



# Short Personal Statement

Products previously branded BT, Westpac or St.George

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## IMPORTANT INFORMATION

This Short Personal Statement is required for the cancellation and replacement of:

- Protection Plans Policies issued under a Product Disclosure Statement (PDS) dated before 28 April 2006; or
- St.George Protection Choices Policies which commenced before 1 January 2008

The ways in which TAL collects, uses, secures and discloses your 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](http://www.tal.com.au/privacy-policy) (applicable to all life insurance policies) and [www.mercer.com.au/privacy.html](http://www.mercer.com.au/privacy.html) (applicable to TAL Super policies only).

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 553 764 or by email to [customerservice@tal.com.au](mailto:customerservice@tal.com.au).

## 1. ANSWERING OUR QUESTIONS – YOUR RESPONSIBILITY

Important notice for the Insured Person – please read before completing this form.

### What you need to tell us

Any cover that is offered to you will be based on the completeness and accuracy of the answers that you give us. It is your responsibility to take reasonable care to answer all our questions honestly, accurately, and completely to the best of your knowledge.

Every person to be insured under the Policy has the same responsibility. If you or any person to be insured under the Policy fail in this responsibility when answering questions, this may lead to us having the right to change the terms of the Policy or treat the Policy as if it never existed, reduce a benefit, or deny a claim in full.

This responsibility relates to your duty to take reasonable care not to make a misrepresentation.

If you are unsure about whether you should include information in response to a question, please include it.

Please remember to check over your application responses very carefully. You need to inform us as soon as possible of any errors, omissions, or matters overlooked in your answers to us.

### Your duty to take reasonable care not to make a misrepresentation

When applying for insurance, there is a legal duty for you to take reasonable care not to make a misrepresentation to us, 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.

### How do the answers impact my cover and payment of a claim?

Your claim may be denied or may not be paid in full, the Policy may be treated as if it never existed or its terms changed, if before the Policy is issued, extended, varied, or reinstated:

- you (or any other person to be insured under the Policy) do not take reasonable care to answer the questions we ask honestly, accurately, and completely to the best of your knowledge; or
- you (or any other person to be insured under the Policy) do not tell us if you think anything you have previously told us is incorrect or incomplete.

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

The insurer and issuer is TAL Life Limited ABN 70 050 109 450 AFSL 237848 (TAL Life) except for Term Life as Superannuation, Income Protection as Superannuation and Income Protection Assured as Superannuation, which are issued by Mercer Superannuation (Australia) Limited ABN 79 004 717 533 AFSL 235906 (MSAL) as trustee of the Mercer Super Trust ABN 19 905 422 981. MSAL does not guarantee the insurance. TAL is part of the TAL Dai-ichi Life Australia Pty Limited ABN 97 150 070 483 group of companies (TAL). MSAL is not part of the TAL group of companies. Any financial product advice is general in nature only and does not take into account any person's objectives, financial situation or needs. Before acting on it, the appropriateness of the advice for any person should be considered, having regard to those factors. Persons deciding whether to acquire or continue to hold life insurance issued by TAL Life should consider the relevant Product Disclosure Statement (PDS) available at [tal.com.au](http://tal.com.au). The Target Market Determination (TMD) for the product (where applicable) is also available at this web address.

### Genetic testing

- You do not need to tell us about any genetic test you have previously had or intend to have unless we specifically ask you.
- You are obliged to inform us of any diagnosis of a medical condition, even if the diagnosis resulted directly or indirectly from a genetic test.
- You may volunteer results of genetics tests where the outcome is favourable.

## 2. DETAILS OF THE INSURED PERSON

**This section should only be completed if your details have changed since the completion of the Initial Claim Form.**

Policy Number(s)	<input type="text"/>	<input type="text"/>	<input type="text"/>				
Title	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	<input type="checkbox"/> Dr	<input type="checkbox"/> Mx	Other <input type="text"/>
Insured Person's name	<input type="text"/>						
Date of birth	<input type="text" value="DD / MM / YYYY"/>						
Home phone number	<input 4"="" type="text" value="( )&lt;/td&gt;&lt;td&gt;Mobile phone number&lt;/td&gt;&lt;td colspan="/> <input type="text"/>						
Email address	<input type="text"/>						

Please indicate your preferred contact number and time(s) if we need to contact you.

<input type="checkbox"/> Home phone	<input type="checkbox"/> Mobile phone	Time:	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
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## 3. SMOKING AND VAPING

1. In the last 12 months, have you smoked or vaped any substance, including cigarettes, e-cigarettes, cigars, pipe tobacco? ☐ Yes ☐ No

Answer yes even if this was only socially, occasionally, or if you have completely stopped smoking/vaping in the last 12 months.

Yes → Please provide details below:

TYPE OF SUBSTANCE SMOKED OR VAPED	QUANTITY SMOKED OR VAPE PER DAY
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

2. In the last 3 months, have you used any nicotine replacement products? ☐ Yes ☐ No

This includes products such as nicotine patches, gum, lozenges, spray or inhalers.

## 4. FAMILY HISTORY

1. Have you or your immediate blood related family (parents, brothers or sisters), living or deceased, had any of the following conditions? ☐ Yes ☐ No

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Alzheimer's disease or any form of dementia</li><li>• Cancer</li><li>• Cardiomyopathy</li><li>• Coronary artery bypass</li><li>• Diabetes</li><li>• Familial polyposis of bowel (FAP)</li><li>• Heart attack</li><li>• Huntington's disease</li></ul> | <ul style="list-style-type: none"><li>• Motor neurone disease</li><li>• Multiple sclerosis</li><li>• Muscular dystrophy</li><li>• Parkinson's disease</li><li>• Polycystic kidney disease</li><li>• Stent</li><li>• Stroke</li><li>• Any other hereditary condition</li></ul> |
|---|---|

Yes → Please provide details below:

FAMILY MEMBER (MOTHER/FATHER/BROTHER/SISTER)	CONDITION	AGE DIAGNOSED
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 5. PERSONAL MEDICAL HISTORY

1. In the last 5 years, have you consulted or been referred to a specialist doctor?

☐ Yes ☐ No

You do not need to tell us about visits to an obstetrician for normal, uncomplicated pregnancy and childbirth.

Medical specialists are doctors, other than general practitioners, who deal with a specific area of medicine or surgery. Examples of medical specialists include dermatologist, cardiologist, gastroenterologist, neurologist, orthopaedic surgeon.

Yes → Reason for consult or referral and when consulted.

2. In the last 5 years, have you had any surgical procedure?

☐ Yes ☐ No

A surgical procedure involves an incision or cut to any part of the body. Examples include cutting out a skin lesion, gallbladder removal, heart surgery.

Yes → Type of surgery and when performed.

3. In the last 5 years, have you attended or been admitted to hospital (including the Emergency Department or Outpatient Clinic)?

☐ Yes ☐ No

You do not need to tell us about visits to hospital for normal, uncomplicated pregnancy and childbirth.

Yes → Date(s) and reason for hospital admission or attendance.

4. In the last 5 years, have you used or been advised to use medication prescribed by a health professional?

☐ Yes ☐ No

You do not need to tell us about medication for:

- Hair loss
- Hay fever
- Cold or flu
- Contraception
- Antibiotics taken for no more than 4 weeks in any 12-month period

Yes → Name(s) or type of medication and reason for use.

5. Have you been told to seek any medical advice, test (excluding genetic tests), investigation or treatment that you have not yet had?

☐ Yes ☐ No

Yes → Reason for advice, tests or investigations and when planned for.

6. Are you now off work or limited in your ability to perform your usual work duties due to any injury, illness or symptoms? ☐ Yes ☐ No

Yes → Please provide details below:

REASON AND TIME OFF WORK OR LIMITATION	DATES OFF WORK OR ON LIMITED DUTIES	TOTAL AMOUNT OF TIME OFF WORK OR LIMITATION
<input type="text"/>	DD / MM / YYYY	<input type="text"/>
<input type="text"/>	DD / MM / YYYY	<input type="text"/>
<input type="text"/>	DD / MM / YYYY	<input type="text"/>
<input type="text"/>	DD / MM / YYYY	<input type="text"/>

7. Are you currently on claim, or are you expecting to make a claim, on any death (including terminal illness), TPD, trauma (critical illness/living) or income protection policy that you have in place with any insurance provider? ☐ Yes ☐ No

Yes → Reason for claim, type of claim and insurance provider

## 6. OCCUPATION AND INCOME

Please only complete this section if you are applying for Income Protection Own Occupation or General Cover, Total and Permanent Disability (TPD) or Business Overheads cover.

1. What is your current occupation(s)?

2. What industry do you work in?

3. Are you an employee or self-employed? You are not considered an 'employee' if you are an owner of the company or trust that pays your salary.

☐ Employee ☐ Self-employed ☐ Not working

4. How many hours per week do you work in a typical week?

5. How many months per year do you work?

6. Please describe the duties you perform as part of your occupation(s) (e.g. office/admin, manual, hazardous duties):

7. What is your current annual income?

Please note that we are not asking for this information for the purpose of adjusting your monthly benefit.

### Definition of Income for Employees

This income amount can only include earnings derived from your personal exertion, before tax is deducted, including:

- Paid salary or wage from employment
- Consultation fees
- Salary sacrifice items (e.g. motor vehicle and personal super contributions)
- Overtime, bonuses, and commissions that are regularly paid to you.

This income amount cannot include:

- Employer superannuation contributions (Income Protection Assured or Income Protection Assured as Superannuation)
- Investment income or other income not earned through personal exertion, such as interest or dividends.

### Definition of Income for Self-employed

This income amount can only include earnings derived from your personal exertion, before tax is deducted, including:

- Your share of net business profit (i.e. your share of business revenue minus business expenses)
- Personal salary/wage
- Director's fees
- Personal superannuation contributions and personal motor vehicle expenses

This income amount cannot include:

- Other income not derived from personal exertion such as dividends, interest, and investment income.

## 7. EXISTING INSURANCE DETAILS

 Please only complete this section if you are applying for income protection or business overheads cover.

1. Do you have or are you applying for any income protection, salary continuance or business expense cover with products previously branded BT, Westpac or St.George or any other insurer, including insurance under a superannuation plan provided by your employer? ☐ Yes ☐ No

Yes → Please provide details below.

### Cover 1

Insurer	<input type="text"/>		
Type of insurance	<input type="text"/>		
Reason for cover	<input type="text"/>		
Was this cover underwritten?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date commenced	<input type="text" value="DD / MM / YYYY"/>	Insured amount	<input type="text" value="\$"/>
Waiting period and benefit period	<input type="text"/>		
Are you cancelling this cover in full?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### Cover 2

Insurer	<input type="text"/>		
Type of insurance	<input type="text"/>		
Reason for cover	<input type="text"/>		
Was this cover underwritten?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Date commenced	<input type="text" value="DD / MM / YYYY"/>	Insured amount	<input type="text" value="\$"/>
Waiting period and benefit period	<input type="text"/>		
Are you cancelling this cover in full?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## 8. APPLICATION FOR BUSINESS OVERHEADS OR BUSINESS OVERHEADS ASSURED

 Please only complete this section if you are applying for Business Overheads or Business Overheads Assured.

1. What percentage share of the business income is produced solely from your personal exertion or efforts?
2. Please list your share of the average monthly business expenses that the business will have to continue to meet if you are unable to work:

Accountant and auditor fees	<input type="text" value="\$"/>
Advertising costs	<input type="text" value="\$"/>
Cleaning, electricity, gas, heating, laundry, telephone, mobile phone, water	<input type="text" value="\$"/>
Leasing costs of equipment and vehicles	<input type="text" value="\$"/>
Rent or mortgage interest payments	<input type="text" value="\$"/>
Property rates and taxes	<input type="text" value="\$"/>
Business insurance premiums	<input type="text" value="\$"/>
Salaries for non-income producing employees, including superannuation, payroll tax and other salary related costs	<input type="text" value="\$"/>

Net costs associated with employing a locum if you are unable to work

\$

Other fixed expenses (give details)

\$

**Total average monthly expenses**

\$

## 9. INSURED PERSON'S DECLARATION AND AGREEMENT

I declare and agree that:

- I have read and understood the section titled 'Answering our questions – Your responsibility' in this form;
- my answers are important to the Insurer and I understand that the Insurer relies on the answers I have given;
- I have taken reasonable care to answer all questions honestly, accurately, and completely to the best of my knowledge;
- I understand that failure to do so may lead to the Insurer having the right to change the terms of the Policy or treat the Policy as if it never existed, reduce a benefit, or deny a claim in full;
- I understand that I am responsible for the answers given even where someone has helped me to complete this form;
- I have read and understood the section titled 'Protection of your privacy' in the PDS and in the privacy policies and I agree to the various uses and disclosures of my personal information as set out in that section;
- I understand that if my application is accepted with an exclusion, the exclusion wording may contain sensitive health information and will appear on the policy schedule and will be available to the Policy Owner(s) and the servicing financial adviser;
- the email address provided in this application may be used to electronically communicate with me, including information in relation to my application and my insurance;
- the replacement Policy I/we have applied for will not become effective until this application is accepted by the Insurer in writing.

☐ I, the Insured Person on this application, authorise the Insurer to disclose personal, medical and financial information obtained in the course of assessing this application for life insurance to my Adviser. This may also include 'Sensitive Information' as defined in the Privacy Act.

I understand that the purpose of disclosing this information is to explain the reason for any loadings, exclusions or alternative terms that may be applied to the above Policy. In addition, if the application on my life application is declined, to explain the reason for this decision.

I understand that the Insurer will not provide copies of medical or other reports to my Adviser.

Signature of  
Insured Person

X

Date

DD / MM / YYYY

Signature of Witness

X

Date

DD / MM / YYYY

### SUBMITTING THIS FORM

Please return your completed form and any supporting documents by either:

✉ TAL Life  
GPO Box 5467  
Sydney NSW 2001

@ PPUWAlterations@tal.com.au

### CONTACTING TAL

@ PPUWAlterations@tal.com.au

☎ 1300 553 764

🌐 tal.com.au

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