No → Go to next question. ☐ Yes → Complete the following:

Weight Loss Questionnaire

i) How many years ago did you have this surgery? years ☐

ii) What was your weight before the surgery? kg ☐

iii) What was your weight once stabilised after the surgery? kg ☐

iv) Did you have any complications from the surgery or require repeat surgeries?

☐ No ☐ Yes → Please provide details.

v) Does your GP have the details of this surgery?

☐ Yes ☐ No → Please provide details of the Doctor who has records.

3. When was the last time you used any tobacco, e-cigarettes or products containing nicotine (including patches)?

☐ Currently or in the last 12 months

a) Which of the following nicotine products do/did you use?

☐ Cigarettes ☐ quantity per ☐ day ☐ or week ☐ or month

☐ Cigars/pipe tobacco

☐ E-cigarettes or ☐ vaping

☐ Nicotine replacement e.g. patches or gum

☐ Other – please provide details:

☐ More than 12 months ago

a) For how many years were you a smoker? years ☐

b) When you smoked, how much did you smoke?

per day ☐ OR per week ☐ OR per month ☐

How many years ago did you stop smoking? years ☐

c) Did you stop smoking due to a health or medical issue?

☐ No → Go to next question. ☐ Yes → What is/was the nature of the health or medical issue?

☐ Never

7. HEALTH AND LIFESTYLE DETAILS (continued)

4. Have you ever smoked, injected or otherwise taken any recreational or illegal drugs?

☐ No → Go to next question. ☐ Yes → Please download and complete the Drugs Use questionnaire on the TAL Adviser Centre and submit with the application.

5. Do you drink alcohol?

☐ No → Go to Question 7. ☐ Yes → Complete the following.

a) On average, how many standard drinks of alcohol do you typically consume per day?
(A standard drink is approximately 285ml full strength beer, 100k=ml wine, 30ml spirits)
If you don't drink daily, take the total number of drinks you have had in the past 30 days and divide by 30.
If this is less than 1 enter 0.

b) How often would you drink more than five standard drinks a day?

☐ Never → Go to Question 7

☐ Once or twice a week → Go to Question 6

☐ Three days a week or more → Go to Question 6

☐ Once or twice a fortnight → Go to Question 6

☐ No more than once a month → Go to Question 7

☐ Infrequently (e.g. 2 or 3 times a year) → Go to Question 7

6. When you do consume more than five standard drinks in a day how many do you have?

7. Have you ever consulted a health professional, rehabilitation provider or support group about a dependency or addiction or received medical advice, counselling or treatment for any dependency or addiction? This includes but is not limited to alcohol, drugs, gaming or gambling. ☐ Yes ☐ No

8. RESIDENCY

1. Are you an Australian citizen or permanent resident or a New Zealand citizen residing in Australia?

☐ Yes → Go to Section 9. ☐ No → Complete Questions 2 to 6.

2. How long have you lived in Australia? years months

3. What are your plans for obtaining permanent residency and when is this likely to be granted?

4. Visa

a) What type of visa do you have?

b) When does it expire? DD / MM / YYYY

5. In what country were you born?

6. What is your nationality or what other countries do you have residency/citizenship rights in?

9. TRAVEL PLANS

1. In the next 12 months do you have definite plans to travel or live overseas or are you required to travel overseas on a regular basis for business?

☐ No → Go to Section 10. ☐ Yes → Complete Questions 2 to 5.

2. Please select the term that best describes your travel plans.

☐ Personal and/or business travel ☐ Living or moving overseas (even temporarily)

3. Please advise the destinations (city and country) you will be travelling to or visit most frequently (if regular businesses travel).

9. TRAVEL PLANS (continued)

4. Please advise departure date, the frequency of travel, the duration of visit and the purpose of each trip.

5. If you live, or are planning to live overseas, please provide full details of where, the length of time and purpose of being there.

10. PURSUITS AND ACTIVITIES

Do you currently participate in, or do you have any intention of participating in, any sports or hazardous activities including aviation (except as a fare paying passenger on a commercial airline), football, scuba diving, motor racing, rock climbing?
A hazardous activity refers to a recreational or occupational activity that has an increased risk of injury when performed.

☐ No ☐ Yes → Complete the relevant questionnaire(s) in Sections 11 to 14.

11. AVIATION QUESTIONNAIRE

If you work for a major commercial (non-charter or private company) airline, please do not complete this questionnaire. Refer to the TAL Occupation List for eligibility guidelines.

1. Do you hold a current pilot's licence? ☐ Yes ☐ No
2. Do you intend to change the scope of your present licence? ☐ Yes ☐ No
3. Do your occupation duties include flying? ☐ Yes ☐ No
4. If you fly as part of your occupation, do you fly charter flights or private company aircraft or participate in aerial photography and surveys? ☐ Yes ☐ No ☐ Not applicable
5. Are you a flying instructor? ☐ Yes ☐ No
6. Does your flying incorporate any special risks such as agricultural flying, flying to oil rigs, record attempts, display flights, aerobatics, or flying outside Australia? ☐ Yes ☐ No
7. Do you fly microlights, ultralights or powered hang-gliders? ☐ Yes ☐ No
8. Have you ever had an accident or been charged with a violation of Department of Transport regulations? ☐ Yes ☐ No
9. Do you land at unauthorised aerodromes, airports or landing areas? ☐ Yes ☐ No
10. How many hours do you fly per annum? hours ☐
11. If you have answered yes to any of the questions above, please describe the scope of your aviation activities including the type and purpose of flying, and aircraft and specific information in relation to the question.

12. SCUBA QUESTIONNAIRE

1. Are you a current certified diver? ☐ Yes ☐ No
2. Do you work as a diving instructor? ☐ Yes ☐ No
3. What are the maximum depths of your dives? ☐ Up to 30 metres ☐ 31 – 40 metres ☐ More than 40 metres
4. Do you participate in mixed gas or decompression diving and/or use explosives while diving? ☐ Yes ☐ No
5. Do you dive in wrecks, pits, caves or potholes or participate in night or abalone diving? ☐ Yes ☐ No
6. Do you intend to change the scope of your diving activities? ☐ Yes ☐ No

12. SCUBA QUESTIONNAIRE (continued)

7. If you answered yes to any of the questions above, please provide any further information you think may assist in underwriting your application.

13. MOTORSPORTS QUESTIONNAIRE (car, bike, boat)

1. Please specify the type of motorsport activities, and type of vehicle and licence held.

a) Engine size

b) Times per annum

c) Maximum speed

d) Years participated in sport

e) Type ☐ Social (non-competition) ☐ Racing (competition) ☐ Professional

2. Please specify the type of events and categories of racing.

3. Do you take part in international events?

☐ No ☐ Yes → Please provide any further information you think may assist in underwriting your application.

14. OTHER ACTIVITIES (for example, but not limited to, football, rock climbing, abseiling, caving, bungee jumping)

1. Please specify the type of activities and events participated in.

2. If relevant please specify:

a) Times participated in per year

b) Location (eg indoor, outdoor, overseas)

c) Contact or non-contact (eg please specify for martial arts or touch football)

d) Type of competition

☐ Social/Amateur ☐ Competition (match payments) ☐ Competition (semi/professional)

14. OTHER ACTIVITIES (for example, but not limited to, football, rock climbing, abseiling, caving, bungee jumping) (continued)

3. Please specify:

   a) Equipment used

   b) Heights or depths involved

4. Please provide any other information you think may assist in underwriting your application.

15. FAMILY HISTORY

1. Has any of your immediate family (mother, father, brother or sister), living or deceased, been diagnosed with any of the following conditions before the age of 65? If family history is unknown, answer no.

☐ No → Go to question 3. ☐ Yes → Please indicate against the following list.

Note Information is only required for first degree blood related family members, living or deceased.

☐ Heart disease (eg angina or heart attack) or stroke

☐ Cardiomyopathy

☐ Breast, cervical and/or ovarian cancer

☐ Bowel cancer or polyposis of the colon

☐ Any other type of cancer

☐ Diabetes Please specify type ☐ Type 1 (early onset, insulin dependent) ☐ Type 2

☐ Polycystic kidney disease

☐ Alzheimer's disease

☐ Multiple sclerosis

☐ Motor neurone disease, Parkinson's disease, Huntington's disease, mental illness and/or any other inherited or neurological disorder not previously listed in this section.

2. If you indicated a condition above, please advise relevant condition, number of relatives and age(s) affected.

RELATIONSHIP	MEDICAL CONDITION (eg breast cancer, heart attack)	AGE WHEN DIAGNOSED	AGE AT DEATH (if applicable)

15. FAMILY HISTORY (continued)

Have you had any investigations performed (excluding a genetic test) as a result of your family history?

☐ No ☐ Yes → Please complete the table below.

CONDITION	TEST OR INVESTIGATION	RESULTS OR COMMENTS

Information about genetic tests

If you have had a genetic test, you only need to answer question 3 if your total insurance cover will be more than:

- $500,000 Life cover,
- $500,000 Total and Permanent Disability (or TPD) cover,
- $200,000 Critical Illness (also known as trauma) cover, or
- $4,000 per month Income Protection cover, salary continuance or business expenses cover.

These amounts apply to all insurance held by you (including held through a superannuation fund) or other life insurance companies, not just under this application.

If you have a favourable (negative) genetic test result, you can provide this information to us , if you wish, regardless of the cover amount.

You are only required to complete question 3 if your cover amount is more than any of the cover amounts specified in the box above. You may choose to disclose any favourable genetic test result (irrespective of the cover amount) if you wish.

3. Have you ever had a genetic test where you received or are awaiting an individual result, or are you considering having a genetic test (excluding prenatal genetic screening)?

☐ No → Go to Section 16. ☐ Yes →Please complete the following.

a) What was the reason for undertaking or considering the genetic test?

☐ Due to my family history

☐ Pregnancy / Fertility / IVF purposes → Go to Section 16

☐ To investigate symptoms → Please specify below

☐ Other → Please specify below

b) What potential condition(s) was being investigated?

☐ Breast cancer ☐ Ovarian cancer ☐ Bowel cancer ☐ Cystic fibrosis

☐ Haemochromatosis ☐ Heart disease ☐ Huntington's disease ☐ Coeliac disease

☐ Muscular dystrophy ☐ Dementia ☐ Thalassaemia

☐ Other → Please specify

15. FAMILY HISTORY (continued)

c) What was the result of the test? Please select the appropriate statement

☐ Negative – I don't have the gene being tested for

☐ Positive – I have the gene being tested for

☐ I am still waiting for the result /I have not had the test yet

d) Please provide details of any relevant family history (if not already disclosed).

e) Please provide the name and address of the doctor who has the details of this.

Doctor's name

Address

Contact number

16. HEALTH DETAILS

Most people, over a lifetime, will experience or develop some form of health condition or require medical investigations or treatment. In order to ensure that we can correctly assess your risk, please indicate which apply (or have applied) to you.

Even if you have a health condition under control with treatment or lifestyle changes, please tell us about it here.

For all yes answers, please provide details using the Additional Medical Statement in Section 17.

If you answer yes to a question marked with an asterisk, please also complete the relevant questionnaire in Sections 20 to 24.

1. Do you currently take prescribed medication? ☐ Yes ☐ No
2. Do you plan to seek or are you awaiting medical advice, test results, investigation or treatment for any symptoms, illness, injury or health condition? ☐ Yes ☐ No
3. In the last five years:
   a) Have you had, or received a recommendation or referral to have any of the following medical tests:
      i) An ECG or stress echocardiogram (ECHO), angiogram or coronary CT scan or other heart investigation? ☐ Yes ☐ No
      ii) An arthroscopy, X-Ray, CT or CAT scan or MRI or other imaging or radiological test? ☐ Yes ☐ No
      iii) A mammogram, colonoscopy, gastroscopy or endoscopy? ☐ Yes ☐ No
      iv) A blood test+? ☐ Yes ☐ No
   b) Aside from childbirth, have you been hospitalised, attended an emergency department or undergone a medical procedure? ☐ Yes ☐ No
   c) Have you been off work or unable to perform your usual duties for a period of more than five consecutive days or had any change to your usual work duties or hours because of injury or illness? ☐ Yes ☐ No
4. Apart from what you've already told us, do you currently have:
   a) Signs or symptoms of an illness, an injury, or a health issue that has lasted more than five consecutive days? ☐ Yes ☐ No
   b) A disability, impaired function or a limitation on your usual activities? ☐ Yes ☐ No
5. Have you ever tested positive for the Human Immunodeficiency Virus (HIV) or been told you have Acquired Immunodeficiency Syndrome (AIDS)? ☐ Yes ☐ No

Apart from any condition you have already told us about, have you <u>ever</u> had or received medical advice or treatment (including surgery) for any of the following:

6. Any disease, disorder or condition relating to the heart, including but not limited to angina, heart attack, heart murmur, embolism, chest pain, palpitations or irregular heart beat? ☐ Yes ☐ No
7. Stroke, Transient Ischaemic Attack (TIA), or brain haemorrhage? ☐ Yes ☐ No
8. Diabetes or raised blood sugar levels? ☐ Yes ☐ No
9. Post traumatic stress disorder, bipolar disorder, personality disorder, Attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), an eating disorder such as anorexia nervosa or bulimia, or psychosis or schizophrenia?* ☐ Yes ☐ No
10. Any cancer, leukaemia, tumour, melanoma, lump, cyst or growth either malignant or benign (i.e. non-malignant)? ☐ Yes ☐ No
11. Crohn's disease, ulcerative colitis, diverticulitis, pancreatitis or cirrhosis of the liver? ☐ Yes ☐ No
12. Autoimmune conditions including, but not limited to rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or lupus? ☐ Yes ☐ No
13. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)? ☐ Yes ☐ No
14. Numbness, tingling, altered sensation, tremor, problems with balance or co-ordination, any form of paralysis or neurological condition, including but not limited to multiple sclerosis, dementia or Alzheimer's disease? ☐ Yes ☐ No

[+] Please refer to 'information about genetic tests' in section 15, Family History, before answering this question.

Apart from any condition you have already told us about, have you <u>in the last 10 years</u> had or received medical advice or treatment (including surgery) for any of the following:

15. High blood pressure, high cholesterol, varicose veins, deep vein thrombosis (DVT) or aneurysm?* ☐ Yes ☐ No
16. Respiratory condition including but not limited to asthma, bronchitis, pneumonia or sleep apnoea?* ☐ Yes ☐ No
17. Been diagnosed with or had any symptoms of a mental health illness or issue, including but not limited to: Depression, anxiety, adjustment disorder, Post natal depression (PND), stress (such as work stress or bullying), grief reaction, insomnia, prolonged fatigue, panic attacks, prolonged sadness, social withdrawal, or any other symptoms that have impacted your mental health or resulted in counselling or a mental health care plan?* ☐ Yes ☐ No
18. Gastrointestinal condition (liver, oesophagus, stomach, gall bladder, pancreas or bowel) including but not limited to irritable bowel syndrome (IBS), polyps, reflux, hernia, ulcer or hepatitis B or C? ☐ Yes ☐ No
19. Thyroid condition including but not limited to hypothyroidism, hyperthyroidism, goitre or thyroiditis? ☐ Yes ☐ No
20. Osteoarthritis, osteoporosis or gout? ☐ Yes ☐ No
21. Back or neck pain, strain or stiffness, sciatica, scoliosis, disc disorders, whiplash or any other non-specific back or neck pain?* ☐ Yes ☐ No
22. Joint (e.g. wrist, elbow, shoulder, ankle, knee, hip), bone or muscle pain or disorder including fractures, ligament injuries or repetitive strain injury (RSI)? ☐ Yes ☐ No
23. Chronic fatigue syndrome, chronic pain or fibromyalgia? ☐ Yes ☐ No
24. Blood condition including but not limited to anaemia, haemochromatosis or haemophilia? ☐ Yes ☐ No
25. Skin cancer, cyst, lesion or mole, Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC)? ☐ Yes ☐ No
26. Eczema, dermatitis, psoriasis or any other skin condition (other than acne)? ☐ Yes ☐ No
27. Kidney or bladder condition, including but not limited to polycystic kidney disease, urinary tract infections, kidney stones, blood or protein in the urine, prostate or testicular disorders (males only)? ☐ Yes ☐ No
28. Head injury, epilepsy, fits, convulsions, fainting attacks or persistent headaches or migraines? ☐ Yes ☐ No
29. Eye condition (other than sight problems corrected by glasses, contact lenses or laser surgery) including but not limited to cataracts, glaucoma, keratoconus, retinal detachment, uveitis, optic neuritis, blurred or double vision or blindness? ☐ Yes ☐ No
30. Ear condition including but not limited to impaired hearing or deafness, tinnitus, Meniere's disease or vertigo? ☐ Yes ☐ No

16. HEALTH DETAILS (continued)

Female Only

31. Any condition of the cervix (including abnormal Pap smear or abnormal cervical screen), ovary, uterus, breast or endometrium? ☐ Yes ☐ No

32. Are you currently pregnant?

☐ No ☐ Yes → What is your due date? DD / MM / YYYY

33. Complication of pregnancy or childbirth or have you had a child with congenital abnormalities? ☐ Yes ☐ No

COVID-19

34. Have you ever been required or advised to self-isolate or quarantine? ☐ Yes ☐ No

35. Do you currently have any flu-like symptoms e.g. fever, cough, sore throat, runny nose or fatigue? ☐ Yes ☐ No

If yes, to either of the above, please advise your circumstances including dates if you have had COVID-19, a description of your symptoms, whether you've been hospitalised and any ongoing issues.

If you have not had COVID-19, please advise any periods of self-isolation or quarantine, including dates and test results.

17. ADDITIONAL MEDICAL STATEMENT

For any questions to which you answered yes in Section 16 (Health details), please complete the relevant questionnaire or add details here. If more information needs to be added please submit separately.

	QUESTION NUMBER _____	QUESTION NUMBER _____	QUESTION NUMBER _____
1. What was the condition and which part of the body was affected?			
2. What was the date symptoms first started including a description of the symptoms?	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
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 the duration of attacks or symptoms?			
6. For how long were you unable to work or perform your normal duties/activities?			
7. If a hospital visit was required, please provide the date and duration of your stay.	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
8. What advice/ treatment did you receive?			
9. Are you still receiving treatment? If so, please advise the nature and the frequency of treatment.			

17. ADDITIONAL MEDICAL STATEMENT (continued)

	QUESTION NUMBER _____	QUESTION NUMBER _____	QUESTION NUMBER _____
10. When did you last suffer from any symptoms?	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
11. What is your degree of recovery (%)?			
12. Please supply the name and address of all doctors or hospitals consulted for this specific condition.			
13. Does your current general practitioner have records for this condition?			
14. Please provide any further information you think may assist in underwriting your application.			

18. INSURANCE DECLINED OR MODIFIED

If more than once, please provide details for all circumstances.

1. Have you ever had any application for Life, TPD, Critical Illness, Income Protection or Business Expense insurance refused, modified or offered on non-standard terms?

☐ No → Go to Section 19. ☐ Yes → Complete Questions 2 to 5.

2. How long ago were these modified terms offered? (select all that apply)

☐ Within the last 3 years ☐ Between 3 and 5 years ago ☐ More than 5 years ago

3. Please advise the type of modified terms offered (if known, select all that apply)

☐ Declined ☐ Loading/Extra premium ☐ Benefits reduced

☐ Deferred/Postponed ☐ Exclusion(s) ☐ Term of plan reduced

☐ None of the above ☐ More than one of the above ☐ Unknown

4. The modified terms were due to which of the following? (select all that apply)

☐ Medical reasons ☐ Occupation ☐ Pastime(s) ☐ Unknown

☐ Other (please specify)

5. If you have ever had an application for insurance refused, modified or offered on non-standard terms, has all information relevant to the reason(s) for these decisions or outcomes been disclosed in this application?

☐ Yes ☐ No→ Please include details.

19. CLAIMS

If more than once, please provide details for all circumstances.

1. Have you ever received claim payments, including but not limited to workers compensation or other insurance payments for an accident, sickness or disability or are you currently making a claim (including by TAL)?

☐ No → Go to Section 20. ☐ Yes → Complete Questions 2 to 6.

2. Has the claim been finalised?

☐ Yes ☐ No→ Please advise the details of the claim including when it was, who it is/was made against (eg workers compensation, an insurance company), the amount of money claimed, the condition claimed for, current status of this condition and total time off work.

3. Have you made a full and complete recovery from the condition for which you claimed?

☐ No ☐ Yes→ How long have you been fully recovered?

☐ Less than 1 year ☐ Between 1 and 2 years ☐ Between 2 and 5 years ☐ More than 5 years

4. How much time did you take off work and/or your usual daily activities due to this condition?

☐ Less than 1 month ☐ Between 1 and 3 months ☐ Between 3 and 6 months ☐ More than 6 months

5. If you haven't made a full recovery, please provide further details including the name of the condition and the nature of the ongoing impairments/symptoms.

6. Is the condition for which you've claimed disclosed in this application? ☐ Yes ☐ No

20. MENTAL HEALTH CONDITION QUESTIONNAIRE

To be completed if you have had depression, anxiety, stress, fatigue or any other mental health condition or symptoms.

1. Did you first experience symptoms within the last six months?

☐ No ☐ Yes→ Please tell us about what you think the underlying cause was/is, number and frequency of episodes, when you last experienced symptoms, treatment received, time off work required and name and address of treating doctor.

2. Has your condition or symptoms ever got to the point where you have considered or attempted suicide or self-harm?

☐ No ☐ Yes→ Please provide as much detail as you are comfortable with (e.g. how often and when this last occurred etc.)

3. In the last 5 years have you been admitted to hospital due to your symptoms?

☐ No ☐ Yes→ Please provide details regarding how often you have been hospitalised, the duration of each stay, and the date of your last stay.

20. MENTAL HEALTH CONDITION QUESTIONNAIRE (continued)

4. In the last 2 years, how many days have you had off work or been unable to carry out your usual daily activities due to this condition?

Days ☐

5. In the last 5 years, have you been you under the care of or been referred to a psychiatrist?

☐ No ☐ Yes→ Please describe the type and frequency of treatment, including any medications taken and the dosage. If medication, please advise when this commenced and the dates of any changes to the treatment type or dosage. If counselling, please advise how regularly this occurs.

6. When did you last experience symptoms of this condition? DD / MM / YYYY

7. Please provide any other information you think may assist in underwriting your application, including the names and addresses of doctors or other health care professionals consulted, and the date first and last consulted.

21. BACK/NECK CONDITION QUESTIONNAIRE

To be completed if you have had a back or neck condition.

1. Do you plan to have surgery for your back/neck condition or have you had surgery in the past?

☐ No ☐ Yes→ Please advise the cause of the condition, the date symptoms were first and last experienced, the type of treatment you are receiving, the type of surgery you've had or which is to be undertaken, the section of the back affected, time off work and the degree of recovery.

2. Have you ever been diagnosed as having a bulging disc, prolapsed disc, slipped disc, disc protrusion, herniated disc or any other disc condition?

☐ No ☐ Yes→ Please advise the type and frequency of medication taken, the cause of the condition, the date symptoms were first and last experienced, the frequency and duration of episodes, the section of the back affected, time off work and whether a full recovery has been made.

3. Do you require regular painkillers/anti-inflammatories or cortisone injections?

☐ No ☐ Yes→ Please advise the type and frequency of medication taken, the cause of the condition, the date symptoms were first and last experienced, the frequency and duration of episodes, the section of the back affected, time off work and whether a full recovery has been made.

21. BACK/NECK CONDITION QUESTIONNAIRE (continued)

4. Have you had to modify your work duties or change your occupation as a result of this condition?

☐ No ☐ Yes→ Please advise the type and frequency of medication taken, the cause of the condition, the date symptoms were first and last experienced, the frequency and duration of episodes, the section of the back affected, time off work and whether a full recovery has been made.

5. Have you had any time off work due to this condition?

☐ No ☐ Yes→ Please advise the amount of time you've taken off work in total, and the amount of time you've taken off work in in the last five years specifically (in days).

6. How many episodes of back/neck pain have you had?

7. How long ago did you last experience symptoms?

☐ Within the last year ☐ 1 to 4 years ☐ 4 to 5 years ☐ More than 5 years

8. Have you required any form of treatment for your back/neck condition? ☐ Yes ☐ No

9. How long ago did you last require treatment?

☐ Within the last year ☐ 1 to 4 years ☐ 4 to 5 years ☐ More than 5 years

10. On average, do/did your symptoms last more than one month? ☐ Yes ☐ No

11. Please indicate which sections of your spine were affected. (select all that apply)

☐ Upper spine only (including neck) ☐ Lower spine only ☐ Middle spine only ☐ More than one section

☐ Not sure

12. Please provide any other information you think may assist us in underwriting your application, including the name and address of medical practitioners attended.

22. ASTHMA QUESTIONNAIRE

To be completed if you have had asthma.

1. Was this childhood asthma only, with no further symptoms or treatment?

☐ Yes → No further details need to be provided in this section.

☐ No → Complete Questions 2 to 6.

2. Within the last two years, have you been admitted to hospital for more than 24 hours for treatment of this condition?

☐ No ☐ Yes→ Please provide full details including name and frequency of treatment, time off work or restriction to usual duties, whether you have an Asthma Action Plan in place and the name and address of the doctor who has records.

22. ASTHMA QUESTIONNAIRE (continued)

3. Within the last 12 months, have you required more than two courses of steroid tablets (not inhalers)?

☐ No ☐ Yes→ Please provide full details of asthma treatment, time off work or restriction to usual duties, whether you have an Asthma Action plan in place and the name and address of the doctor who has records.

4. How often would you experience symptoms (eg coughing, wheezing, shortness of breath or chest tightness)?

5. Do you experience symptoms at night?

☐ No ☐ Yes→ Please provide full details of this condition including date of first and last symptoms, frequency and severity of episodes, any types of treatment required, and the name and address of your treating doctor.

6. Within the last 12 months, have you had more than five consecutive days off work or been unable to carry out your normal daily activities due to asthma only?

☐ No ☐ Yes→ Please provide full details of asthma treatment, time off work or restriction to usual duties, whether you have an Asthma Action plan in place and the name and address of your treating doctor.

23. CHOLESTEROL QUESTIONNAIRE

To be completed if you have had raised cholesterol.

1. When was your raised cholesterol diagnosed? DD / MM / YYYY

2. What type of treatment are you taking for your raised cholesterol?

3. What was your latest reading?

4. Apart from the regular blood tests for your cholesterol, have you been advised to have any further cardiovascular investigations?

☐ No ☐ Yes→ Please provide information to assist in underwriting your application including details and date of latest readings (including HDL/LDL if known), details of medication, investigations and follow up and the name and address of the doctor consulted.

23. CHOLESTEROL QUESTIONNAIRE (continued)

5. Are you currently on medication for this condition?

☐ Yes ☐ No→ Please provide details.

a) Did you cease medication for raised cholesterol on the advice of your doctor? ☐ Yes ☐ No

b) Has your cholesterol been checked since ceasing medication? ☐ Yes ☐ No

c) What was your latest reading?

6. Please provide any further information you think may assist in underwriting your application, including the name and address of the doctor who treats this condition.

24. HIGH BLOOD PRESSURE QUESTIONNAIRE

To be completed if you have had high blood pressure.

1. When was your high blood pressure diagnosed? DD / MM / YYYY
2. Have you had your blood pressure taken since being told you had high blood pressure? ☐ Yes ☐ No
3. What was your latest reading?
4. If latest reading unknown, what did your doctor advise in relation to your blood pressure reading?
5. What type of treatments are you currently undertaking?
6. If you are taking medication, how many types do you take per day to control your blood pressure?
7. How often do you attend your GP to have your prescription for blood pressure tablets renewed?
8. Apart from the initial investigations when first diagnosed, have you been advised to have or have you undergone any further cardiovascular (eg ECG) or urinary investigations in the last 12 months?

☐ No ☐ Yes→ Please provide any other information to assist us in underwriting your application such as medications (including previous medications and dates changed), results of tests and the names and addresses of health professionals consulted.

24. HIGH BLOOD PRESSURE QUESTIONNAIRE (continued)

9. For females, was your high blood pressure diagnosed during pregnancy? ☐ Yes ☐ No ☐ Not applicable

If yes, please advise if your blood pressure has returned to normal, whether any treatment was required and whether this treatment has ceased or is required on an ongoing basis.

10. Please provide any other information you think may assist in underwriting your application including the name and address of the doctor who treats this condition.

Would you like TAL to arrange any medical exams or blood tests that may be required to complete this application?

☐ Yes ☐ No

25. DOCTOR/CLINIC DETAILS

1. Do you have a general practitioner (GP) or medical practice that you usually attend?

☐ No ☐ Yes→ Complete the following.

Name

Street address

Suburb State Postcode

Country

Contact number Contact type Business ☐ Mobile ☐

Email

2. How long ago was your last consultation with this GP or medical practice?

☐ Less than 6 months ☐ 6 to 12 months ☐ 1 to 2 years ☐ 2 to 5 years ☐ 5 years or more

3. How long have you been attending this GP or medical practice?

☐ Less than 6 months ☐ 6 to 12 months ☐ 1 to 2 years ☐ 2 to 5 years ☐ 5 years or more

4. If less than two years, or you don't currently have a GP or medical practice that you usually attend, please provide the name and contact details of your previous GP or medical practice attended.

Name

Street address

Suburb State Postcode

Country

Contact number Contact type Business ☐ Mobile ☐

Email

26. PROVIDING YOUR TAX FILE NUMBER

The *Superannuation Industry (Supervision) Act 1993* allows the trustee of a superannuation fund to collect your tax file number (TFN).

Your TFN will be used for authorised purposes only. This includes finding and identifying your superannuation benefits, calculating tax on any benefit payments and providing information to the Australian Taxation Office (ATO) or other prescribed authority. These purposes may change in the future. It is not an offence if you do not provide your TFN but if we do not hold your TFN, the following may apply:

- we may not be able to process your application
- your insurance cover could lapse, as we are unable to accept personal contributions to pay for insurance and/or your contributions may not be enough to cover premiums due to the extra tax being applied to the contributions
- you will not be able to make personal or spouse contributions to your superannuation
- employer and salary sacrifice contributions will be taxed at the highest marginal tax rate plus the Medicare levy. Please refer to www.ato.gov.au for more information on income tax rates
- for pre 1 July 2007 members, concessional contributions of up to $1,000 will be taxed at 15%. For concessional contributions in excess of $1,000, the whole amount will be taxed at the highest marginal tax rate plus the Medicare levy.
- locating all your superannuation benefits when you retire may be harder, and
- lump sum withdrawals will not be concessionally taxed.

We may also provide your TFN to another superannuation provider if your benefits are being transferred to that superannuation provider, unless you request in writing that it not be disclosed.

By completing and returning this form, you agree to provide your TFN to the Trustee of TAL Super.

27. DECLARATION

I/We declare that I/we have read the following statements, and I/we agree and acknowledge that:

- I/we have received a copy of and read the Accelerated Protection Combined Product Disclosure Statement and Policy Document (PDS) and, if my/our cover is to be structured through TAL Super, the Accelerated Protection through TAL Super Product Disclosure Statement (TAL Super PDS), dated 24 September 2021
- I/We understand there is a duty to take reasonable care not to make a misrepresentation to the insurer before entering into a contract of insurance, extending or making changes to existing insurance, and reinstating insurance.
- I/We also understand that if this duty is not met it can have serious impacts on my/our insurance
- I/We have understood all the questions I/we have been asked and I/we have provided TAL with true, accurate and complete answers in my/our application (including this Application Form, quotes and all other forms, questionnaires and information provided to TAL)
- To the extent that any of the questions were answered by my/our financial adviser, those answers have been checked by me/us and I/we certify that they are true, accurate and complete
- I/we acknowledge and agree that the answers and information provided in my/our application (including this Application Form, quotes and all other forms, questionnaires and information provided to TAL) shall be relied upon by TAL in deciding whether to issue a policy and if so on what terms and for what premium. I understand that, notwithstanding any Authorities which may be provided to TAL by me/us, TAL will not necessarily seek or obtain any further information in relation to my/our application, and that any decision to seek further information is solely within TAL's discretion
- Where my/our application has been submitted electronically to TAL, I/we will review
  - a printout of the application submitted and will notify my/our financial adviser of any answers which are incorrect, incomplete or inaccurate, or
  - a summary received by email (if I/we have provided TAL with an email address for the purpose of receiving a summary of the application by email) and will notify TAL of any answers which are incorrect, incomplete or inaccurate within five business days
- I/we will cooperate with TAL if modifications to the Policy conditions are required because of any changes to the answers TAL are notified of
- Where I/We have not notified TAL that I/We prefer to receive communication by post, I/We agree to receive any communications relating to my/our policy/ies and TAL's products and services electronically, including by email or SMS, where this is permitted by law.
- I/We acknowledge that electronic communications may include attachments or hyperlinks to the communication, requiring the communication to be opened on a web page or using a software reader.
- I/We acknowledge that such communications may include (without limitation), personal and sensitive information (as those terms are defined in the Privacy Act 1988), Product Disclosure Statements or Financial Services Guides, policy documents, copies of application forms, and other disclosure documents and communications.
- I/We understand that it is my/our responsibility to ensure that I/We provide to TAL and keep up to date an electronic address capable of receiving these electronic communications.
- I/we understand that by signing this form, I/we consent to the collection, use and disclosure of my/our personal information in accordance with the section in the PDS headed 'Your Privacy'
- I/we understand that my/our financial adviser is my/our agent and not the agent of TAL
- I/we understand that TAL may accept information from my/our financial adviser or their representative, and that TAL will rely on any such information in deciding whether or not to accept my/our application and in relation to all matters of administration
- In relation to any tax returns submitted in support of this application, I/we confirm that these are the tax returns submitted to the Australian Taxation Office and no subsequent adjustments have been made or are expected

27. DECLARATION (continued)

- In the event that TAL determines to not accept my/our application on standard terms
  - I/we authorise TAL to inform my/our financial adviser or their representative, of the reasons for that decision
  - I/we understand that TAL will not provide copies of medical or other reports to my financial adviser or their business without first obtaining my/our consent, and
  - I/we authorise my/our financial adviser or their representative to communicate to TAL my/our acceptance of any alternative terms on my/our behalf, and
- I/we have authorised TAL to debit my/our premiums if credit card or bank account details are provided with my/our application.

Signature of life to be insured ✗ Date DD / MM / YYYY

Signature of Policy Owner 1 ✗ Date DD / MM / YYYY
(if different to the life to be insured)

Signature of Policy Owner 2 ✗ Date DD / MM / YYYY
(if different to the life to be insured)

(For adviser reference only, this form is not to be submitted for new applications)

28. ADVISER DETAILS

Principal authorised representative

TAL adviser number

Authorised representative name

Dealer group

Commission split (whole numbers) New business % Servicing %

Contact number Contact type Business ☐ Mobile ☐

Email

Shared authorised representative

TAL adviser number

Authorised representative name

Dealer group

Commission split (whole numbers) New business % Servicing %

Contact number Contact type Business ☐ Mobile ☐

Email

Note If splitting commission, new business and servicing commission must each total 100%.

29. ADVISER NOTES

CONTACTING TAL

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1300 351 133

tal.com.au

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