

Member's Personal Statement

Policy number

Member number

Plan administrator

YOUR DUTY OF DISCLOSURE

Before you enter into a life insurance contract, you have a duty to tell us anything that you know, or could reasonably be expected to know, 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 contract.

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 you do not tell us something

In exercising the following rights, we may consider whether different types of cover can constitute separate contracts 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 contract within 3 years of entering into it.

If we choose not to avoid the contract, 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 contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the contract or reduce the amount you have been insured for, we may, at any time vary the contract 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 contract has a surrender value or provides cover on death.

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

1. PERSONAL DETAILS

Name of plan

Policy Number

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

☐ Other

Surname

Given name

Date of birth

Gender

Female ☐ Male ☐

May TAL contact you directly to clarify or gather information in relation to this application?

If yes, preferred method of contact:

Email ☐

Phone ☐

Contact time

Email address

Phone No.

2. OCCUPATION DETAILS

1. ☐ Self employed ☐ Employee full-time OR ☐ Part-time hours p/week weeks p/year
2. Your occupation Industry
3. Duties performed, including % of time spent in each.
-
4. Annual salary (includes packaged items but excludes bonuses/commission) \$

3. INSURANCE APPLICATION

- Death sum insured TPD sum insured
- Monthly income benefit \$ Benefit period Waiting period
1. Is this an increase? Yes ☐ No ☐
2. Have you ever held or applied for any life, disability, accident & sickness or trauma insurance, that was declined, postponed, had the premium increased or modified, or had a current policy cancelled or renewal refused? Yes ☐ No ☐
3. Have you claimed on any type of disability, trauma, accident and sickness or such benefits as Workers' Compensation or Motor Vehicle Third Party? Yes ☐ No ☐
4. Do you have, or are you applying for, any other life or disability cover? Yes ☐ No ☐

If yes to 2, 3 and or 4, please provide full details below.

Name of company	Cover type	Sum insured /monthly benefit	Date of application or claim	State any loadings/ exclusions	Reason for decision/ claim	Duration of claim	Recovery %	Is cover to be replaced? Y/N
		\$	/ /					
		\$	/ /					
		\$	/ /					

4. HABITS AND ACTIVITIES

1. Do you drink alcohol? Yes ☐ No ☐
- If yes, state type, number of standard drinks per day and number of days per week when alcohol is consumed.
Standard drink = 1 nip spirits, 1 wine glass (100ml), 10oz/285ml beer.
-
2. Have you smoked in the past 12 months? Yes ☐ No ☐
- If yes, state form and daily quantity.
-
3. Have you ever used or injected yourself with any drug not prescribed by a doctor, or received counselling or treatment for the use of alcohol or drugs? Yes ☐ No ☐
- If yes, complete a drug use or alcohol consumption questionnaire.
4. Do you currently, or do you intend to engage in any hazardous pastime and/or sporting activity such as aviation (other than as a fare paying passenger travelling over recognised routes), motor racing, diving, football, parachuting, hang-gliding or any other sport? Yes ☐ No ☐
- If yes, please complete a sports and pastimes statement.

4. HABITS AND ACTIVITIES (CONTINUED)

5. Do you intend travelling outside Australia within the next two years?
If yes, please provide details below (where, when, duration and reason).

Yes ☐ No ☐

6. Are you an Australian or New Zealand citizen?

Yes ☐ No ☐

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

Yes ☐ No ☐

If no to 6 and 7, please advise type of visa, expiry date, plans for applying for permanent residency and nationality/current citizenship.

5. PERSONAL STATEMENT

1. Please state your:

Height (cm)

Weight (kg)

2. Name and address of your usual doctor or medical centre

Surname

Given name

Address

Suburb

State

Postcode

3. Details of last medical consultation with your usual doctor or medical centre

Date

DD / MM / YYYY

Reason

Outcome/results

4. If you have attended that doctor for less than 12 months, name and address of previous doctor

Surname

Given name

Address

Suburb

State

Postcode

5. a) Within the LAST THREE YEARS have you consulted, been examined, treated by, or received advice from any doctor, psychologist, psychiatrist, counsellor, chiropractor, physiotherapist or any other health care professional (naturopath, etc) or been in a hospital or been advised to have an operation or taken any medication, drugs, stimulants, sedatives or tranquillisers?

Yes ☐ No ☐

- b) Have you EVER had an ECG, X-ray, transfusion, mammogram, ultrasound, surgery or any other investigation?

Yes ☐ No ☐

- c) Have you EVER had any blood tests which revealed an abnormality e.g. raised blood sugar, liver function, renal function results, or anaemia, etc?

Yes ☐ No ☐

- d) Do you contemplate seeking any medical examination, advice, treatment or surgery for any other current health condition, in the future?

Yes ☐ No ☐

5. PERSONAL STATEMENT (CONTINUED)

Please provide full details for all 'Yes' answers.

Question	Dates (from/to)	Name / Address of doctor, hospital or clinic	Condition, medications, treatments & time off work	Recovery %

6. PERSONAL STATEMENT (GENERAL MEDICAL QUESTIONS)

Please provide details for all 'Yes' answers in General Medical Questionnaire at Section 7.

1. Have you ever had, been advised that you had, or received advice or treatment for any of the following:

a) High blood pressure, raised cholesterol, chest pain, heart attack, rheumatic fever, stroke or circulatory disorder?

Yes ☐ No ☐

b) Bowel, stomach or intestinal problem, gall bladder, hepatitis or liver disease?

Yes ☐ No ☐

c) Epilepsy, stroke, paralysis, multiple sclerosis, fainting attacks?

Yes ☐ No ☐

d) Depression, anxiety, panic attacks, stress, chronic fatigue, fibromyalgia or any mental or nervous condition?

Yes ☐ No ☐

e) Diabetes, sugar in urine, pancreatic or thyroid problem?

Yes ☐ No ☐

f) Cancer, tumour, melanoma, sunspots, mole or growth of any kind?

Yes ☐ No ☐

g) Disease, injury or disorder of joints, neck, back or bones, gout, arthritis or a repetitive strain injury or tendonitis?

Yes ☐ No ☐

h) Impairment of sight, hearing or speech?

Yes ☐ No ☐

i) Asthma, bronchitis, sleep apnoea, or any lung complaint?

Yes ☐ No ☐

j) Leukaemia, haemochromatosis, anaemia, or any blood problems?

Yes ☐ No ☐

k) Kidney, prostate, or bladder problems?

Yes ☐ No ☐

l) Psoriasis, eczema, or any skin problem?

Yes ☐ No ☐

m) Any other disability, congenital abnormality, deformity or symptoms of ill health, illness or injury?

Yes ☐ No ☐

n) Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus?

Yes ☐ No ☐

o) Have you ever engaged in any activity/ies reasonably accepted to having an increased risk of exposure to the HIV/AIDS virus?

Yes ☐ No ☐

6. PERSONAL STATEMENT (GENERAL MEDICAL QUESTIONS) CONTINUED

Females only

p) Have you ever had any gynaecological conditions (e.g. endometriosis, abnormal Pap smear, etc)?

Yes ☐No ☐

q) Have you ever had any complications of pregnancy or childbirth?

Yes ☐No ☐

r) Are you currently pregnant?

Yes ☐No ☐

If yes, what is the expected delivery date?

 / /

s) Have you ever had a breast lump (even if you have not seen a doctor about it)?

Yes ☐No ☐

2. Family History

Has any of your immediate family (mother, father, brother or sister), suffered from diabetes, heart disease, cancer, kidney disease, high blood pressure, mental health condition, haemophilia, Huntington's disease or any other hereditary disease?

Yes ☐No ☐

3. If yes, please provide details in the table below.

Relationship to member	Medical condition (e.g. breast cancer, heart attack, type 2 diabetes)	Age when diagnosed	Age at death (if applicable)

7. GENERAL MEDICAL QUESTIONNAIRE

Please provide details for all 'Yes' answers in Section 6 A to S. Please complete on a separate sheet if required.

Question No.	Q.	Q.	Q.	Q.
Specific condition				
a) Date symptoms first started and description of symptoms.				
b) What was the condition and which part and side of the body was affected?				
c) What was the medical diagnosis including results of x-rays and investigations?				
d) What was the frequency (daily, weekly, etc) of attacks or symptoms?				
e) What was the severity (mild/moderate/severe) and duration of attacks or symptoms?				
f) How long were you unable to work or perform your normal duties/activities?				
g) If a hospital visit was required, please provide date and duration of your stay.				
h) What advice/treatment did you receive?				
i) Are you still receiving treatment? If so, please advise nature and frequency of treatment.				
j) Date treatment/medication ceased.				
k) When did you last suffer from any symptoms?				
l) Degree of recovery (%).				
m) Please supply the name and address of all doctors, hospitals or other practitioners consulted.				

PRIVACY

The Privacy of TAL customers is important and TAL is bound by obligations imposed by current privacy laws including the Australian Privacy Principles.

The way in which TAL collects, uses, secures and discloses your personal information is set out in the TAL Privacy Policy available at <http://www.tal.com.au/Privacy-Policy> or free of charge on request to TAL by telephoning 1800 666 136.

Collection and use of personal information

We collect personal information, including your name, age, gender, contact details, health information, salary, and employment information so that we may assess and administer our products and services to you. In certain circumstances, such as applications for life insurance products and claims, we may be required to collect personal information of a sensitive nature such as lifestyle and medical history information. If you do not supply the information that is required, we may not be able to provide our products and services to you or pay the claim.

We may take steps to verify the information we collect; for example, a birth certificate provided as identification may be verified with records held by Births, Deaths and Marriages to protect against impersonation, or we may verify with an employer regarding remuneration information provided in a claim for income protection to ensure that it is accurate.

Disclosure of personal information

We disclose relevant personal information to external organisations that help us provide our services and may also disclose some of your personal information to other parties, when required to do so to provide our products and services to you, such as the following:

- Claims assessors and investigators, claims managers and reinsurers;
- Medical practitioners (to verify or clarify, if necessary, any health information you may provide);
- Any person acting on your behalf, including your financial advisor, solicitor, accountant, executor, administrator, trustee, guardian or attorney;
- Other insurers;
- For members of superannuation funds where TAL is the insurer, to the trustee, or administrator of the superannuation fund; and
- Other organisations to whom we outsource certain functions during the underwriting and claims processes, such as obtaining blood tests for underwriting purposes, rehabilitation providers, surveillance providers and forensic accountants.

There are situations where we may also disclose your personal information in circumstances where it is:

- Required by law (such as to the police or Australian Tax Office), and
- Authorised by law (e.g. under Court Orders or Statutory Notices).

DECLARATION

I acknowledge that I have read the notice of my duty of disclosure and understand that this duty also applies until formal notification of acceptance.

I have read and checked any answers not completed in my handwriting and to the best of my knowledge and belief all the answers to the questions in this Application and any supplementary application or personal statement which relate to me are true and correct and no information material to the assessment of this insurance has been withheld.

I, the Member, authorise and direct any medical or other practitioner to divulge at any time to TAL Life Limited or to any lawfully constituted tribunal any and all information concerning my state of health and medical history, acquired in the course of professional attendance or consultation. A photocopy of this authority is as valid as the original. To this extent, all professional confidence and privilege is waived.

I consent to my personal information (including health and sensitive information) being collected, used or disclosed by TAL Life Limited to its external service providers/contractors as contemplated in this form, including collecting it from or disclosing it to any medical practitioner or third party as required to assess, verify or process my application. This consent applies to any health and sensitive information collected on this form or future forms in relation to this insurance.

Full name of Member

Signature of Member

Date

DD / MM / YYYY

MEDICAL AUTHORITY

I agree that any medical practitioner or any other person who has been or may hereafter be consulted by me whether named by me or not will be hereby authorised and directed by me to divulge to TAL Life Limited or any legal tribunal all medical or surgical information he/she may have acquired with regard to myself. A copy of this authorisation shall be considered as effective and valid as the original.

Full name of Member

Signature of Member

Date

DD / MM / YYYY

Please return the completed form to:
Hejaz Financial Services, PO BOX 316 Thomastown VIC 3074