Insurance application/ variation form

primesuper
surprisingly straightforward

Complete this form to:

- Apply for new cover or increase existing, Death only, Death & Total and Permanent Disablement (TPD) and/or Income Protection
- Alter your Income Protection insurance waiting period
- Change your occupation rating.

Please complete all relevant sections of the form as follows. If you are:

- Applying for or increasing your current insurance
  - You must complete Sections 1 through to 4, 6, and Sections A through to G and Member Declaration (as directed on the form).
- Applying to change your Income Protection waiting period
  - If you would like to decrease your waiting period you must complete Sections 1 through to 3, 5, 6, and Sections A through G and Member Declaration (as directed on the form).
  - If you would like to increase your waiting period you must complete Sections 2, 5, 6 and and Member Declaration
- Change of occupation rating
  - Complete section 1, 2, 3 and Member Declaration (as directed on the form)

Complete the form in pen using BLOCK letters. Print 'X' to mark boxes where applicable.

Please provide as much information as possible to assist us in processing your request. Before completing this form, ensure you read the relevant Member Guide and Product Disclosure Statement – Super, Health or Education Division (together referred to as the PDS or Member Guide) and your Member Statement to identify your current insurance cover with the fund.

1 Your Duty of Disclosure

Before you enter into a life insurance contract, you have a duty to tell the insurer anything that you know, or could reasonably be expected to know, may affect their decision to insure you and on what terms.

You have this duty until the insurer agrees to insure you.

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

You do not need to tell the insurer anything that:

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

If you do not tell us something

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

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

If the insurer chooses not to avoid the contract, they 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 them everything you should have. However, if the contract has a surrender value, or provides cover on death, the insurer we may only exercise this right within 3 years of entering into the contract.

If the insurer chooses not to avoid the contract or reduce the amount you have been insured for, they may, at any time vary the contract in a way that places them in the same position they would have been in if you had told them 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 the insurer is fraudulent, they may refuse to pay a claim and treat the contract as if it never existed.

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2 Your personal details

Member number

Surname

Title

Given names

Other/Previous names

Residential address

Town/Suburb/City

State

Postcode

Date of birth (DD/MM/YY)

Phone number

Mobile

Email

(Please ensure the email address provided is your personal address as we may send information of a sensitive and personal nature to it.)

Occupation

Employer

3 Changing your occupational ratings

! For Prime Super or Health Division members only

If you are in a low risk occupation, you may be entitled to be in White collar or Professional occupation category. These occupation categories offer a higher level of cover than the Standard occupation category. If you do not complete this section, or do not qualify for a White Collar or Professional rating, your occupational rating will be Standard.

What is your current occupation?

Your employment status ☐ Full-time ☐ Part-time ☐ Casual

What is the average number of hours you work in a week in your main occupation? hours

Please provide a brief description of your duties.

Please indicate below whether the following statements are correct.

White Collar

1. My usual work duties do not require me to perform duties of a manual nature. ☐ Yes ☐ No

2. My work duties are of a clerical, administrative or management nature. ☐ Yes ☐ No

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3 Changing your occupational ratings (continued)

3. My work duties are undertaken within an office environment for 80% of the time (excluding travel time between offices). If you answered Yes to all questions, you are eligible to be in White collar occupation category. ☐ Yes ☐ No

If you answered Yes to all questions, you are eligible to be in White collar occupation category.

Professional

In addition to the requirements set out under White Collar:

1. I hold a tertiary qualification relevant to my current occupation, or am a member of a professional institute, or am a senior member of my organisation's executive team. ☐ Yes ☐ No
2. I earn in excess of $100,000 per annum from my profession. ☐ Yes ☐ No

If you qualify for a White collar occupation category rating and answered Yes to statements 1 and 2 above, you are eligible for a Professional occupation category rating.

4 Applying for/Increasing your cover

1. Type of cover

Please indicate the type of cover/additional cover you are applying for.

☐ Death only (including terminal illness) ☐ Death & TPD ☐ Income protection

Do you want the cover received in this application to replace your existing cover? ☐ Yes ☐ No

(If you choose no, any cover received in this application will be in addition to your existing cover and any existing cover will be matched to your election. This means if you're applying for fixed cover any existing unitised cover will also be converted to fixed cover.)

2. Death only (including terminal illness) or Death & TPD

Please indicate whether you would like unitised or fixed cover (you cannot have a combination of both). Please refer to Section 8 of the PDS and the Member Guide for information on unit based cover vs fixed cover.

☐ Unitised cover **OR** ☐ Fixed cover

Note: You can apply for a maximum of $5 million Death only (including terminal illness) and $2.5 million for TPD insurance.

Unitised cover: Please insert the number of units of cover you require. (Refer to the PDS and Member Guide for details of the cover available).

Death only (including terminal illness) _____ units **OR**

Death & TPD cover _____ units

Fixed cover: Please insert the dollar amount of cover you require.

Death only (including terminal illness) $_____ **OR**

Death & TPD cover $_____

3. Income protection cover

What is your current gross monthly income? $_____ (Please refer to the Member Guide for the definition of income)

How much cover do you require per month? $_____ (You can only insure up to 85% of your monthly income. Maximum $30,000 per month.)

What waiting period would you like to apply for? (for new member IP applications only) ☐ 30 days* ☐ 60 days ☐ 90 days*

5 Changing your income protection waiting period

I want to reduce my waiting period to ☐ 30 days* ☐ 60 days

I want to increase my waiting period to ☐ 60 days ☐ 90 days*

*Not available to Education division members

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6 Insurance: member election to maintain insurance cover

A. In the event of future account inactivity

We are required to cancel your insurance cover if your account has been inactive for a continuous period of 16 months, and you have not made an election to maintain your insurance cover. Please refer to Section 8 of the relevant Member Guide for the division applicable to you for details on when this may occur.

☐ By ticking this box, you consent to maintaining your insurance cover in the event that your account becomes inactive for a continuous period of 16 months.

If you do not tick this box, we will be required to cancel all your insurance cover in the event your account is inactive for a continuous period of 16 months.

B. In the event that your member account balance is less than $6000

The Putting Members' Interest First legislation (PMIF), which took effect on 1 April 2020 requires the Fund to cancel insurance cover for members with balances of less than $6,000, unless you communicate to us in writing that you wish to keep your insurance cover.

☐ By ticking this box, you consent to maintaining your insurance cover in the event that your account balance is less than $6000.

If you do not tick this box, and have not elected to opt in to Default cover, we will be required to cancel all your insurance cover.

C. In the event that you are aged between 15 and 24 years

In addition, the PMIF legislation effective 1 April 2020 also requires that any new members joining Prime Super will not be allocated Default cover until they are at least age 25, unless:

- They apply to receive Default cover (subject to other rules of the super fund regarding when insurance cover is provided).

☐ Ticking this box also opts you in to receiving Default cover or request additional or increased cover over and above the Prime Super Default cover offering (subject to eligibility) even if you are under age 25 and/or have an account balance of less than $6,000.

7 Reducing/cancelling your existing cover

A. I want to reduce my current level of cover and require the following NEW units/level of cover. (Please note that the amounts you enter here will REPLACE your existing level of cover)

	Units of cover		Fixed cover	
Death only (including terminal illness)		units	$	
Death & TPD		units	$	
Income protection	Not applicable		$	per month

B. I want to opt-out of my insurance cover within Prime Super.

☐ I am a new Prime Super member and wish to opt-out of Default insurance. I understand that this means I will have no insurance in the Fund and any premiums I have paid will be refunded to my member account. I understand that by requesting this I am opting out of insurance from the inception of my account and that I will not be eligible to make any retrospective insurance claims. If at some point in the future I choose to take out insurance through Prime Super, my application will be subject to the standard underwriting process which may include the need to provide detailed health and medical information.

To be eligible for this option, you must cancel your cover within 60 days from the date on your Welcome Letter from Prime Super. If it is after the 60 day period, you can still cancel your default insurance cover but any premiums paid will not be refunded to your member account.

C. I want to cancel my insurance cover with Prime Super.

☐ I have been a member of Prime Super for longer than 60 days and wish to cancel the following insurance I hold with Prime Super. I understand that any cancellation I request will only be effective once my application has been received by Prime Super.

- ☐ Death only (including terminal illness)
- ☐ Death & TPD
- ☐ Income protection

Please go straight to Member Declaration.
The reduction/cancellation is valid from the date of the receipt of this form.

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A Your Details

1. What is your: Height cm or ft/in Weight kg or st/lb

2. Have you smoked tobacco, e-cigarettes or any other substance in the last 12 months?

Yes ☐ No ☐ If Yes, please indicate what you smoke

What is the average you smoke? per day or per week or per year

3. Do you drink alcohol? Yes ☐ No ☐

If Yes, please provide the average number of standard drinks consumed:

per day or per week or per year

A standard drink is 375ml of mid strength beer, 100ml of wine or 30ml of spirits.

B Personal Statement

1. 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 on a commercial airline), football, scuba diving, motor sports, trail bike riding or rock climbing? Yes ☐ No ☐

2. The next three questions are about life insurance*. You may have this cover as part of your super or you may have bought it separately.

a) Apart from this application, do you have or are you applying for any other life insurance*? Yes ☐ No ☐

b) Have you ever had an application for life insurance* turned down, been asked to pay higher premiums or had exclusions or special terms applied? Yes ☐ No ☐

c) Are you claiming or have you ever claimed a benefit from any source, e.g, TPD benefit, from any superannuation fund, Workers Compensation, Disability Pension, Veterans Affairs, TAC (Transport Accident Commission) or any other insurance policy providing accident or sickness benefits? Yes ☐ No ☐

* Life insurance includes cover which pays out if you die (Life cover), or if you get sick or seriously injured (Trauma, Total and Permanent Disability (TPD), Salary Continuance or Income Protection cover).

3. Have you ever had or received medical advice or treatment (including surgery) for any of the following conditions?

a) Chest pain, high blood pressure, raised cholesterol or any heart/ circulatory disorder? Yes ☐ No ☐

b) Stroke, paralysis, epilepsy, multiple sclerosis or any blood or neurological condition? Yes ☐ No ☐

c) Diabetes, hepatitis, or any condition of the thyroid, liver, kidneys, prostate or urinary bladder? Yes ☐ No ☐

d) Asthma, sleep apnoea, respiratory or any other lung condition (other than the common cold)? Yes ☐ No ☐

e) Any injury, disease or disorder of the back, neck, knee, shoulder or other joint, bone, muscle, tendon or ligament condition, including arthritis or gout? Yes ☐ No ☐

f) Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition? Yes ☐ No ☐

g) Cancer, tumour, melanoma, sun spot, mole or malignant growth of any kind? Yes ☐ No ☐

h) Hernia, gall bladder, bowel or stomach condition (other than constipation, upset stomach, diarrhea, or gastro where these were short, isolated episodes from which you have made a full recovery? Yes ☐ No ☐

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B Personal Statement (continued)

i) Any condition of the eyes causing visual impairment (partial or complete loss of sight that can't be corrected by glasses, contact lenses or laser eye surgery) or impaired hearing or tinnitus? Yes ☐ No ☐

4. a) In the last five years have you taken any illegal drugs or drugs that weren't prescribed for you? Yes ☐ No ☐

b) Has a doctor or healthcare provider told you to reduce or stop drinking alcohol, or have you received counselling or treatment for alcohol, substance or drug use? Yes ☐ No ☐

c) Have you been infected with the Human Immunodeficiency Virus (HIV) or tested positive for Acquired Immune Deficiency Syndrome (AIDS)? Yes ☐ No ☐

d) In the last 5 years have you engaged in any activity reasonably expected to having an increased risk of exposure to the HIV/AIDS virus? (This includes unprotected anal sex, sex with a sex worker or sex with someone you know, or suspect to be HIV positive)? Yes ☐ No ☐

5. a) Apart from any condition you have already disclosed, are you currently off work due to injury or illness, or restricted from being capable of performing your full and normal duties on a full time basis (for at least 30 hours per week), even if your actual employment is on part-time or casual basis? Yes ☐ No ☐

b) Apart from any condition you have already disclosed, have you been unable to work because of injury or illness (excluding pregnancy) for more than two consecutive weeks in the last 3 years? Yes ☐ No ☐

6. This question is about your family's medical history. As far as you know, has your mother, father, sisters or brothers had any of the following (please select all that apply):

a) Heart or circulatory problems, stroke, cardiomyopathy, diabetes? Yes ☐ No ☐

b) Depression or any other mental illness? Yes ☐ No ☐

c) Cancer of any type? Yes ☐ No ☐

d) Huntington's disease, muscular dystrophy, MS (multiple sclerosis), polycystic kidney disease, Parkinson's disease or any other inherited blood or neurological disorder? Yes ☐ No ☐

! Only complete if you answered **Yes** to any part **question 6** of **Section B – Personal Statement**

Please complete the table below:

Family member	Condition – if cancer please state type	Age diagnosed

7. Except for holidays, do you intend to live or travel anywhere outside Western Europe, North America, Australia or New Zealand in the next 12 months? Yes ☐ No ☐

Before answering these questions you may wish to check the Smart Traveller website: www.smarttraveller.gov.au

If Yes please provide details below:

Country/destination	Date of departure from Australia (if applicable)	Date of return/arrival in Australia	Reason for travel

For each **Yes** answer you must complete a corresponding questionnaire as noted in the column beside your **Yes** answer above. Proceed to relevant questionnaire in **Section C**.

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C Questionnaire A – Pastimes

Only complete if you answered **Yes** to **question 1** of **Section B – Personal Statement**

1. Do you engage in any high risk sports or activities:

a) Aviation (other than as a fare paying passenger on a commercial airline)? Yes ☐ No ☐

b) Underwater diving (scuba)?

If Yes

i. do you dive at more than 40 metres, or engage in cave, nitrox or wreck diving? Yes ☐ No ☐

ii. do you dive alone? Yes ☐ No ☐

c) Football of any code (other than touch or Oztag)? Yes ☐ No ☐

d) Motorised sports of any kind, e.g. motor cross, rally driving, ocean racing, motor car or bike racing? Yes ☐ No ☐

e) Trail bike or quad bike riding (including off road and dirt bike)? Yes ☐ No ☐

f) Any other sport or hazardous activity, e.g. parachuting, hang-gliding, body contact sports, para-gliding, competitive water sports, horse riding, abseiling, mountaineering or recreations involving heights? Yes ☐ No ☐

If you have answered Yes to any of the above questions, please answer the following questions:

What are the activity(ies) you engage in?

At what level do you participate? (tick ✓ the appropriate box)

Recreational only (non competition) ☐

Recreational with competition ☐

Semi-professional/professional ☐

Number of times you participate on average in this activity(ies) per annum, e.g. hours flown, number of dives, events?

Do you receive income from participating in this activity(ies)? Yes ☐ No ☐

If Yes, please provide full details

C Questionnaire B – Insurance history

Only complete if you answered **Yes** to any part of **question 2** of **Section B – Personal Statement**

1. Apart from this application, do you have or have you recently applied for life, total and permanent disability, trauma, income protection or salary continuance on your life with TAL or any other insurance company? Yes ☐ No ☐

If Yes, please provide details below:

Insurance company	Type of cover	Insurance benefit	To be replaced?		Date commenced
		$	Yes	No	/ /
		$	Yes	No	/ /
		$	Yes	No	/ /

2. Have you ever had an application for life, total and permanent disability, trauma, or salary continuance on your life turned down, been asked to pay higher premiums or had exclusions or special terms applied? Yes ☐ No ☐

If Yes please provide details below:

Insurance company	When was the decision made on the application?	Terms offered and reason

3. Are you claiming or have you ever claimed a benefit from any source, e.g. TPD benefit, Workers Compensation, Disability Pension, Veterans Affairs, TAC (Transport Accident Commission) or any other insurance policy providing accident or sickness benefits? Yes ☐ No ☐

If Yes please provide details below:

Benefit type/source/reason for claim	Date commenced	Claim amount	Date finalised
	/ /	$	/ /
	/ /	$	/ /
	/ /	$	/ /

C Questionnaire C – Joint/musculoskeletal

Only complete if you answered **Yes** to **question 3e** of **Section B – Personal Statement**

1. Nature of complaint (doctor's diagnosis), e.g. sciatica, back pain, broken bone.

2. Location of complaint, e.g. lower back, right knee, sciatic nerve.

3. When did your symptoms first begin?

4. Cause of condition, e.g. lifting, car accident, fall in workplace, unknown.

C Questionnaire D – Mental health

Only complete if you answered **Yes** to **question 3f** of **Section B – Personal Statement**

1. Please provide details of your condition (doctor's diagnosis):

2. Please indicate the reason or cause by ticking the appropriate box(es):

- ☐ Bereavement/family illness
- ☐ Marital problems
- ☐ Post natal
- ☐ Work related
- ☐ Other (please specify)

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C Questionnaire C – Joint/musculoskeletal (continued)

5. Was an x-ray or scan taken? Yes ☐ No ☐

If Yes, please complete the details below:

Date of your most recent test

/ /

Details of results of tests taken:

6. Is the nature of your condition degenerative or a disc problem? Yes ☐ No ☐

7. Are you still undergoing treatment or experiencing symptoms? Yes ☐ No ☐

If No, please complete the details below:

Date your symptoms ceased

/ /

Date your treatment ceased

/ /

8. Have you been off work as a result of this complaint or been unable to perform your normal day to day activities? Yes ☐ No ☐

If Yes, please indicate period(s) off work:

9. Do you have any residual, ongoing effects or restrictions as a result of this condition? Yes ☐ No ☐

If Yes, please provide dates and details:

10. Is your treating doctor different from your usual doctor? Yes ☐ No ☐

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State Postcode

Phone number

( )

Fax number

( )

C Questionnaire D – Mental health (continued)

3. Date symptoms first commenced:

/ /

4. Have the symptoms ceased? Yes ☐ No ☐

If Yes, please provide the date symptoms ceased:

/ /

5. Have you taken or are you taking medication? Yes ☐ No ☐

If Yes, please provide details

Type of medication	Dosage	Date ceased (if not ongoing)
		/ /
		/ /
		/ /

6. Have you attempted suicide or had suicidal thoughts? Yes ☐ No ☐

7. Have you ever been hospitalised? Yes ☐ No ☐

If Yes, please indicate period(s) hospitalised:

8. Did the condition ever cause you to take time off work? Yes ☐ No ☐

If Yes, please indicate period(s) off work

9. Has your ability to perform daily activities been restricted in any way? Yes ☐ No ☐

If Yes, please provide dates and details:

10. Is your treating doctor different from your usual doctor? Yes ☐ No ☐

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State Postcode

Phone number

( )

Fax number

( )

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C Questionnaire E – High blood pressure/ Raised cholesterol

Only complete if you answered **Yes** to **question 3a** of **Section B – Personal Statement**

1. Name of condition

   High blood pressure ☐

   Raised cholesterol ☐

2. When were you first diagnosed with this condition?

3. Do you have any problems or complications resulting from this condition? e.g. heart disease, chest pain? Yes ☐ No ☐

   If Yes, please provide details, including dosage:

4. Are you taking regular medication for this condition? Yes ☐ No ☐

   If Yes, please provide details, including dosage:

5. High blood pressure
   When was your last blood pressure reading?

   / /

   Was it considered to be well controlled, e.g. less than 140/90?

   ☐ Yes ☐ No ☐ Don't know

   Raised cholesterol
   When was your last cholesterol reading?

   / /

   What was the result of your last cholesterol reading?

   ☐ 2.0 to 6.5 mmol ☐ 6.6 to 7.5 mmol

   ☐ 7.6 or above ☐ Don't know

C Questionnaire F – Cysts, moles, sunspots or skin lesion

Only complete if you answered **Yes** to **question 3g** of **Section B – Personal Statement**

1. Please provide type:

   ☐ Cyst

   ☐ Mole

   ☐ Sunspot

   ☐ Skin lesion

   ☐ Melanoma

   ☐ Basal cell carcinoma

   ☐ Other (please specify)

2. Location of growth(s)

   ☐ Face/head

   ☐ Back/shoulder

   ☐ Chest/front

   ☐ Arm/leg

3. When was this?

4. Was/were the growth(s) removed? Yes ☐ No ☐

   If Yes, please complete below:

   When was it removed?

   / /

   How many growths were removed?

   Method of removal:

   ☐ Frozen/burnt off

   ☐ Surgical/cut out

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C Questionnaire E – High blood pressure/ Raised cholesterol (continued)

6. Is your treating doctor different from your usual doctor? Yes ☐ No ☐

If Yes, please complete the details below:

Name of doctor

Doctor's Address

Phone number

( )

Fax number

( )

C Questionnaire F – Cysts, moles, sunspots or skin lesion (continued)

5. Was/were the growth(s) reported as cancerous (malignant)? Yes ☐ No ☐

If Yes, were any further tests, investigations, treatments, follow up or re-excision required? Yes ☐ No ☐

If Yes, please provide dates and details of further tests, investigations, treatments, follow up or re-excision: Yes ☐ No ☐

6. Is your treating doctor different from your usual doctor? Yes ☐ No ☐

If Yes, please complete the details below:

Name of doctor

Doctor's Address

State

Postcode

Phone number

( )

Fax number

( )

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D General health

If you have answered **Yes** to any part of **Section B**, please complete the table below:

Details for question number:	Question ( )	Question ( )	Question ( )
1. Name of injury, illness, condition or tests?			
2. Date symptoms first started?			
3. Date symptoms ceased (if applicable)?			
4. Are these symptoms singular, recurrent or ongoing?			
5. How often do/did you have symptoms? Please choose one of the following: daily, weekly, monthly, quarterly, half yearly, one off, other (please specify).			
6. Severity of symptoms? Please choose one of the following: mild, moderate, severe, never had symptoms, symptoms ceased.			
7. Did you take medication or have any other treatment for this condition? If Yes please give details of the medication/treatment.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Are you still on treatment, including medication?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. Have you ever been off work as a result of this condition? If Yes, please indicate the total time off work.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10. Do you have or have you had any residual, ongoing effects or restrictions as a result of this condition?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
11. Have you ever had an x-ray, scan or blood test for this condition?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
12. Is your treating doctor different from your usual doctor? If Yes, please provide the doctor's name and contact details.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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E Your personal information privacy

Your privacy as a member of Prime Super

The information you provide in this form is collected by and held for Prime Super by the fund Administrator, in accordance with the Australian Privacy Principles of the *Privacy Act*. Such information is usually disclosed to third parties, including the Insurer or medical consultant who may be involved with the assessment of this application, and is held by the fund Administrator and the Insurer. For further information about privacy or to obtain a free copy of our Privacy Policy, please visit our website primesuper.com.au or by contacting customer service on 1800 675 839, write to us at Locked Bag 5103, Parramatta, NSW 2124 or email us at administration@primesuper.com.au.

Your privacy and the Insurer

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 and sensitive information is set out in the TAL Privacy Policy available at https://www.tal.com.au/Privacy-Policy or free of charge on request to TAL by telephoning 1300 209 088.

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).

These sections must be completed in all circumstances

F Telephone underwriting

The telephone underwriting facility reduces the need for follow-up information and medical reports, resulting in faster completion.

I permit the insurer (TAL) to call me (the life to be insured) to clarify or gain further information regarding any matter pertaining to the assessment and processing of this application. I understand that the call will form part of my Duty of Disclosure as described in Section 1.

Yes ☐ No ☐ If Yes, I am contactable on the following number ( )

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G Your doctor's details

In the event that we require further medical information, we require the contact details of your usual GP/doctor.

Name of doctor

Doctor's address

Town/Suburb/City | State | Postcode

Phone number | Fax number

( ) | ( )

If you have been a patient of this doctor for less than 12 months, please provide details of your previous doctor/medical centres:

Name of doctor

Doctor's address

Town/Suburb/City | State | Phone number

( )

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Member declaration

I have read the duty of disclosure in this Personal Statement and I am aware of the consequences of non-disclosure.

I understand that the duty of disclosure continues after I have completed this statement until my application for cover has been accepted by TAL Life Limited ABN 70 050 109 450 (TAL) in writing.

I authorise:

- the insurer to refer any statements that have been made in connection with my application for cover and any medical reports to other entities involved in providing or administering the insurance (for example reinsurers, medical consultants, legal advisers)
- the insurer and any person appointed by the insurer to obtain information on my medical claims and financial history from the Insurance Reference Association and any other body holding information on me
- any hospital, doctor or other person who has treated or examined me to give to TAL any information on my illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical reports

I agree to provide further medical authorities if requested.

I declare that:

- the answers to all the questions and the declarations in this Personal Statement are true and correct (including those not in my own handwriting);
- I have not withheld any information which may affect TAL's decision to provide insurance
- I acknowledge that the answers I have provided, together with any special conditions, will form the basis of the contract of insurance
- Being a Prime Super or Prime Super Health Division member, I acknowledge that if I am increasing my cover through a change in occupation category, then my cover is Limited Cover for the increased amount for 24 months and will remain until I have been in Active Employment for 30 consecutive days after the end of the initial 24 month period
- I agree to be bound by the terms and conditions set out in the Insurance Policy Document (between Prime Super and the Insurer)
- I have read and understood the "Your personal information privacy" in Section E. I acknowledge and consent to the collection, use and disclosure of my personal information as outlined in that section
- I have read and understand the obligations outlined in the "Your Duty of Disclosure" in Section 1.
- I agree that a photocopy or an electronically transmitted image of this authorisation shall be considered as effective and valid as the original signed authorisation.

Full name

Signature of life to be insured

Date of signature (DDMMYY)

Please ensure that you initial any amendments or changes made throughout this form

Return this form to us via mail, email or fax.

mail Prime Super
Reply Paid 85860
PARRAMATTA NSW 2124
No stamp required

email administration@primesuper.com.au
fax 1800 023 662
visit primesuper.com.au
or call 1800 675 839

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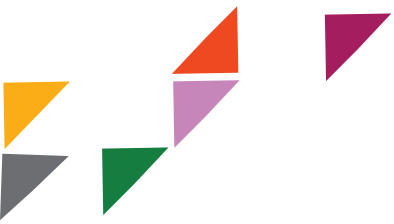

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