

# Prime Super Full Personal Statement

Note: This form is to be returned with the Prime Super Insurance Application.



Part of your Community

Complete this form if the total sum of your Death only or Death and TPD insurance through Prime Super will exceed \$300,000 including any cover you already hold. Check your last statement to see your level of cover at that time.

**Prime Super**  
 ABN 60 562 335 823  
 RN 1000276

This application is also to be completed if you are applying for Income Protection cover.

**Trustee**  
 Farm Plan Pty Limited  
 ABN 81 067 241 016  
 AFSL 219723  
 RSE L0000277

Please ensure that this form is completed in full prior to returning the form. Where a form is not fully completed, we will have to return the form to you for completion prior to starting the assessment process.

## Part A - Personal Details

Title (Please Tick One)  Mr  Mrs  Miss  Ms  Dr

Membership Number

Date of Birth

Surname

Gender  Male  Female

Given Names

In order to speed up the processing of this application the insurer may contact you on these numbers to obtain or clarify information provided.

Contact Numbers Business Hours  Mobile  Best time to contact you

## Part B - Insurance History

1. Has an application for Life, Trauma, TPD, Accident or Disability Insurance on your life ever been declined, deferred or accepted with a loading, exclusion or any other special condition or terms (Other than applied for here)?

(Please Tick One)  
 Yes  No

If YES, please give details:

Insurance Company Name	Date	Terms Offered and Reason	In force/Status
	/ /		
	/ /		
	/ /		

2. Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit from a superannuation fund, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any form of sickness, accident or disability compensation?

(Please Tick One)  
 Yes  No

If YES, please give details:

Benefit Type	Source	Reason for Claim	Date of Claim	Claim Amount	Date Claim Finished
			/ /	\$	/ /
			/ /	\$	/ /
			/ /	\$	/ /

## Part C - Activities and Pastimes

1. Do you currently engage in any of the following sports or other activities

a) Flying (other than as a fare paying passenger on a commercial airline)?

(Please Tick One)  
 Yes  No

b) Motor sports or racing (e.g. rally driving, trail bike riding)?

Yes  No

c) Scuba/Skin Diving?

Yes  No

d) Football of any code (including touch football or tag)?

Yes  No

e) Any other sport or hazardous activities, (e.g. parachuting, hang-gliding, ocean racing, body contact sports or recreation involving heights)?

Yes  No

If you have answered YES to any of the questions in section C, please provide further details in the table on the following page.

**Part C - Activities and Pastimes (Continued)**

Activity	Level of Participation (Recreational) (Recreational with Competition) (Semi Professional / Professional)	Number of times you participate per annum eg. Hours flown, number of dives / matches.	Do you receive an income from participating in this activity? (Yes/No)

Please provide any further details on any activity you perform (such as qualifications, average depth and maximum depth of dives etc).

(Please Tick One)

2. Do you plan to travel, reside or work overseas in the next 12 months?  Yes  No **If YES, please give details:**

**Part D - Doctor Details**

1. What is the name, address and telephone number of your usual Doctor? If you don't have a usual Doctor, give details of the last Doctor visited.

<p>Name of Doctor</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Street Address</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<p>Phone Number</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Fax Number</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>State <span style="margin-left: 20px;">Postcode</span></p> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 30%; height: 20px;"></div> <div style="border: 1px solid black; width: 30%; height: 20px;"></div> </div>
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2. What was the date of your last consultation? DDMMYYYY

3. Reason for last consultation?

4. Result of last consultation (e.g. Referral to specialist, ongoing treatment, routine with clear/normal results)?

**Part E - Family History**

1. Has any immediate family member (parents, brothers, siblings) suffered from or been diagnosed with diabetes, heart disease, cancer, stroke, kidney disease, mental illness, haemophilia, Huntington's disease or any other inherited or hereditary disease? (Please Tick One)  
 Yes  No **If YES, please give details:**

Relationship	Condition (If cancer please specify site and type)	Age at Diagnosis	Age at Death (if applicable)

**Part F - Personal Health Details**

1. What is your Height and Weight?      What is your **Height** (cm)      What is your **Height** (ft/ins)      What is your **Weight** (kgs)      What is your **Weight** (st/lbs)

     or                     or     

2. Have you smoked tobacco or any other substance at any time during the last 12 months? (Please Tick One)

Yes  No      **If YES, please give details:**

Substance Smoked (eg. Cigarettes, Cigars, etc.)	Amount Per Day	Amount Per Week	Amount Per Year

3. Do you drink alcohol? (Please Tick One)

Yes  No      **If YES, please give details:**

Type of Alcohol	Amount Per Day	Amount Per Week	Amount Per Year

**Part G – Medical History**

1. Have you ever had or sought advice or treatment, experienced symptoms, or suffered from any of the following:

- a) Stomach, intestinal or rectal disorder, gall bladder or liver disorder, including hepatitis? (Please Tick One)  Yes  No
- b) Paralysis or disorder of the brain or spinal cord, multiple sclerosis or any other neurological disorder?  Yes  No
- c) Any skin disorder (e.g. dermatitis, eczema or psoriasis)?  Yes  No
- d) Kidney disease (e.g. renal colic) or bladder disorder?  Yes  No
- e) Any defect in sight, hearing or speech, or any other physical deformity or abnormality?  Yes  No
- f) Any blood disorder (e.g. leukaemia, haemophilia or anaemia)?  Yes  No
- g) Drug or alcohol dependence, or used any drug not prescribed by a doctor (other than over-the-counter medicines for colds, etc)?  Yes  No
- h) Asthma, bronchitis or any other lung complaint?  Yes  No
- j) Chest pain, high blood pressure, heart or circulatory disorder, stroke or vascular disorder?  Yes  No
- k) Gastric or duodenal ulcer, or persistent indigestion?  Yes  No
- l) Thyroid disorder, diabetes or other pancreas disorder?  Yes  No
- m) Epilepsy, fainting or fits?  Yes  No
- n) Cancer, tumour, cyst or skin lesion?  Yes  No
- o) Disease (e.g. arthritis, gout) or injury to the muscles, tendons, bones, or joints, including the neck and back?  Yes  No
- p) Mental or nervous disorder including but not limited to depression, anxiety, stress, chronic tiredness or fatigue?  Yes  No
- q) Any other illness, injury, disease or disorder not mentioned above in this section G ?  Yes  No

2. Other than for those conditions mentioned above, have you within the last 5 years:
- a) Taken any prescribed medication on a regular basis (other than the contraceptive pill)?  Yes  No
  - b) Had any blood tests which revealed an abnormality?  Yes  No
  - c) Had any tests such as ECG, x-rays?  Yes  No

3. Are you considering seeking medical advice, treatment, tests or surgery in the next 12 months? (Please Tick One)

Yes  No

4. For Females (Please Tick One)

a) Are you currently pregnant?  Yes  No

**If Yes, when is the due date of the birth?**

b) Have you ever had any abnormal pap smear, breast ultrasound/mammogram or breast lump? (Please Tick One)

Yes  No

**If you have answered Yes to any question in Part G you will need to complete Part I - Health Questionnaire**

**Part G – Medical History**

To the best of your knowledge, is there any possibility that you have ever been infected with or have you ever tested positive for HIV (Human Immunodeficiency Virus) or Hepatitis or are you in a high-risk category (eg. Injected drugs other than as prescribed by a medical practitioner, shared needles, engaged in unprotected male to male sexual intercourse, worked as or engaged the services of a prostitute)?

(Please Tick One)

**If YES, please provide details:**  Yes  No

**Part I - Health Questionnaire**

Questions answered Yes to:

If there is insufficient room for your answer please attach an additional sheet (signed and dated).

**Part I - Health Questionnaire (Continued)**

a) Specify illness, injury or complaint:

b) Date the symptoms first started:

c) Date symptoms ceased:

d) Describe the symptoms:

e) How many times have you suffered from this condition?

f) How often do/did you have symptoms?  
Please choose one of the following:

Please tick one:

Daily	Weekly	Monthly	Quarterly	Half Yearly	Yearly	One Off	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**IF OTHER** (please specify)

g) Date of last attack / symptom:

h) How severe are / were attacks / symptoms? Mild  Moderate  Severe

i) Did you take medication or have you had any other treatment (eg. Physiotherapy or operation) for this condition? (Please Tick One)  Yes  No

**If Yes**, name the treatment/operation

j) Are you on treatment or still being treated? (Please Tick One)  Yes  No

**If Yes**, please describe the treatments(s):

k) Have you ever been off work for this condition? (Please Tick One)  Yes  No

**If Yes**, for how many Days?

From Date:

To Date:

**Doctor 1: Details**

l) State name and address of Doctor(s) consulted, and date of last consultation:

Name of Doctor

Address

**Doctor 2: Details**

m) State name and address of Doctor(s) consulted, and date of last consultation:

Name of Doctor

Address

**Part J - Duty of Disclosure**

**Please note that your duty of disclosure continues until cover is accepted.** Before you enter into a contract of life insurance with an Insurer, you have a duty, under the Insurance Contracts Act 1984, to disclose to the Insurer every matter that you know, or could reasonably be expected to know, is relevant to the Insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the Insurer before you vary or reinstate a contract of life insurance. Your duty however does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the Insurer;
  - that is common knowledge;
  - that your insurer knows or, in the ordinary course of business, ought to know;
- or**
- as to which compliance with your duty is waived by the Insurer.

**Non-disclosure**

If you fail to comply with your duty of disclosure and the Insurer would not have entered into the contract on any terms if the failure had not occurred, the Insurer may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, the Insurer may avoid the contract at any time. An Insurer who is entitled to avoid a contract of life insurance may, within 3 years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the Insurer.

**Part K - Declaration**

**I declare that:**

- I have read and understand my duty of disclosure and understand that this duty applies until formal notification of acceptance.
- My answers to the questions are true, and I have not deliberately withheld any information material to the proposed insurance.
- I agree to be bound by the terms and conditions set out in the Insurance Policy Document.
- I consent to the collection, use and disclosure of personal information by MetLife and its service providers in order to assess my application and any claim under the policy.
- I have read and understood the Privacy Statement and agree to the collection, use and disclosure of personal information as described.
- I consent to MetLife seeking medical information from any doctor who I have consulted.
- I understand that cover under a policy does not begin until acceptance by the insurer, of which I will be notified in writing.
- I have read the insurance section of the current Prime Super Product Disclosure Statement

**Signature**

Print Full Name

Date